South West London Primary Care Organisation
Personal Medical Services (PMS) pilot

King's Fund Evaluation Report
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- a "snapshot" of clinical quality is provided through an audit of angina management in the pilot's third year

Key findings

- The pilot has set up a new model of providing primary care by working collaboratively as a group of seven practices, and formalised this by the formation of an overarching partnership.

- The first-wave pilot has, together with 12 second-wave pilot practices, formed one of the first Primary Care Trusts (PCTs) in the country (and one of the first to use PMS across an entire PCT). Learning from this model is likely to be invaluable as PCTs develop across the country.

- The practices feel confident that they are providing high quality primary care to their practice populations. Patient satisfaction levels recorded on the GPAS survey were lower overall than National Evaluation PMS and non-PMS control practices. However, it is worth noting that none of the National Evaluation PMS pilot practices were based in London, although some of the non-PMS practices were. Practice Profile questionnaire and Angina Audit scores overall were higher in the SWLPCO, in some cases markedly so, than in National Evaluation PMS and non-PMS practices, suggesting that for the domains of care measured by these tools at least, the practices were providing high quality services.

- Health authority staff feel that changes in the pilot have focused on organisational change rather than delivering visible quality improvements, and this view appears to be confirmed by the data collected. Patient satisfaction in general, measured by GPAS, has not increased during the time between the two surveys. Several of the achievements of which practice staff are most positive – such as the integrated nursing teams and the intermediate care project - are developments that were initiated by the TPP and maintained under PMS.

- There is some disappointment that more progress has not been made to date by the pilot, and a sense that much time has been lost in debating the geographical configuration of local Primary Care Groups (PCG) and the pilot's potential fit with these.

- Practice staff have found closer inter-practice working, (first developed under fundholding, continuing through the TPP, and now being built on as a PMS pilot and a PCT), to be extremely beneficial. However, it is clear that in the early stages of the pilot, nurses and practice managers in particular, were less engaged in the PMS pilot process than the lead GPs who sat on the management board of the pilot, and who made most of the key decisions.

- Key stakeholders have described an 'us and them' situation locally between the pilot and neighbouring practices. The tension, due to a belief that PMS pilots were being more favoured financially than equivalent GMS practices, has been a common finding from the other three London PMS pilots taking part in the King's Fund evaluation. As in the other pilots, relationships have improved over time as the pilots have become embedded in their local health economies.

Conclusion

The SWLPCO have assessed themselves to be providing high quality primary care, and have scored highly on practice profile and chronic disease management measures. It is worth considering the extent to which this level of quality is due to a 'PMS effect'. On the basis of this evaluation, and on findings from other London PMS pilots involved in the King's Fund evaluation, the answer would appear to be 'not yet'. There has been some disappointment about the slow progress of the pilot and a sense of regret that development had been waylaid by other events. However, there was a feeling that the pilot, which had previously been described as 'treading water', was now beginning to re-energise. The PMS pilot was seen as a crucial stepping stone towards PCT status. The original seven first-wave practices are now part of a whole-PMS PCT, and the experiences of the last three years will provide valuable learning for primary care development.

Introduction to the South West London Primary Care Organisation PMS pilot

The South West London Primary Care Organisation (SWLPCO) is a large multi-site practice. It was originally made up of eight practices with 44 GPs and 12 surgeries, serving a population of 81,000 patients in three London boroughs (11.5% of the residents of Merton, Sutton and Wandsworth). Although some of the eight practices covered geographical areas with significant levels of deprivation, taken as a whole, the level of social need in the PMS pilot area was described as 'average' when compared with national figures. The practices originally formed a Total Purchasing Pilot (TPP) and provided general medical services (GMS) independently of one another. The main achievements of the TPP were described as follows:

- Setting up self-managed nursing teams in each of the practices – made up of practice nurses, nurse practitioners, district nurses and health visitors
- Introducing intermediate care services to provide an alternative to hospital admission for up to 24 patients at a time, 24 hours a day, seven days a week.[1]

A PMS pilot bid was put together in 1997 by the eight TPP practices in order to address the four key problem areas they had identified:[2]

- The level of access to secondary care services
- The capacity of the practices to adequately focus on the management of chronic diseases
- The level of integration with community based care and social services
- The level of administration within the practices

The aims and objectives of the PMS pilot were:[2]

- To improve the quality and range of Personal Medical Services provided for patients by developing new models of delivering primary care services
- To improve the level of patient access to secondary care services through greater integration of services
- To develop integrated pathways for the management of chronic conditions
- To improve the integration of practice-based and community-based services particularly in providing services to the mentally ill and older people
- To reduce the level of administration in general practice

The PMS pilot was given permission by the Secretary of State for Health to go live in April 1998 – the only PMS pilot in the Merton, Sutton and Wandsworth health authority area. The formation of the PMS pilot was complicated by difficulties in agreeing Primary Care Group (PCG) configuration in the area, and one of the eight practices, in Wandsworth, left the PMS pilot at the end of the first year for this reason. The remaining practices formalised their *de facto* partnership by applying to

[1] South West London Primary Care Organization, PMS pilot network launch document, 1998
[2] South West London PMS plus pilot, the South West London Total Purchasing Project (SWLTPP): Application for a Personal Medical Services pilot under the NHS (Primary Care) Act, 1997. PHD, 1997.

become the largest single GP partnership in the country.[3] In April 2000, the Nelson PCG, in which the PMS pilot was situated became one of the first primary care trusts – the Nelson and West Merton PCT, and in July 1999 the remaining 12 GMS practices in the PCT area (with a combined population of 57,500 people) heard that they had been successful in their application to become a second wave PMS pilot.

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.[4] A first wave of 83 PMS pilots 'went live' in April 1998.[5] A second wave, which went live between October 1999 and April 2000, increased the number of pilots to nearly 300[6] 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.[7] 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.[8]

[3] Dunne, Ray. Into the age of the GP super-practice. Doctor, 10 December 1998, pp43-44.
[4] Department of Health. Personal medical services pilots under the NHS (Primary Care) Act 1997: a comprehensive guide - second edition. London: NHSE, 1998.
[5] 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.
[6] Department of Health press release 99/0520. 32 new pilots takes total to nearly 300: additional personal medical services pilots announced. 1999.
[7] Department of Health press release 2000/0724. Local doctors and nurses voting with their feet for reform. 2000.
[8] Great Britain. Parliament. The NHS Plan: a plan for investment, a plan for reform. London: Stationery Office, 2000.

Practice characteristics

The seven first wave PMS pilot practices are all group practices. The numbers of patients registered at each practice and the numbers of doctors and practice nurses employed are given in Table 1 below.

Table 1: Practice list sizes and staffing (clinical posts)

	Benhill Belmont	Cannon Hill Lane	Cheam Family	Morden Hall	Stonecot Surgery	Tod Practice	Wrythe Green
No of patients registered (Jan 2001)	9,340	*	10,093	12,655	8,640	*	11,880
No. of GP principals (wte)	4	*	5.75	6	4	*	6
No. of additional GPs: registrars, assistants, retainees (wte)	1.4	*	1	2	1.25	*	2.2
No. of nurse practitioners (wte)	0	*	0	0.5	0.75	*	0
No. of practice nurses (wte)	2	*	2.25	2.79	1.3	*	2.6
No. of vacant practice nurse posts (wte)	0	*	0	0	0	*	0.4

Wte = whole time equivalent
* information not provided

Evaluation

Evaluation is a key component of the PMS process – all pilots are expected to carry out a local evaluation of the services they provide, at a scale relative to the size and complexity of the project. In addition, the Department of Health has commissioned a national evaluation,[9] co-ordinated 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 (GPAS), audit of chronic disease management and a descriptive questionnaire of practice characteristics (see table below). Where appropriate, we have used the same research tools as those used in the National Evaluation (marked * below), to allow us to compare the results of the four London PMS pilots taking part in our evaluation with a larger sample of PMS pilots nationally.[10]

	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	×	Sep 00	Mar 00	April 00
Registration questionnaire	×	×	Spring 99	×

[9] 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.

[10] 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 SWL PCO PMS pilot

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

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

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 3: Interviews carried out at the SWLPCO PMS pilot

	Year 1	Year 2	Year 3	Total
Practice interviews (incl project lead)	33	11	12	56
Health authority interviews	3	2	1	6
'other' interviews	-	2*	1*	3
Total	36	15	15	65

(* 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 set up from scratch and we carried out the audit as late as possible in our 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 provide us with 20 patients with a diagnosis of angina – Lambeth was unable to provide us with 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 (NPCRDC) 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, which are not used in the calculation of the nine scale scores – these relate to referral, co-ordination, likelihood of recommendation of GP to family and friends, overall satisfaction and a number of socio-demographic questions. Scale scores are calculated from the results recorded in each scale – a minimum number of items must have been recorded (normally half) for an item to be calculated. If there are insufficient scores recorded for any scale, then the scale as a whole is listed as missing. In all scales, the possible range of scores is 0-100 – interpreted as the percentage of the maximum possible score. GPAS is only available in English at present, and therefore is unsuitable for use by those patients who do not understand written English. A study testing the psychometric properties of GPAS has assessed it as being a useful and reliable instrument for assessing a number of dimensions of primary care.[11]

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 South West London, the questionnaires were sent out in November 1998 to 200 randomly selected patients aged 16 and over, who had been registered for more than 12 months at each of the seven practices. A reminder letter to non-responders was sent in February 1999. The second round of questionnaires was sent out in September 2000, with reminders sent to non-responders in October. The overall response rate in the practices to the second round of GPAS ranged from 32% to 65%, with a mean response rate of 57.1%. This response is comparable with a 56.4% response rate to the *1998 National Survey of NHS Patients: General Practice*[12] in Merton, Sutton and Wandsworth and a slight improvement on the response rate in the seven practices for the first round of GPAS, of 54.4%. The full results of the second round of GPAS in South West London are given in Appendix 5.

Comparative data from the National Evaluation GPAS study of 23 PMS pilot practices (making up 19 PMS pilots) and 23 comparator practices is referred to in this report. The National Evaluation GPAS study differed slightly from the King's Fund use of GPAS. In our study, questionnaires were sent to patients aged 16 and over, whereas in the National Evaluation, GPAS was sent to patients aged 18 and over. We sent one reminder to non-responders, while the National Evaluation study sent two reminders to all but one of the participating practices.

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

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[11] 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.

[12] National Survey of NHS Patients: General Practice 1998. Department of Health, London. 1999.

be assessed.[13] The indicators, all of which have been validated, assess the following areas of care:

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

We sent out the Practice Profile Questionnaire 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. We hoped that this would provide us with 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 four 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 SWLPCO PMS pilot was to improve the services the practices provided to patients with mental illness, and we used this as a theme for our focus group discussion. In addition to two members of King's Fund staff, five key stakeholders involved in the initiation of the mental health project in South West London 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. We did not replicate the use of this questionnaire at our other three PMS pilot sites.

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

The Findings

The main findings from the interviews we carried out in South West London in the first year have already been reported (Appendix 8). The main themes, which emerged, can be summarised as follows:

- Our first year interviews were carried out at a time of great uncertainty within the pilot. A number of options for the configuration of PCG boundaries in Merton, Sutton and Wandsworth were being discussed, and it was not certain that the eight practices would be able to stay together.
- PMS was seen as a logical extension of the TPP, and it was planned that the original PMS option of taking on unified budgets would be utilised. Unified budgets were subsequently dropped from the PMS legislation.
- PMS was viewed by the pilot as being a step towards a single integrated primary care organisation, although PCTs had not yet become government policy.
- The pilot was keen to move away from the National GP Contract towards a local contract in which remuneration would follow the improved quality of care within the practices.
- There was some questioning about whether there really had been a choice to move towards PMS pilot status – as one GP noted "....this is a natural evolution from fundholding – having started on that road, there's no turning back".
- Staff in the practices were generally supportive about the move to PMS, although levels of understanding were highest overall amongst lead GPs, and less so amongst the nurses and practice managers we interviewed.
- Staff felt that they had taken a risk in choosing the PMS option for their practices, and there were concerns that, as one practice manager said "the health authority may pull the rug from under us".
- The view from the practices was that the health authority was being 'obstructive' in their approach to the pilot. The health authority however, maintained that they were supporting the pilot, but had concerns about the direction the pilot might lead them in and questioned whether they could deal with "one hundred flowers blooming" on their patch.
- In common with the other three PMS pilots taking part in the King's Fund evaluation in London, practice staff felt that the pilot was viewed with antagonism and as a threat to neighbouring GP practices – with a perception nationally that the PMS practices were 'scabs' for moving out of GMS, and locally that they were 'non-sharing, exclusive and especially favoured by the health authority'.
- Practice staff felt that their morale, in general, was high, although many found the PCG configuration discussions unsettling and upsetting. Uncertainty was expressed by nurses and practice managers in particular, about the long-term impact of the PMS pilot on their job-security.
- Apart from the 'big flurry of activity' at the outset of the project, and the 'rush' to get the contract signed, there was recognition that any changes brought about as a result of moving to pilot status would not begin to emerge immediately. The project lead summed this up by stating that he would "...just be pleased to get things off the ground in year one, but by the end of year three, we should see some improvements in the quality of service provision".

The themes arising from the various methods of data collection over the three years of the evaluation include the following topics:

- Local contracting
- Quality of care
- Inter-practice and partnership working
- Relationship with other organisations
- Roles
- Workload

The rest of this report considers the developments that have taken place in the PMS pilot under the above headings, together with overall conclusions.

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. When we interviewed in year one, the SWLPCO PMS pilot contract mirrored GMS with little evidence that the flexibilities produced under PMS had been used. This finding was common to many first wave pilots.[14] In the second year, the contract had been altered, to become, in the words of the health authority, 'more adventurous':

> ***(the contract is)*** **completely rewritten with more reflection. It's simpler, more streamlined (PCT, year 2)**

> **The quarterly payment system will stop – it'll be monthly payments and we are moving on trying to achieve a global annual payment and we will work out how to divide it internally between the practices, and that's very complex, but that's what we're aiming to do. And within that, of course, you'll lose a lot of the bureaucracy around writing the services claims and so on. It's payment for a complete service as opposed to an item of service (practice, year 2)**

> **.....what we've done is we've tied quality to clinical governance, so the contract now requires compliance with clinical governance. Now, that in itself is a relatively minor change, *(but)*.....it effectively allows the PCT to commission primary care that meets clinical governance standards, and that means different things for different practices (PCT, year 3)**

At the health authority, there was a feeling that the difficulties in configuring the PCG had meant that changing the contract had not occurred as quickly as they would have been hoped:

> ***....(it)*** **felt difficult to pursue the agenda with the vigour we would have liked..... (health authority, year 2)**

[14] 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.

In addition, staff at the health authority found the responsibility of writing a brand new contract worrying:

> **.....*(it)* felt like no maps no rules, no boundaries and it could be a highly risky area with profound national consequence. It feels odd that this level of flexibility exists given the importance. The health authority feels quite nervous about proceeding without legal advice – and setting benchmarks with no sense of whether these are reasonable..... (health authority, year 2)**

They were also concerned that, with high levels of uptake of PMS in Merton, Sutton and Wandsworth, there would be a significant impact on their ability to monitor quality:

> **One of the impacts on the health authority (or a PCT) is the level of monitoring that it will require. We've worked out that if we have a quarterly meeting with each practice – it *(has)* much more significant impact on the health authority than ever GMS did (health authority, year 3)**

The impact on the practices in year three was described by the health authority as being about 'much more organisational change than patient benefit change'. The practices felt that such organisational change had been of benefit to them:

> **Cash flow, it's made a *huge* difference – the money comes monthly, instead of three monthly in arrears (practice, year 3)**

However, some of the practices were concerned about the equity of inter-practice funding:

> **Particularly for here, thinking about the historical advantages of the big practices – this just carries on. We've only got four partners, the big ones have seven. We're having to work quite hard to try and preserve our income when the contract was devised (practice, year 3)**

In fact, two of the larger practices described a situation where there had been a 'levelling down' of services, such as physiotherapy and bereavement counselling:

> **There's been a feeling that all the advancements of TPP (we were a winner under this – our practice manager was a good negotiator) haven't continued (practice, year 3)**
>
> **The funding for our assistant was stopped – because we had one and others didn't. We can't do any more unless funding follows (practice, year 3)**
>
> **This practice had an awful lot under fundholding – we haven't really progressed any further (practice, year 3)**

The SWLPCO first wave PMS pilot, together with the second wave PMS pilot make up all the practices within the Nelson and West Merton PCT. The project lead felt that this kind of structure was important for the operation of their PCT:

> **All practices in the PCT are now PMS. I think it's the right contracting framework for primary care. I think it is fundamentally right in the context of PCTs, that PCTs commission primary care via PMS. If you don't have PMS, PCTs are fairly impotent in terms of managing primary care. Conceptually it's the right structure (PCT, year 3)**

However, it was felt that the rigorous application of a core contract might stifle local innovation:

> **The real danger is we'll end up with just as much legislation/regulation around PMS as we do around GMS – the book of rules is looking horrendously thick. So the danger is that they'll keep trying to control it and it'll end up no more advantageous than GMS.....(PCT, year 3)**

And there was some concern in the practices that perhaps PMS wasn't as different from GMS as they had initially hoped:

> **....there's no rocket science in PMS, it's just GMS under a different name. Quality issues are now core for everybody for example, clinical governance and revalidation. Quality isn't just a key issue of PMS – others do it too (practice, year 3)**

Notwithstanding the concern that the contractual forms for PMS may simply replicate GMS, the pilot also introduced an additional "accountability framework". This framework, among other things specified:

- a Steering Group involving membership from a wide range of stakeholders
- an annual business plan
- incorporation of views of patients

Quality of Care

When we interviewed in year one, the practices felt that they were already providing high quality primary care. Stakeholders in the practices highlighted the intermediate care project as an area where quality improvements for patients had been made:

> **The patients are much happier with the intermediate care beds, particularly the elderly (practice, year 2)**

However, the intermediate care project arose from the TPP work, and there was no substantive evidence that PMS had any direct impact on the intermediate care work.

It was hoped that the introduction of the pharmaceutical advisor and the setting up of the mental health project would improve quality in these areas further, and while the focus group and interviews provided some useful information about the mental

health project, the role of the pharmaceutical advisor was not mentioned by interviewees.

By the time we interviewed in year three, a number of respondents questioned whether PMS really had influenced quality to any great degree, and felt that quality was:

> **....pretty much the same as before – we've maintained our good clinical services (practice, year 3)**

There was a feeling though, that the way in which quality was *thought* about had changed for the better:

> **.....there is now a group of seven practices who work closely together. There's quite a feeling of being able to think about improving quality and delivering services. Because of these dialogues between us – this bolsters morale and improves care and lets you think in a structured way (practice, year 3)**

> **I think it's made us more aware of quality. I mean, I think we're dealing with a number of practices that basically are fairly high performing anyway. I think what we're becoming is increasingly aware of the *nature* of quality and how do you measure it and how do you make it visible (PCT, year 3)**

In addition to the self-reported views on service quality, we used three additional data collection methods to assess more objectively the quality of care provided in the practices – the Angina Audit, the Practice Profile Questionnaire and GPAS, a patient satisfaction questionnaire.

The Angina Audit

The results of the angina audit are given in Table 4 below, and show that although the practice scores vary quite widely, all but one of the practices score more highly, often markedly so, than the five national evaluation PMS pilot practices and controls. This suggests that in relation to these aspects of disease management, the pilot as a whole provides a relatively high quality of care. As the table shows, one practice (Stonecot surgery) recorded a significantly lower mean score than the others. It is not clear why this should be and this suggests that further investigation by the practice and the pilot would be beneficial.

Table 4: Angina Audit results for SWLPCO PMS pilot

Practice	Mean score	Sample size	Std. deviation	Min score	Max score
Benhill and Belmont	66.96	20	20.06	20	92
Cannon Hill Lane	63.88	12	18.68	22	90
Cheam Family Practice	61.07	11	20.12	33	90
Morden Hall	82.03	19	11.35	55	100
Stonecot Surgery	42.33	15	15.12	20	73
Tod Practice	83.25	10	8.54	70	100
Wrythe Green Lane	60.86	16	23.63	18	100
SWLPCO total	65.80	103	21.49	18	100
King's Fund PMS practices (n=11)*	67.8659	1454	20.7482	18	100
National evaluation PMS pilots (n=5)	55.6	78	18.26	24.46	84.7
National evaluation controls (n=5)	62.5	100	25.14	25.42	95.42

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

Practice Profile Questionnaire

The results of the Practice Profile questionnaire are given in Table 5 below. They show that, in the SWLPCO, organisation and chronic disease management scales have improved or stayed the same between the first and second data collection rounds, but scores on the access and prescribing scales appear to have fallen. However, missing data were recorded for one of the practices on the prescribing scale, which could account for the apparent fall on this scale. In addition, questionnaires were sometimes filled in by different members of staff in the first and second rounds of data collection, which may have led to differences in recording, rather than actual differences in quality in the practices. Compared with National Evaluation data for year two, the SWLPCO scored more highly on all scores than the national sample of PMS pilot practices. The results for all scales are high, with little variability between the seven SWLPCO practices, and it would appear that this is a relatively insensitive tool with which to measure variation between practices.

Table 5: Practice Profile questionnaire results for SWLPCO 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
	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1	Yr 2
Benhill and Belmont	100.0	100.0	75.0	50.0	80.0	100.0	72.7	90.9
Cannon Hill Lane	100.0	-	100.0	-	80.0	-	81.8	-
Cheam Family Practice	100.0	100.0	100.0	100.0	100.0	*60.0	81.8	81.8
Morden Hall	-	100.0	-	100.0	-	100.0	-	100.0
Stonecot Surgery	100.0	100.0	100.0	100.0	80.0	100.0	81.8	100.0
Tod Practice	100.0	-	100.0	-	100.0	-	100.0	-
Wrythe Green Lane	100.0	100.0	100.0	75.0	100.0	80.0	100.0	90.9
SWL total	**100.0**	**100.0**	**95.8**	**85.0**	**90.0**	***88.0***	**86.4**	**92.7**
King's Fund pilot practices (n=12)	87.8	*90.0	86.4	87.5	80.0	*86.0	*82.6	*90.9
National eval'n PMS pilots (n=23)	94.2	95.7	80.4	84.2	68.2	75.2	72.4	85.5
National eval'n controls (n=23)	-	97.1	-	84.2	-	71.3	-	80.2

** missing data for this scale*

GPAS Questionnaire

Both the angina audit and the practice profile questionnaire analysed self-reported data from the practices. The GPAS patient satisfaction questionnaire allowed a random sample of patients to give their own assessment of the quality of care provided by the PMS pilot practices. In our evaluation of four London PMS pilot practices, we used the questionnaire twice during the study, and hoped that by using GPAS as early as possible, and then as late as possible in the initial three years of the PMS pilot's life, we would be able to look on the results as providing a 'before' and 'after' snapshot of patient satisfaction with the PMS pilot. 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 South West London can be found in Appendix 5. In summarising the data, Table 6 below shows the overall scale scores for each of the domains of quality, together with results from the 23 National Evaluation PMS pilot practices and 23 control practices.

For the seven practices overall, scores on each scale were less than the National Evaluation sample of 23 PMS practices. The individual practices show a level of variability in their GPAS results, with most scales for most of the practices being lower than the National Evaluation PMS pilot practices. Scores from the practices largely follow the pattern of national evaluation scores, with scores on the practice nursing scale being most likely to approach (or exceed) the national evaluation mean on this scale. However, it is worth noting that the socio-demographic data for the practices is also variable (for example, the responders to GPAS at the Tod practice were more likely to be young, single, non-home-owners and non-car owners). It is also worth remembering that the National Evaluation sample of PMS practices did not include any London PMS pilots.

Table 6: GPAS scores for SWLPCO PMS pilot

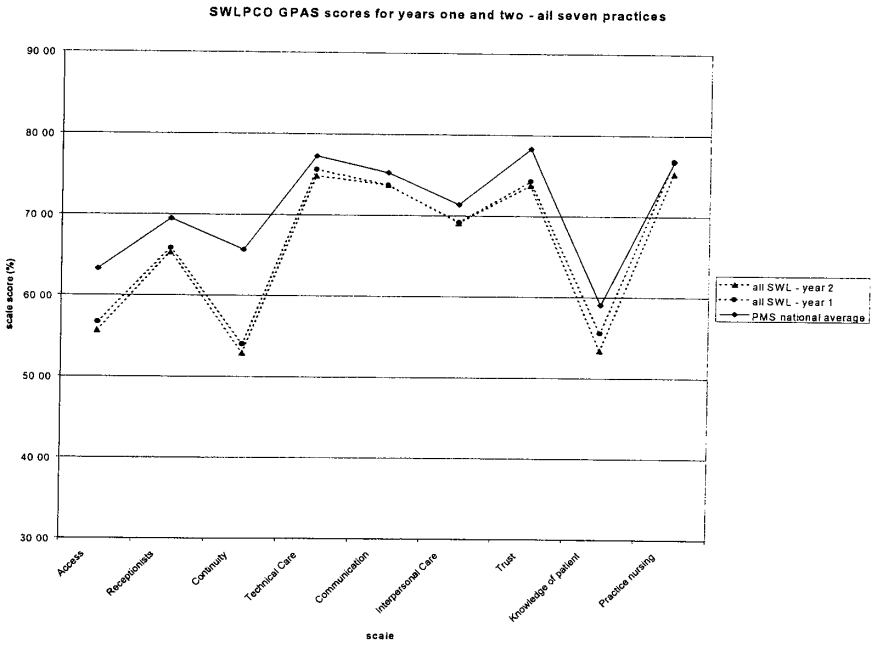
	Response rate		Access		Recept-ionists		Continuity		Technical care	
	%	N	Mean	N	Mean	N	Mean	N	Mean	N
Overall SWLPCO scores	57.1	800	55.7	784	65.4	796	52.9	759	74.9	679
Nat Eval PMS pilots	64.8	2940	63.3	2877	69.5	2899	65.7	2731	77.3	2530
Nat Eval Control practices	39.5	1751	63.5	1716	71.0	1730	69.1	1704	77.4	1599

	Comm-unication		Interpers-onal care		Trust		Knowledge of patient		Practice nursing	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
Overall SWLPCO scores	73.8	701	69.1	698	73.8	698	53.4	676	75.3	429
Nat Eval PMS pilots	75.3	2633	71.4	2625	78.3	2631	59.1	2565	76.8	1590
Nat Eval Control practices	73.9	1661	71.5	1659	77.7	1656	61.4	1614	76.4	1075

The charts on the following pages show the year one and year two GPAS results for the seven SWLPCO PMS pilot practices, firstly as a overall pilot mean, and then for each individual practice, in each case using the National Evaluation PMS pilot sample (made up of 23 PMS pilot practices) as a comparator. 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,

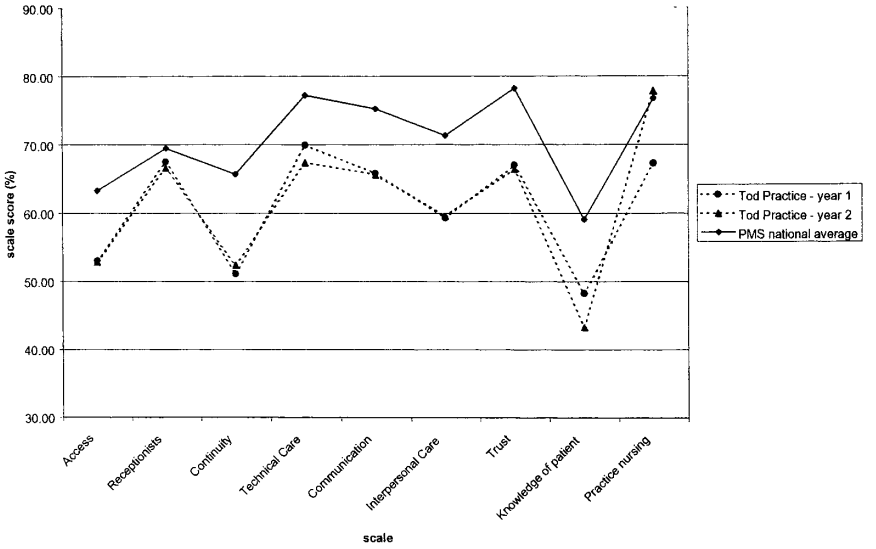
particularly older patients, tending to express greater levels of satisfaction with the services they receive.[15]

In summary, the results from the three research tools we used to assess quality showed variability between practices (as would be expected). GPAS scores were generally low in comparison with National Evaluation comparators, and showed little change between the first and second rounds of data collection. Practice Profile Questionnaire results were higher than National Evaluation PMS pilot practices in both round one and round two of data collection. Results from the Angina Audit showed that six out of seven of the SWLPCO practices scored more highly than the National Evaluation PMS pilot practices, often markedly so. While it is clear from these results that the SWLPCO practices perform highly in terms of chronic disease management and on practice profile measures in comparison to a national sample of PMS pilot practices, there is little evidence of a 'PMS effect' impacting directly on the performance of these practices.

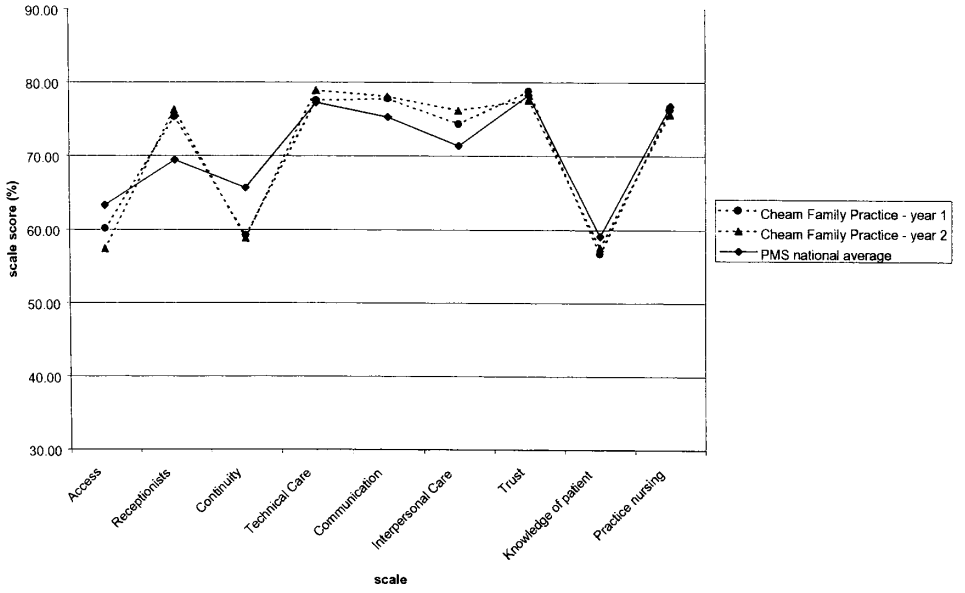


[15] Gill Malbon, Clare Jenkins, Steve Gillam. What do Londoners think of their general practice? King's Fund, London. 1999

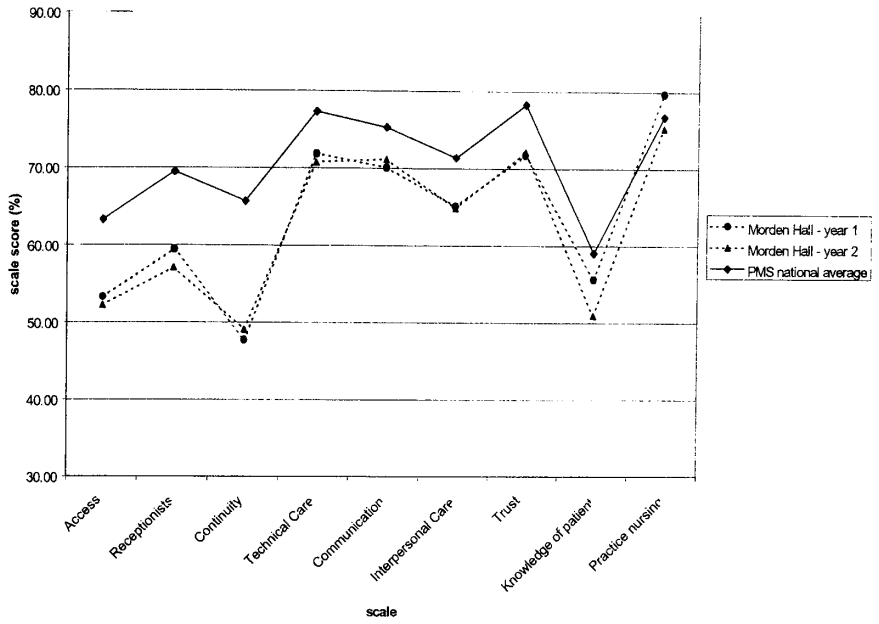
GPAS - Tod Practice, SWL



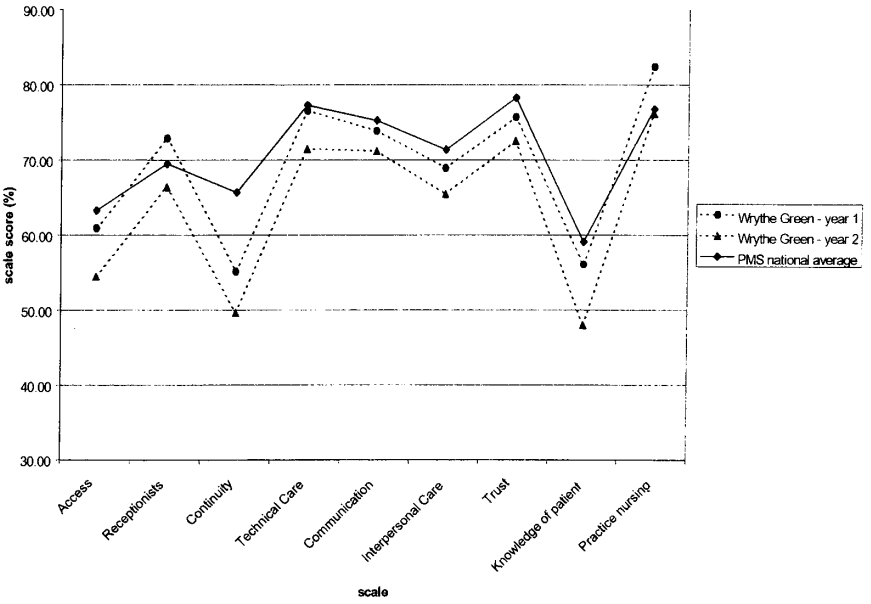
GPAS - Cheam Family Practice, SWL



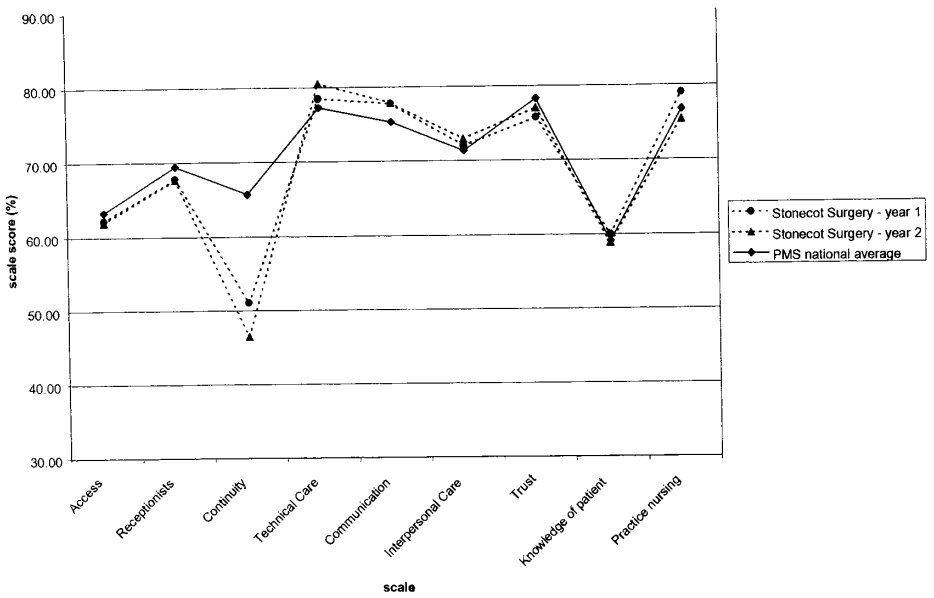
GPAS - Morden Hall, SWL



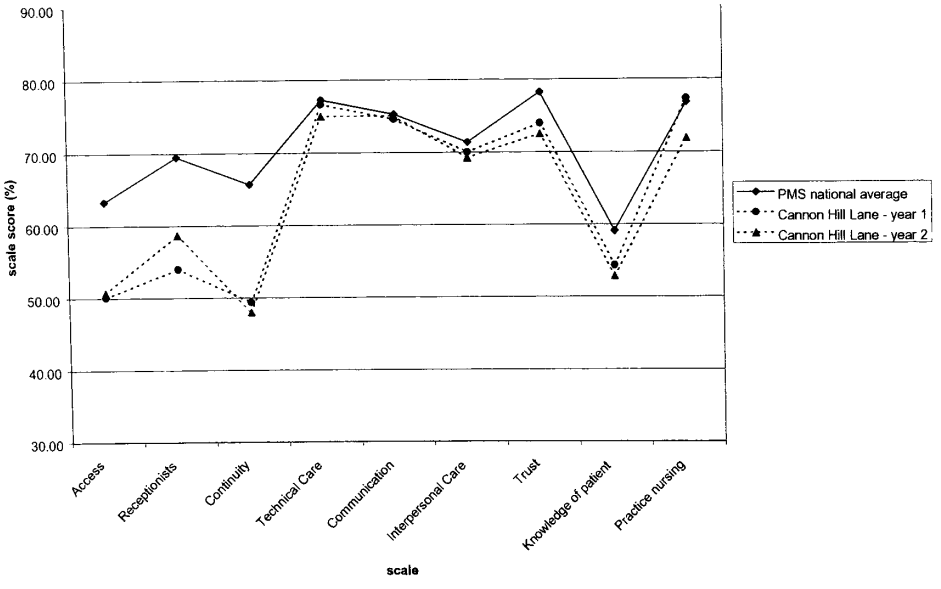
GPAS - Wrythe Green Lane, SWL

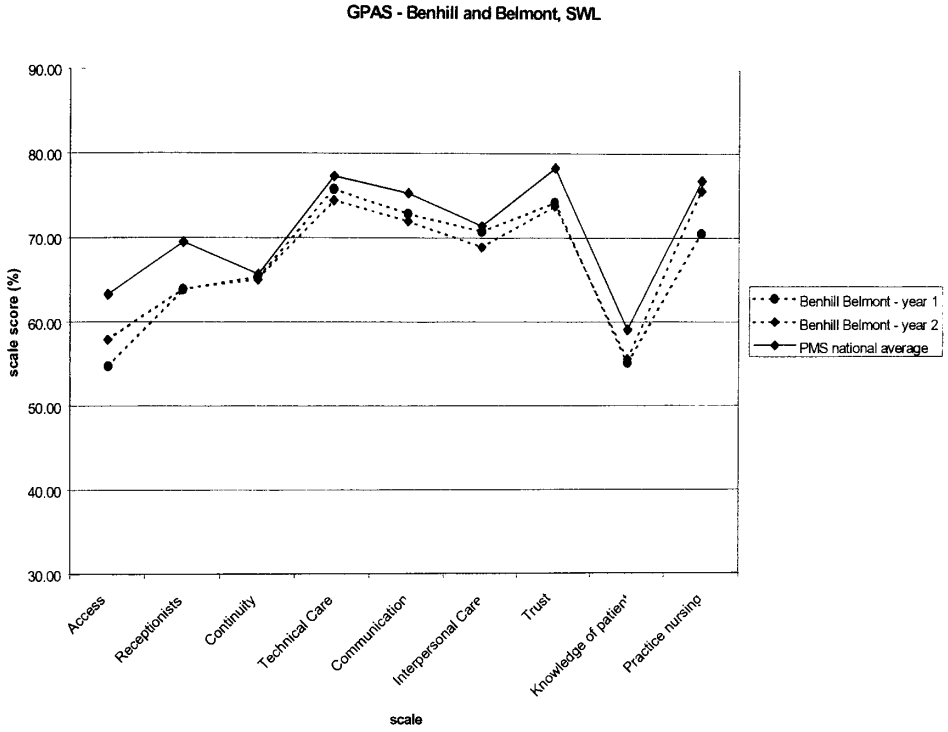


GPAS - Stonecot Surgery, SWL



GPAS - Cannon Hill Lane, SWL





When comparing King's Fund evaluation results with National Evaluation results, it is worth noting that none of the National Evaluation PMS pilot sample sites were in London or the South East, although several of the non-PMS sites were. In the National Survey of NHS patients[16] 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.

Inter-practice and partnership working

Some of the most positive comments made by the key stakeholders we interviewed over the three years of the project concerned the benefits that increased communication between groups of staff in the seven practices had brought about:

> **Pooling knowledge and resources from all levels, doctors and nurses, that's good. You can draw on knowledge for example, *(one of the GPs)* and his mental health work. That's excellent. The nurses, too, it's a wonderful resource, other peoples experience and knowledge. And not working in so much isolation – that helps (practice, year 2)**

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

The main benefit is that it has brought us together with the other practices and we're starting to understand each others' problems and draw upon their experience (practice, year 2)

Although key stakeholders were generally positive about the benefits of closer working, there was a recognition of the difficulty of communication amongst a larger group of practices, and also a concern that the group might become too big and unwieldy:

Disseminating knowledge to all staff – that gets to be a bit of a headache. When we have meetings, not everyone can go – it's difficult to keep everyone abreast of what's happening (practice, year 2)

....it's quite difficult to draw together all the aspects all practices think are important. It'll be difficult to decide which direction to go and to get everybody's agreement (practice, year 2)

As far as the ancillary staff are concerned – they're still very much practice-focussed, rather than thinking on a wider basis (practice, year 2)

In addition, it was felt that due to the large scale of the pilot, the practices might lose their individual identities:

It could get too big, it could get too impersonal. Individual practices have their own peculiar problems – some might be in more disadvantaged areas, or some, like *(named practice)* have lots of mental health problems. We have to take these things on board and not think that everyone's the same (practice, year 2)

Perceptions of the care provided for the long-term severely mentally ill were described in year one as 'patchy', partly because the catchment area of the PMS pilot stretched from the inner city to the suburbs. It was envisaged that the mental health project would work towards integrating services and improving co-ordination between the pilot practices and providers. Partnership working was seen as being particularly important in launching the initiative. At the time we held our focus group, six out of seven of the practices had identified a mental health lead champion, and had set up serious mental illness registers in which patients were identified according to a specified methodology:

...we have been very fortunate that there have been local champions in mental health, which isn't always the case, and there are particular champions in this group, but also in other parts of the catchment - but here we've been able to work particularly closely and to build and develop our understanding (focus group, year 2)

...we have worked together for five years, so there's a long history of us working together. History of an element of trust, and moral support. Also, we are a self-selecting group and we selected this work. It wasn't imposed from outside at all, it wasn't imposed (focus group, year 2)

The pilot's work on mental health demonstrates that greater consistency in approach to care delivery can be achieved across a number of autonomous primary care teams. However, this has only been achieved following a significant work programme carried out by the pilot's shared mental health resource and only after considerable time has elapsed. The preparation and "lead time" required to implement changes to services should not be underestimated.

Relationships with other organisations

Primary Care

The closer working relationships described by interview respondents did not necessarily extend beyond the seven practices, with some doubts expressed about the impact of the pilot in the surrounding area:

> **It's been quite divisive amongst the GP community – there's a whole body of opinion that the pilot was given unfair financial advantages – not only in terms of clinical resources, but also management resources (LMC, year 2)**

> **It made *(other local providers)* apprehensive about the possibility that this PMS pilot will gain financial or service advantages (CHC, year 2)**

However, this divisiveness in the early years of the pilot, did not emerge as a theme in year three. It would appear that, in common with the other three PMS pilots taking part in the King's Fund evaluation, the antagonism described early on dissipated as the projects became more established.

Within the PCT, there was some feeling of the first wave PMS pilot being 'different' because of the close working relationships built up between the seven practices over many years:

> **We were together as a TPP before for a long time – there's a bit of an "us and them" within the PCT, which we don't generate, its just because we've been together for so long (practice, year 3)**

Despite the sometimes negative view of the pilot locally, there was a feeling that where the PMS pilot had led, other practices would follow in future:

> **There's been a great interest in third and future waves – probably the biggest impact *(of this PMS pilot)* has been that they've made the commitment to move off GMS – so it's given others the confidence to consider it for themselves (health authority, year 3)**

> **It's been important locally – they were willing to stick their necks out to become a PMS pilot and a partnership. They are very pioneering and able to put up with local criticism. This spurred on the second wave. It is quite significant that the PCT is contracting on a PMS basis with all practices – this wouldn't have happened without the first wave (PCT, year 3)**

The Health Authority

In the earlier years of the PMS pilot project, the poor relationship with the health authority was of concern to pilot staff. In year two, the health authority felt that they had not had as much input into the development of the pilot as they might have wished:

> **Over the last six months *(the PMS pilot has)* felt like a regrettably low priority. We did want to put a lot of effort into it ..... (health authority, year 2)**

> **.....*(there are)* bigger fish to fry (health authority, year 2)**

However, by years two and three, the relationship between the pilot and the health authority was felt to have improved (albeit the nature of the relationship has fundamentally altered with the achievement of PCT status)

> **....*(the health authority has)* moved from a position of being sceptical and slightly obstructive, in the very early days, to much more, wanting to help us make it work. It's much more in a spirit of 'you need to overcome this in order to do something'. So, I think we've moved in the last year (PCT, year 2)**

> **With us, *(the health authority)* did not support the concept. It was terrified of the concept and did nothing to support us in practice. I think that has now changed. I think it certainly supports the concept, but has problems with delivering tangible support.....I think policy clearly changed and it was not appropriate any longer for it not to support, in principle, PMS (practice, year 2)**

By building closer relationships within the PCT, the relationship with the health authority had, of necessity, become more remote:

> **....the fact that the (*PCT*) is there means they've even more distant than they ever were – now the relationship is quite distant (health authority, year 3)**

> **.....the health authority has been put in a difficult position. The PCT holds the PMS pilot contracts and it's had an impact on the health authority. It's been a learning experience for the health authority to learn that they're not holders of GP contracts, but still involved in quality and performance management (PCT, year 3)**

Other Relationships

The impact of the pilot on local community and acute trusts was identified at interview. However it is again difficult to determine the extent to which these impacts

can be ascribed to PMS, rather than to other changes (particularly the work of the PCG/T).

> **It's probably, to a certain extent destabilised Merton and Sutton Community Trust. The PMS pilot changed their contract to Wandsworth and the two Trusts have now merged, but whether that would have happened anyway.... Local hospitals – they're worried about the degree of financial clout the pilot carries – there's a feeling that they are a very powerful body.... (LMC, year 2)**

> **With the intermediate care beds, we treat more patients at home – the acute trusts have less admissions (practice, year 2)**

The pilot also developed a new relationship with local Community Health Councils (CHCs). While CHCs have no rights to inspect and report on GMS premises and services, the SWLPCO voluntarily negotiated such rights in relation to practices within the pilot. CHC members have been invited to visit constituent practices and to present a report of other findings back to the practice. This is a highly innovative initiative designed to involve patient representatives in monitoring and developing primary medical care. However, to date, the process has been slow to get off the ground. One visit took place in the summer of 1998 and a second visit in April 2001.

Despite the acknowledged importance of the PMS pilot locally, within the pilot itself there was a view that perhaps there hadn't been enough recognition for their ground-breaking work:

> **...we haven't been particularly valued in the local health economy (practice, year 3)**

> **The impact this pilot has had on others in the PCT has been huge – we did the developmental work – then transmitted into the Wimbledon PMS. The intermediate care project has now rolled out to Wimbledon PMS – it's an excellent service, but I find myself feeling a bit bitter, as part of the first wave PMS – we've done a lot of hard work.....the third wave have a lot more advantages – the first wave's work is just being absorbed. They haven't grown up with it, or developed it – for them, it's just been bolted on (practice, year 3)**

Roles

One of the key aims of the PMS pilot initiative nationally was to 'provide opportunities and incentives for primary care professionals to use their skills to the full' and to 'provide more flexible employment opportunities in primary care'.[17] By the time the second edition of the comprehensive guide to PMS had been published, the Government were specifically calling for PMS pilot schemes which offered other

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

professionals, particularly nurses, 'the opportunity to be full partners and explore the better use of skill mix'.

The GPs we interviewed at the SWLPCO felt that differences in their role as a result of PMS were minimal, or there was no discernible difference:

> **I don't notice any difference (practice, year 3)**
>
> **There is minimal difference - but you are aware that you don't have to sign silly forms, but you're still recording them on the computer. It doesn't really change much (practice, year 3)**
>
> **There's no noticeable difference (practice, year 3)**

Nurses, likewise, felt that the day-to-day work they carried out was unaffected by PMS:

> **As far as nurses go, we carry on much as usual – those sorts of things don't affect us too directly (practice, year 2)**
>
> **Again, people like me just want to do their job – I don't get involved. I do my job and I go home. I haven't got time. Most practice nurses are the same (practice, year 2)**
>
> **My job hasn't changed at all since last time. There are areas I've moved into in care – but not because of PMS pilots.... (practice, year 2)**

However, the nurses in particular did feel that although their actual roles hadn't changed, they were working more closely with medical and nursing colleagues, and some of this they attributed to the integrated nursing teams (which predated the PMS pilot):

> **It's the same job, but the role change is being aware of each other (practice, year 2)**
>
> **I don't know if my actual role has changed. We're all more aware of improving standards and keeping up. We liaise more with other health professionals than before, and we're part of a much bigger set up, so you need to look beyond your own narrow practice (practice, year 2)**
>
> **There's been more communication *within* the pilot – both nursing teams and GPs. GPs tended to work in isolation - now there's a sharing of expertise, they attend meetings etc (practice, year 3)**

A more creative use of skill mix was starting to be considered when new members of staff were appointed:

> **I think they're beginning now, as partners move on – there's always a turnover of partners – they're beginning now to use flexibilities of PMS, to look at different ways of meeting requirements. It isn't an automatic 'let's**

put another partner in'. So they're looking at 'should we use salaried assistants?', 'should we use nurse practitioners?'. That can't move fast because there isn't a fast turnover of partners, but as people leave, they're increasingly looking at new ways of handling that (PCT, year 3)

However, as part of our evaluation, we did not collect data that would confirm, or otherwise, this view that skill-mix in the practices was increasing. It is worth noting though, that while the proportion of patients responding to GPAS who had seen a practice nurse in the previous twelve months, increased in some practices, it decreased in others.

Morale amongst pilot staff was generally high in years two and three, and the PMS pilot was not felt to have had any particular impact on job satisfaction, with five out of eleven interviewees in year three feeling that their job satisfaction had remained the same under PMS, two felt that their job satisfaction had improved, one felt that job satisfaction had improved in certain areas, and three felt that it was not possible to say whether PMS had impacted on their level of job satisfaction.

Workload

Levels of workload were not felt to have changed dramatically as a result of PMS, although it was acknowledged that setting up projects such the mental health project had meant more demands on people's time, and the intermediate care project meant that patients were more likely to be looked after by their own GP at home:

The idea of the PMS is that you do more secondary care in primary care – we haven't got the funding for staff, so we have to do the extra work ourselves (practice, year 3)

In year three, we asked whether PMS had caused an increase in workload. Of the eleven interviews we carried out in the pilot, five people felt that workload had increased (although three felt that this could not be attributed to PMS, and one felt that their increase in workload arose because they led the pilot). Four felt that their workload had remained the same, one felt that the level of clinical work had stayed the same while administrative tasks had decreased, and one felt that it was too difficult to say.

Nursing staff, however, all felt that they were carrying out different kinds of work. Some of this, they felt, could be attributed to the different ways of working within the integrated nursing teams, set up as part of the TPP, and not a direct result of PMS:

Over the last couple of years there's been much greater pressure on nurse appointments - patients are asking to see the nurses more. We've increased nurses' hours more, but we've stood our ground so that our diabetic nurse can have half a day's admin time – this helps our efficiency. Patients often ask to see nurses in preference to GPs, especially on the specialist side – diabetes and asthma (practice, year 3)

Overall impact of the pilot

One of the key themes arising from the interviews, both in years two and three, was the disappointment at the pace of change that the pilot had brought about:

> **(*I*) Don't think it's delivered anything yet (health authority, year 2)**

> **It takes a lot longer than you think to make significant change. You can do small things quickly, big change takes a long time (PCT, year 2)**

This feeling that the pace of change had been slower than people would have wished, was a common theme in all the four London PMS pilots taking part in the King's Fund evaluation, and it is worth asking how much progress can realistically be expected within a three-year timescale? In this pilot, far more so than in any of the other King's Fund London PMS pilots, was the sense that the crowded agenda around the setting up of PCGs, and then the move to PCT status, had had an adverse impact on the speed of development:

> **We'd have done far more if so much time hadn't been devoted to the PCG (practice, year 2)**

> **We lost a lot of energy and time with the PCG (PCT, year 2)**

> **I just feel that it's such a shame that the PCGs came in and muddied the water. I have a feeling that we would have achieved more if we'd just been able to go from TPP to a pilot, and developed (practice, year 2)**

By the time we interviewed in year three, there was some feeling that perhaps the project was re-emerging from the background:

> **.....*(the)* PMS pilot *(has been)* successful – most things we set ourselves are achieved or being achieved (practice, year 3)**

> **I think that the mental health work been great. The project they've now got running to look at the physical health of seriously mentally ill patients, that's now coming together very nicely. So yes, I think it is delivering (PCT, year 3)**

> **It's really only in the last year it's come back to life again. So, the first was good, the middle year was sort of, we lost time with the configuration issues, and the third year we're gradually getting it back to life again. It's certainly the right way forward, no *doubts* about it being that. I think it probably takes longer than you think its going to take (PCT, year 3)**

However, despite these more optimistic comments, there was still a sense that the pilot hadn't advanced as much as had been anticipated, particularly in the area of quality improvement, and there was a feeling of disappointment about this:

> **I'd probably say it hasn't gone as far as we would have anticipated at the outset. It's been very much a change of the organisation in terms of the**

contract, in terms of what the PCT would wish to do, rather than delivering quality improvements (health authority, year 3)

I'm disappointed by the speed with which we've been able to bring about service change through it. I mean, part of that has been the context has been so changeable around us, but also I think we probably underestimated the amount of work to move that number of clinicians and we could have done more.....we've not developed, in a sense, the 'plus' side of PMS, and all the enhanced services that GPs could have provided, we've not had a chance to develop that the way we would have liked to. We've also not got the explicit monitoring of quality I'd like to have got out of it (PCT, year 3)

We could have done better with our pilot – we haven't made the best of this opportunity (practice, year 3)

Despite this slightly downbeat feeling, when we asked staff whether they would choose the PMS pilot option again, seven out of the eleven interviewees said 'yes' (for a range of reasons which included being a motivator for change, working more closely as part of a nursing team, the advantages of 'going first' and for the potential to develop for the future). One person felt that the pilot had made no change, and three felt that they weren't involved enough or didn't know enough about it.

Overall, the feeling at the end of year three seemed to be that the pilot was 'coming about very gradually'.

SWL PCO PMS pilot: meeting local and national objectives?

Local objectives[18]	
• **To improve the quality and range of Personal Medical Services provided for patients by developing new models of delivering primary care services**	The structure of this pilot provides a new collaborative model of primary care – the seven pilot practices formed the largest GP partnership in the country. The pilot was set up to provide 'PMS plus' services – although there was a feeling that the 'plus' side had not been developed as fully as had been hoped. The mental health project had set out to improve the range and quality of services for patients with mental illness. The intermediate care project, an extension of the TPP and not an innovation of PMS, was felt to have been very popular with patients.
• **To improve the level of patient access to secondary care services through greater integration of services**	Again, the mental health project and the intermediate care project were set up to provide more integration between primary and secondary care.

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

• **To develop integrated pathways for the management of chronic conditions**	Some of the practices scored very highly in comparison with national comparators in the angina audit . Integrated care pathways were being developed as part of the mental health project
• **To improve the integration of practice-based and community-based services particularly in providing services to the mentally ill and the elderly**	The mental health project and the intermediate care project had set out to improve services to both these groups of patients. No evidence was found of specific service developments in relation to older people.
• **To reduce the level of administration in general practice**	Practices reported that they were still recording Items of Service in year three. In year one, practice managers were concerned about their long-term security that might arise from any centralisation of the practice managers' role – there was no evidence that this had happened. Workloads for some staff members had increased as a result of setting up new projects.
Key national questions[19]	
❑ **Have pilots improved *fairness* of provision by developing needs-related services, enhancing quality and improving access for disadvantaged groups?**	The mental health project and the intermediate care project were set up to improve services provision for the long-term mentally ill and the older people. A concern expressed by the health authority in year one was that the pilot, by not being geographically focussed, 'does not fit with a public health model'. There was variability between the practices as measured on GPAS, angina audit and practice profile questionnaires.
❑ **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 has been assessed using the angina audit and the Practice Profile Questionnaire, both of which show that the SWLPCO overall achieved higher scores than PMS pilots included in the national evaluation (although there was some inter-practice variation). Nurses felt that their roles had extended, although they did not attribute this directly to PMS. The pilot reported that skill mix was now being considered when new appointments were made.
❑ **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, suggesting that most of the practices were providing a high level of care (and recording data efficiently) to these patients. Practice staff were positive about the close working relationships with the other SWLPCO practices they had built up over many years, and described the benefits they achieved from this.

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

❑ **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. GPAS scores were generally lower than National Evaluation PMS pilot practices – although there may be a 'London effect' on scores. There are interesting differences between the seven practices, but the different socio-economic characteristics of the different practice populations need to be taken into account. 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 both within the NHS and with other local services by enhancing team working, increasing cooperation among clinical and inter-sector professionals and contributing to strategic planning of local health services?**	Practice staff were very positive about the closer working relationships within the PMS pilot. With the addition of the 12 second-wave PMS pilots, the PCT was now entirely PMS. There was a feeling that the pilot had (inevitably) moved away from the health authority, becoming more distant as contracts were now held by the PCT. The health authority still has responsibility for ensuring accountability. The mental health project was assessed by focus group attendees as being a positive example of inter-sector partnership working.
❑ **Have pilots introduced new *flexibility* in working relationships, organisational forms and employment arrangements which might improve professional morale, recruitment and retention in primary care?**	Morale within the pilot was assessed by practice staff as being generally high, although PMS was not felt to have had any direct impact on job-satisfaction. Staff were enthusiastic about the closer working relationships that had been built up over a long period of working together under fundholding, as a TPP, as a PMS pilot, and now as part of a PCT. Although it was felt that the pilot was 'coming back to life in year three', there was a sense of disappointment about the pace of change within the pilot.
❑ **Have pilots improved *accountability* to local communities and to health authorities?**	The first-wave PMS pilot is part of a PCT-wide PMS pilot with responsibility to a defined population. Accountability remains with the health authority – although the relationship between the two has been described as inevitably becoming more distant and remote. An accountability framework was drawn up and a steering group, with representatives from a range of local organisations, set up to oversee the local contract. A primary care charter was drawn up the local Community Health Council (CHC) which included visiting rights to the SWLPCO practices for CHC members.

Appendix 1

Example of interview schedule

PMS pilot interviews – year 3

General practitioner

Achievements

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

2. Impact on other organizations

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

3. Contracts, quality and efficiency

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

- Do you anticipate altering it in the future?

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

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

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

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

4. Roles, Workload and Job Satisfaction

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

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

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

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

5. Summary

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

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

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

Appendix 2

sc:3/9/1998 angina.fin

Angina review criteria

For Office use only

i). Health Authority

ii. Practice ID

iii). Chronic ID **Angina**

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

v). Age .....

vi). Sex Male ❑ 1 Female ❑ 2

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

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

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

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

If yes, list .....

x). Does the patient have:

a). Diabetes Yes ❑ 1 No ❑ 2

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

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

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

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

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

Any Comments (For example, incomplete notes)

.....

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

DRUG TREATMENT **CURRENT**

Does current medication include:

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

YES❑1 NO ❑2 NA ❑ 3 *(NA = Contraindicated)*

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

YES ❑1 NO ❑2

c). Beta-blocker

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

YES ❑1 *(If yes go to d)* NO ❑2

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

YES ❑1 NO ❑2 NA ❑ 3 (NA= not on maintenance treatment - c,d, e or f)

d). Calcium antagonist

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

YES ❑1 NO ❑2 *(If 'no' go to e). nitrate)*

If yes,

i). Short-acting nifedipine *(Nifedipine or Adalat only)* YES ❑1 NO ❑2

ii). Verapamil *(Verapamil or Cordilox)* YES ❑1 NO ❑2

iii). Beta-Adalat or Tenif *(Atenalol Beta-blocker/Nifedipine combinations)* YES ❑1 NO ❑2

iv). More than one calcium antagonist YES ❑1 NO ❑2

e). Nitrate

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

YES ❑1 NO ❑2

f). Potassium Channel Blocker : **Nicorandil** (Ikorel) YES ❑1 NO ❑2

g). Cholesterol lowering treatment

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

YES ❑1 NO ❑2

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

FREQUENCY OF ANGINA EPISODES **LAST 14 MONTHS**

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

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

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

1c. Is the patient more than minimally symptomatic?

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

Annotate answer:

CHOLESTEROL

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

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

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

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

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

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

BLOOD PRESSURE **LAST 14 MONTHS**

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

(i) Last BP / date .....

(ii) 2nd BP / date .....

(iii) 3rd BP / date ..... .

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

(iv) AVERAGE BP /

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

YES ❑1 NO ❑2

Annotate answer:

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

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 POSITIVE 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 NEGATIVE 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.

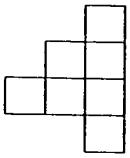
If in doubt annotate and check with clinician.

'Top 20' sampling frame of drugs - Angina

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

appendix 1.

NATIONAL PRIMARY CARE RESEARCH AND DEVELOPMENT CENTRE



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	2	3	4
Less than 1 year	**1 to 2 years**	**3 to 4 years**	**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	2	3	4
None	**Once or twice**	**Three or four times**	**Five times or more**

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

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

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

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

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

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

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

1	2	3	4
Early morning	**Evenings**	**Week-ends**	**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	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**

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

a) How quickly do you get an appointment?

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

b) How do you rate this?

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

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

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

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

1 **Not at all, they begin on time**
2 **Less than 5 minutes**
3 **6 to 10 minutes**
4 **11 to 20 minutes**
5 **21 to 30 minutes**
6 **31 to 45 minutes**
7 **More than 45 minutes**

b) How do you rate this?

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

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

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

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

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

b) How do you rate this?

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

12. **The next questions ask you about your <u>usual doctor</u>. 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 **<u>technical aspects</u>** 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 **<u>talking</u>** 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 **Always**	2 **Almost always**	3 **A lot of the time**	4 **Some of the time**	5 **Almost never**	6 **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 **doing what is needed for my health** than about keeping down costs	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 **Definitely not**	2 **Probably not**	3 **Not sure**	5 **Probably yes**	6 **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
Black – Caribbean
Black – African
Black – Other
Indian
Pakistani
Bangladeshi
Chinese
Any other ethnic group

Please describe .....

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	☐ 2	☐ 3	☐ 4	☐ 5
Very good	**Good**	**Fair**	**Bad**	**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.

Appendix 5

South West London Primary Care Organisation GPAS results – second round

Table 1: Response rates

	Benhill Belmont		Cannon Hill		Cheam Family		Morden Hall		Stonecot Surgery		Tod Practice		Wrythe Green	
	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1
% overall response rate	62	*50*	61	*55*	63	*56*	56	*61*	65	*65*	32	*37*	63	*59*
Base	123	99	121	110	125	111	112	121	130	129	63	74	126	118

Table 2: Socio demographic characteristics of patients

	%	Benhill Belmont		Cannon Hill		Cheam Family		Morden Hall		Stonecot Surgery		Tod Practice		Wrythe Green	
	Year	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1
Sex	male	39	36	40	*40*	28	*42*	38	*39*	39	*38*	37	*47*	47	*38*
	female	61	64	60	*60*	72	*58*	63	*61*	61	*63*	63	*53*	53	*62*
	base	121	98	119	109	123	110	112	121	130	128	62	74	125	117
Age group	16 to 24	11	8	11	*8*	6	*6*	10	*11*	7	*7*	*7*	*4*	9	*5*
	25 to 34	13	9	11	*17*	25	*14*	13	*14*	15	*17*	58	*17*	24	*19*
	35 to 44	23	30	27	*20*	17	*29*	19	*14*	17	*23*	13	*39*	16	*17*
	45 to 54	16	23	19	*21*	18	*25*	12	*18*	19	*12*	10	*10*	16	*26*
	55 to 64	17	15	11	*14*	16	*18*	18	*19*	17	*13*	3	*6*	9	*7*
	65 to 74	8	15	15	*19*	9	*8*	17	*14*	15	*15*	5	*12*	17	*18*
	75 +	13		6	*2*	9		11	*10*	10	*14*	3	*12*	9	*8*
	base	120	96	114	106	117	106	107	114	126	123	60	69	122	111
Marital status	single	19	17	19	*17*	13	*10*	32	*16*	13	*15*	42	*31*	20	*18*
	Married*	67	65	70	*77*	73	*81*	50	*71*	73	*74*	53	*50*	68	*65*
	Separated*	14	17	11	*6*	15	*9*	18	*13*	14	*11*	5	*19*	12	*17*
	base	121	98	119	109	120	110	111	121	130	128	62	74	124	116
Ethnic group	white	93	88	88	*92*	92	*94*	88	*82*	96	*97*	74	*76*	98	*95*
	other	7	12	12	*8*	8	*6*	12	*18*	4	*3*	26	*24*	2	*5*
	base	123	98	119	108	123	108	111	121	129	128	61	72	125	116
Accommodation	Owner#	81	78	84	*88*	90	*92*	78	*85*	87	*88*	58	*59*	83	*80*
	LA/HA#	12	13	7	*6*	3	*3*	13	*9*	5	*7*	13	*21*	7	*11*
	Private#	3	5	2	*2*	5	*3*	4	*3*	2	*2*	29	*19*	8	*5*
	Other#	4	3	7	*4*	2	*3*	5	*3*	5	*3*		*1*	2	*4*
	Base	120	97	116	109	121	111	111	117	130	124	62	70	121	114
Car available?	yes	79	76	82	*85*	80	*90*	64	*81*	81	*79*	53	*57*	76	*78*
	no	21	24	18	*15*	20	*10*	36	*19*	19	*21*	47	*43*	24	*22*
	base	122	96	117	110	119	111	108	115	127	125	62	69	123	113

* married = married/cohabiting, separated = widow/er, divorced or separated

Owner = owner occupied, LA/HA = rented from local authority/housing association, private = rented from a private landlord, other = under other arrangements

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

	%	Benhill Belmont		Cannon Hill Lane		Cheam Family		Morden Hall		Stonecot Surgery		Tod Practice		Wrythe Green	
	Year	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1
How long have you been registered with your practice?	1-2 yrs	*14*	*11*	*3*	*5*	*13*	*15*	*8*	*6*	*2*	*9*	*56*	*14*	*6*	*3*
	3-4 yrs	*11*	*8*	*11*	*5*	*18*	*5*	*9*	*9*	*7*	*12*	*38*	*15*	*13*	*8*
	>4 yrs	*75*	*81*	*86*	*89*	*69*	*79*	*83*	*85*	*91*	*79*	*6*	*72*	*80*	*90*
	Base	123	99	121	110	125	111	112	121	130	129	63	74	126	118
In the last 12 months, how often have you seen a doctor or nurse from your practice?	None	*8*	*11*	*9*	*9*	*8*	*11*	*13*	*7*	*8*	*7*	*6*	*14*	*7*	*10*
	1-2 times	*31*	*25*	*39*	*24*	*25*	*36*	*29*	*21*	*35*	*30*	*32*	*30*	*36*	*38*
	3-4 times	*38*	*38*	*28*	*35*	*34*	*26*	*27*	*35*	*28*	*33*	*41*	*26*	*30*	*22*
	5+ times	*23*	*25*	*24*	*33*	*33*	*26*	*32*	*36*	*29*	*29*	*21*	*31*	*27*	*29*
	Base	123	99	120	110	125	110	111	121	130	129	63	74	126	117
Do you have any long-standing illness, disability or infirmity?	Yes	*42*	38	*41*	38	*47*	41	*40*	46	*46*	41	*31*	56	*39*	49
	No	*58*	63	*59*	62	*53*	59	*60*	54	*54*	59	*69*	44	*61*	51
	Base	121	96	115	110	119	109	108	116	128	127	62	70	122	115
How is your health in general?	Very good	*25*	31	*29*	19	*20*	19	*18*	30	*22*	25	*37*	17	*20*	30
	Good	*58*	50	*48*	57	*53*	60	*54*	43	*51*	48	*44*	44	*49*	47
	Fair	*14*	17	*18*	21	*22*	18	*26*	25	*23*	24	*17*	35	*29*	20
	Bad	*2*	2	*4*	2	*2*	3	*2*	2	*3*	2	*2*	4	*2*	3
	Very bad			*1*	1	*2*				*2*	2				
	Base	122	96	118	110	122	111	110	118	130	126	63	71	124	116

Table 4: Access scores

	%	Benhill Belmont		Cannon Hill Lane		Cheam Family		Morden Hall		Stonecot Surgery		Tod Practice		Wrythe Green	
	Year	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1
Overall access score	Score	57.9	54.8	50.7	50.1	57.4	60.1	52.2	53.3	62.0	62.2	52.9	53.1	54.5	61.0
	Base	122	97	119	107	122	105	110	116	127	126	61	71	123	117
How would you rate the convenience of your practice's location?	Poor	*3*	*2*	*1*	*1*	*2*	*5*	*5*	*8*		*0*		*1*	*2*	*0*
	Fair	*7*	*7*	*14*	*11*	*13*	*10*	*14*	*18*	*12*	*9*	*11*	*12*	*8*	*2*
	Good	*89*	*91*	*85*	*88*	*85*	*86*	*80*	*74*	*88*	*91*	*89*	*86*	*90*	*98*
	Base	122	98	121	110	125	111	112	120	130	129	63	74	125	117
How would you rate the hours that your practice is open for appointments?	Poor	*3*	*11*	*10*	*8*	*3*	*7*	*5*	*3*	*2*	*2*	*6*	*8*	*2*	*3*
	Fair	*26*	*22*	*26*	*23*	*27*	*24*	*22*	*17*	*18*	*9*	*35*	*24*	*18*	*10*
	Good	*71*	*67*	*64*	*69*	*70*	*68*	*74*	*81*	*80*	*88*	*58*	*68*	*80*	*87*
	Base	123	99	120	110	119	111	110	118	130	128	62	72	125	118
What additional hours would you like your practice to be open?	Early am	*15*	*16*	*16*	*15*	*14*	*15*	*13*	*6*	*9*	*9*	*24*	*19*	*10*	*8*
	Evenings	*29*	*34*	*34*	*26*	*27*	*29*	*22*	*25*	*17*	*20*	*48*	*32*	*28*	*22*
	Weekends	*34*	*32*	*39*	*33*	*36*	*33*	*35*	*33*	*22*	*21*	*52*	*34*	*28*	*25*
	Base	123	99	121	110	125	111	112	121	130	129	63	74	126	118
How quickly do you get an appointment when you want to see a particular doctor?	Same day	*4*	*5*	*3*	*5*	*10*	*9*	*2*	*3*	*6*	*7*	*3*	*7*	*6*	*3*
	Next day	*24*	*16*	*7*	*6*	*7*	*7*	*6*	*11*	*2*	*4*	*8*	*10*	*2*	*4*
	2-3 days	*44*	*49*	*7*	*13*	*32*	*45*	*28*	*26*	*21*	*20*	*30*	*30*	*15*	*18*
	4-5 days	*14*	*20*	*17*	*18*	*25*	*20*	*18*	*26*	*12*	*24*	*26*	*23*	*23*	*30*
	5+ days	*8*	*4*	*60*	*48*	*21*	*6*	*32*	*20*	*48*	*37*	*18*	*16*	*45*	*36*
	Not apply	*6*	*5*	*7*	*9*	*6*	*13*	*14*	*14*	*12*	*8*	*15*	*14*	*9*	*10*
	Base	121	99	121	110	125	111	111	120	130	128	61	73	123	118

Table 4: Access (contd)

	%	Benhill Belmont		Cannon Hill Lane		Cheam Family		Morden Hall		Stonecot Surgery		Tod Practice		Wrythe Green	
	Year	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1
How do you rate this?	Poor	*17*	*28*	*56*	*56*	*33*	*20*	*38*	*33*	*32*	*36*	*32*	*32*	*43*	*30*
	Fair	*41*	*36*	*23*	*25*	*28*	*35*	*29*	*33*	*35*	*39*	*29*	*28*	*33*	*35*
	Good	*35*	*31*	*13*	*10*	*34*	*33*	*19*	*19*	*22*	*20*	*26*	*28*	*16*	*26*
	Not apply	*7*	*4*	*8*	*9*	*6*	*12*	*14*	*14*	*12*	*5*	*13*	*13*	*8*	*9*
	Base	122	99	120	110	125	110	110	120	130	128	62	72	122	117
How quickly do you get an appointment when you want to see any doctor?	Same day	*23*	*23*	*24*	*26*	*27*	*26*	*25*	*35*	*52*	*46*	*20*	*19*	*28*	*28*
	Next day	*32*	*32*	*21*	*21*	*26*	*28*	*21*	*24*	*16*	*25*	*21*	*28*	*16*	*18*
	2-3 days	*30*	*26*	*27*	*29*	*26*	*36*	*34*	*30*	*24*	*21*	*25*	*29*	*27*	*37*
	4-5 days		*2*	*13*	*11*	*8*	*4*	*9*	*3*	*2*	*3*	*16*	*8*	*12*	*9*
	5+ days	*1*	*1*	*10*	*6*	*4*	*1*	*4*	*1*	*2*		*11*	*7*	*13*	*3*
	Not apply	*15*	*16*	*6*	*7*	*10*	*6*	*7*	*7*	*3*	*5*	*7*	*8*	*4*	*4*
	Base	122	98	120	109	124	108	109	121	128	127	61	72	122	116
How do you rate this? *(any GP)*	Poor	*12*	*13*	*29*	*33*	*19*	*16*	*27*	*19*	*6*	*6*	*28*	*24*	*27*	*15*
	Fair	*23*	*32*	*29*	*30*	*26*	*27*	*23*	*27*	*22*	*23*	*23*	*26*	*26*	*27*
	Good	*52*	*43*	*37*	*32*	*46*	*51*	*42*	*47*	*69*	*67*	*41*	*42*	*44*	*54*
	Not apply	*13*	*13*	*5*	*6*	*9*	*6*	*8*	*7*	*2*	*4*	*8*	*8*	*3*	*4*
	Base	120	96	117	107	121	105	103	118	124	125	61	72	119	114
If you need an urgent appointment to see your GP, can you normally get one on the same day?	Yes	*47*	*42*	*42*	*45*	*57*	*64*	*45*	*45*	*69*	*67*	*52*	*41*	*50*	*46*
	No	*15*	*26*	*33*	*29*	*12*	*10*	*28*	*23*	*13*	*15*	*24*	*36*	*24*	*23*
	DK/never needed	*38*	*32*	*26*	*26*	*31*	*25*	*27*	*31*	*17*	*18*	*24*	*23*	*26*	*30*
	Base	118	97	120	107	122	107	110	121	127	129	62	73	125	115
How long do you have to wait at the practice for appointments to begin?	<6 mins	*9*	*8*	*7*	*4*	*13*	*18*	*5*	*1*	*7*	*9*	*13*	*6*	*16*	*35*
	6-10 mins	*31*	*28*	*26*	*21*	*33*	*48*	*14*	*16*	*23*	*31*	*44*	*42*	*41*	*38*
	11-20 mins	*34*	*29*	*44*	*44*	*39*	*30*	*32*	*34*	*39*	*40*	*21*	*37*	*31*	*17*
	21-30 mins	*15*	*18*	*15*	*20*	*13*	*4*	*29*	*26*	*20*	*14*	*13*	*11*	*8*	*9*
	31-45 mins	*9*	*17*	*5*	*11*	*1*	*1*	*10*	*22*	*10*	*6*	*6*	*4*	*2*	*1*
	>45 mins	*3*		*2*				*10*		*1*		*3*		*2*	
	Base	118	98	117	108	123	107	108	116	124	126	62	71	121	117
How do you rate this?	Poor	*24*	*30*	*27*	*31*	*10*	*7*	*39*	*36*	*18*	*18*	*25*	*26*	*15*	*5*
	Fair	*40*	*43*	*43*	*40*	*46*	*38*	*38*	*42*	*46*	*38*	*26*	*29*	*48*	*30*
	Good	*36*	*27*	*30*	*30*	*44*	*55*	*23*	*22*	*36*	*44*	*49*	*45*	*37*	*65*
	Base	118	96	113	108	119	104	104	114	123	125	61	69	119	113
How would you rate your ability to get through to the practice on the phone?	Poor	*6*	*10*	*9*	*16*	*30*	*22*	*5*	*7*	*9*	*3*	*22*	*15*	*21*	*10*
	Fair	*29*	*22*	*28*	*27*	*26*	*28*	*32*	*20*	*19*	*13*	*29*	*34*	*36*	*32*
	Good	*63*	*64*	*60*	*56*	*42*	*46*	*57*	*69*	*71*	*82*	*44*	*47*	*38*	*53*
	don't know	*2*	*4*	*3*	*2*	*2*	*4*	*5*	*5*	*2*	*2*	*5*	*4*	*5*	*5*
	Base	122	99	118	109	125	108	110	121	128	127	63	73	125	118
How would you rate your ability to speak to a doctor when you have a question/need medical advice?	Poor	*13*	*15*	*22*	*22*	*11*	*12*	*18*	*14*	*16*	*10*	*29*	*19*	*17*	*13*
	Fair	*14*	*10*	*11*	*15*	*14*	*14*	*12*	*15*	*11*	*9*	*5*	*13*	*21*	*11*
	Good	*24*	*24*	*13*	*12*	*21*	*31*	*20*	*24*	*20*	*20*	*6*	*14*	*28*	*34*
	Don't know	*49*	*51*	*53*	*51*	*54*	*43*	*50*	*47*	*54*	*61*	*60*	*54*	*35*	*42*
	Base	120	94	116	109	123	108	107	120	123	126	62	69	121	116

Table 5: Receptionists

		Benhill Belmont		Cannon Hill Lane		Cheam Family		Morden Hall		Stonecot Surgery		Tod Practice		Wrythe Green	
	Year	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1
Overall receptionist score	Score	63.9	63.9	58.7	54.0	76.3	75.3	57.1	59.5	67.7	67.8	66.7	67.6	66.4	72.9
	Base	121	98	121	110	125	111	111	121	130	128	63	74	125	118
How would you rate the way you are treated by receptionists in the practice?	Poor	*7*	9	*14*	14	*5*	2	*14*	10	*4*	4	*10*	7	2	2
	Fair	*19*	18	*18*	28	*6*	12	*24*	25	*18*	17	*10*	15	*22*	11
	Good	*74*	72	*68*	58	*90*	86	*62*	65	*78*	79	*81*	78	*76*	87
	Base	121	98	121	110	125	111	111	121	130	128	63	74	125	118

Table 6: Continuity

		Benhill Belmont		Cannon Hill Lane		Cheam Family		Morden Hall		Stonecot Surgery		Tod Practice		Wrythe Green	
	Year	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1
Overall continuity score	Scale	65.1	65.4	48.0	49.3	58.9	59.2	49.2	47.7	46.6	51.1	52.4	51.1	49.7	55.1
	Base	118	96	115	107	122	102	107	111	119	119	58	70	120	111
In general, how often do you see your usual doctor (not an assistant or partners)?	Always*	*78*	*79*	*50*	*47*	*59*	*56*	*45*	*40*	*35*	*36*	*49*	*37*	*37*	*41*
	Some*	*13*	*15*	*24*	*31*	*20*	*30*	*28*	*36*	*33*	*37*	*29*	*44*	*38*	*32*
	Never*	*9*	*5*	*27*	*21*	*20*	*14*	*27*	*24*	*32*	*28*	*22*	*20*	*25*	*26*
	Base	122	97	119	109	122	109	108	115	124	126	59	71	123	117
How do you rate this?	Poor	*9*	*9*	*28*	*25*	*11*	*2*	*22*	*20*	*24*	*18*	*16*	*19*	*21*	*14*
	Fair	*10*	*16*	*24*	*27*	*26*	*35*	*32*	*36*	*42*	*36*	*29*	*34*	*36*	*27*
	Good	*81*	*75*	*48*	*48*	*63*	*63*	*46*	*44*	*34*	*46*	*55*	*47*	*43*	*59*
	Base	118	96	115	107	122	102	107	111	119	119	58	70	120	111

*always/lot = always, almost always, a lot of the time, some = some of the time, never = never, almost never

Table 7: Technical care

		Benhill Belmont		Cannon Hill Lane		Cheam Family		Morden Hall		Stonecot Surgery		Tod Practice		Wrythe Green	
	Year	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1
Overall technical care score	Score	*74.5*	*75.8*	*75.0*	*76.6*	*79.0*	*77.5*	*70.8*	*71.9*	*80.5*	*78.5*	*67.5*	*70.0*	*71.5*	*76.6*
	Base	113	89	110	97	110	92	92	93	112	108	52	65	90	104
Thinking about the technical aspects of your doctor's care, how do you rate the following:		Benhill Belmont		Cannon Hill Lane		Cheam Family		Morden Hall		Stonecot Surgery		Tod Practice		Wrythe Green	
Your doctor's technical knowledge?	Poor	*2*	1			*1*	2		0		3	*2*	1	*1*	2
	Fair	*4*	8	*5*	3	*4*	3	*11*	16	*3*	2	*9*	12	*5*	5
	Good	*82*	84	*88*	87	*91*	90	*86*	80	*93*	90	*84*	79	*86*	91
	DK	*12*	8	*7*	11	*4*	5	*3*	4	*4*	6	*5*	7	*7*	2
	Base	115	93	116	104	112	97	93	95	114	109	55	67	94	105
The thoroughness of your doctor's physical examination?	Poor	*6*	*4*	*3*	*3*	*2*	*2*	*3*	*6*	*1*	*5*	*11*	*9*	*3*	*7*
	Fair	*9*	*11*	*10*	*6*	*4*	*3*	*16*	*14*	*4*	*6*	*26*	*16*	*13*	*8*
	Good	*83*	*80*	*83*	*85*	*91*	*90*	*80*	*78*	*93*	*86*	*57*	*69*	*82*	*83*
	DK	*3*	5	*4*	*7*	*3*	5	*1*	2	*2*	*3*	*6*	6	*2*	3
	Base	116	93	115	104	113	97	93	94	114	109	54	67	93	105
The arranging of tests you need when you are unwell eg blood tests, x-rays etc	Poor	*3*	*2*	*1*	*2*		*1*	*2*	*3*		*2*	*11*	*3*	*2*	*3*
	Fair	*8*	*5*	*6*	*3*	*4*	*4*	*10*	*11*	*3*	*4*	*7*	*7*	*6*	*7*
	Good	*80*	*80*	*84*	*87*	*86*	*88*	*82*	*75*	*91*	*87*	*69*	*79*	*82*	*81*
	DK	*10*	*12*	*9*	*9*	*11*	*7*	*6*	*12*	*6*	*7*	*13*	*10*	*10*	*10*
	Base	114	92	115	104	112	96	93	95	114	110	55	67	94	105
Prescribing the right treatment for you?	Poor	*5*	*5*		*3*	*1*	*3*	*2*	*2*		*3*	*7*	*6*	*2*	*4*
	Fair	*7*	*6*	*9*	*7*	*4*	*6*	*14*	*14*	*5*	*5*	*7*	*12*	*11*	*11*
	Good	*84*	*84*	*88*	*83*	*94*	*86*	*80*	*81*	*92*	*90*	*80*	*78*	*83*	*82*
	DK	*3*	*4*	*3*	*7*	*2*	*4*	*4*	*3*	*3*	*2*	*5*	*4*	*4*	*3*
	Base	115	93	115	103	113	94	93	95	114	110	55	67	93	105
Making the right diagnosis?	Poor	*6*	*4*	*1*	*3*	*1*	*5*	*2*	*3*	*1*	*4*	*6*	*7*	*4*	*6*
	Fair	*5*	*6*	*11*	*4*	*4*	*7*	*16*	*12*	*5*	*2*	*13*	*10*	*12*	*7*
	Good	*85*	*83*	*80*	*83*	*89*	*83*	*77*	*83*	*90*	*91*	*69*	*75*	*78*	*85*
	DK	*3*	*6*	*8*	*11*	*5*	*4*	*4*	*2*	*3*	*4*	*13*	*7*	*5*	*2*
	Base	115	93	115	103	113	95	93	94	115	109	54	67	93	103

Table 8: Communication

		Benhill Belmont		Cannon Hill Lane		Cheam Family		Morden Hall		Stonecot Surgery		Tod Practice		Wrythe Green	
	Year	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1
Overall communication score	Score	72.0	*72.8*	75.0	*74.6*	78.1	*77.8*	71.2	*70.1*	77.9	*77.8*	65.7	*65.9*	71.2	*73.9*
	Base	116	93	115	102	114	99	93	95	114	110	54	66	95	106
Thinking about talking with your doctor, how would you rate the following:		Benhill Belmont		Cannon Hill Lane		Cheam Family		Morden Hall		Stonecot Surgery		Tod Practice		Wrythe Green	
The thoroughness of the doctor's questions?	Poor	*6*	*4*		*3*	*2*	*2*	*3*	*2*	*2*	*3*	*11*	*11*	*2*	*5*
	Fair	*12*	*14*	*13*	*8*	*5*	*8*	*15*	*17*	*6*	*5*	*15*	*14*	*13*	*11*
	Good	*82*	*82*	*87*	*89*	*93*	*90*	*82*	*81*	*92*	*92*	*74*	*76*	*85*	*84*
	Base	116	93	115	102	114	99	93	95	114	110	54	66	95	106
The attention the doctor gives to what you say?	Poor	*5*	*5*	*1*	*3*	*1*	*2*	*5*	*4*		*3*	*17*	*11*	*6*	*5*
	Fair	*13*	*13*	*12*	*8*	*5*	*7*	*15*	*15*	*7*	*4*	*8*	*14*	*11*	*10*
	Good	*82*	*82*	*87*	*89*	*94*	*91*	*80*	*81*	*93*	*94*	*75*	*76*	*83*	*85*
	Base	115	93	115	103	113	99	93	95	114	110	53	66	95	106
Doctor's explanations of your health problems or treatments you need?	Poor	*5*	*5*	*3*	*5*	*2*	*2*		*4*	*3*	*3*	*8*	*11*	*6*	*5*
	Fair	*14*	*19*	*13*	*7*	*9*	*11*	*18*	*18*	*4*	*5*	*13*	*17*	*7*	*9*
	Good	*81*	*75*	*84*	*88*	*89*	*87*	*82*	*78*	*93*	*93*	*79*	*73*	*86*	*86*
	Base	115	93	115	102	114	99	93	95	114	110	52	66	95	106
How often do you leave the surgery with unanswered questions?	Always*	*7*	*14*	*6*	*5*	*4*	*6*	*5*	*7*	*6*	*5*	*11*	*11*	*7*	*8*
	Some*	*23*	*16*	*23*	*31*	*19*	*17*	*29*	*31*	*20*	*20*	*28*	*37*	*23*	*20*
	Never*	*70*	*70*	*70*	*64*	*77*	*77*	*66*	*61*	*73*	*75*	*61*	*52*	*70*	*72*
	Base	115	93	111	103	114	101	93	96	113	110	54	65	96	105

*always/lot = always, almost always, a lot of the time, some = some of the time, never = never, almost never

Table 9: Interpersonal care

		Benhill Belmont		Cannon Hill Lane		Cheam Family		Morden Hall		Stonecot Surgery		Tod Practice		Wrythe Green	
	Year	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1
Overall interpersonal care score	Score	68.9	*70.8*	69.3	*70.0*	76.2	*74.4*	64.9	*65.1*	73.0	*72.1*	59.6	*59.4*	65.5	*69.0*
	Base	113	93	113	103	115	101	92	95	115	111	54	67	96	106
Thinking about the personal aspects of care you receive from your usual doctor, how do you rate the following?		Benhill Belmont		Cannon Hill Lane		Cheam Family		Morden Hall		Stonecot Surgery		Tod Practice		Wrythe Green	
The amount of time the doctor spends with you?	Poor	*4*	*0*	*5*	*4*		*1*	*5*	*5*	*2*	*3*	*9*	*7*	*7*	*6*
	Fair	*18*	*23*	*19*	*21*	*10*	*15*	*26*	*29*	*23*	*17*	*30*	*36*	*33*	*23*
	Good	*78*	*77*	*75*	*75*	*90*	*84*	*69*	*65*	*76*	*80*	*61*	*57*	*59*	*72*
	Base	114	93	113	104	115	101	93	95	115	111	54	67	96	106
Doctor's patience with your questions or worries?	Poor	*6*	1	*3*	2	*1*	2	*7*	5		3	*9*	9	*2*	3
	Fair	*14*	16	*17*	14	*8*	8	*19*	19	*10*	10	*26*	21	*18*	11
	Good	*80*	83	*81*	84	*91*	90	*75*	76	*90*	87	*65*	70	*80*	86
	Base	113	93	113	102	114	101	91	95	115	111	54	67	96	106
Doctor's caring and concern for you?	Poor	*9*	*2*	*3*	*1*	*3*	*3*	*3*	*6*		*4*	*7*	*11*	*1*	*3*
	Fair	*14*	*19*	*17*	*22*	*9*	*9*	*23*	*20*	*11*	*6*	*28*	*17*	*15*	*17*
	Good	*77*	*78*	*81*	*77*	*89*	*88*	*74*	*74*	*89*	*90*	*65*	*72*	*84*	*80*
	Base	112	93	113	103	115	101	92	95	115	111	54	65	96	105

Table 10: Trust

	%	Benhill Belmont		Cannon Hill Lane		Cheam Family		Morden Hall		Stonecot Surgery		Tod Practice		Wrythe Green	
	Year	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1
Overall trust score	Score	73.8	*74.2*	72.5	*74.0*	77.6	*78.8*	72.2	*71.8*	77.1	*75.8*	66.5	*67.1*	72.6	*75.7*
	Base	114	92	113	104	113	101	93	94	115	110	54	67	96	106
I completely trust my doctor's judgement about my medical care	Disagree	*9*	*80*	*7*	*82*	*3*	*84*	*5*	*71*	*3*	*83*	*17*	*63*	*5*	*76*
	not sure	*16*	*14*	*26*	*13*	*17*	*13*	*24*	*24*	*13*	*13*	*31*	*31*	*25*	*16*
	Agree	*75*	*5*	*67*	*6*	*81*	*3*	*71*	*4*	*84*	*5*	*52*	*6*	*70*	*8*
	Base	113	92	113	104	113	101	92	94	115	109	54	67	96	105
My doctor would always tell me the truth about my health	Disagree	*1*	*70*	*4*	*71*	*2*	*80*		*60*	*1*	*73*	*2*	*59*	*3*	*66*
	not sure	*27*	*29*	*24*	*28*	*28*	*20*	*32*	*39*	*28*	*25*	*34*	*35*	*29*	*33*
	Agree	*73*	*1*	*73*	*1*	*70*	*0*	*68*	*1*	*71*	*2*	*64*	*6*	*67*	*1*
	Base	113	91	113	102	109	100	90	94	114	107	53	66	95	105
My doctor cares more about keeping costs down than about my health	Disagree	*66*	*11*	*69*	*15*	*82*	*2*	*62*	*10*	*72*	*7*	*59*	*17*	*59*	*10*
	not sure	*22*	*30*	*20*	*24*	*15*	*21*	*30*	*30*	*23*	*22*	*29*	*33*	*34*	*23*
	Agree	*12*	*59*	*11*	*61*	*3*	*77*	*8*	*60*	*4*	*70*	*12*	*50*	*7*	*67*
	Base	113	91	111	103	113	100	92	93	112	108	51	66	95	106
How much do you trust your GP?	(mean 1=not, 10=totally)	8.2	8.23	8.0	8.24	8.3	8.56	7.9	7.95	8.5	8.38	7.1	7.57	8.0	8.6
		111	93	113	104	114	101	93	94	114	110	53	67	96	105

Table 11: Knowledge of patient

	%	Benhill Belmont		Cannon Hill Lane		Cheam Family		Morden Hall		Stonecot Surgery		Tod Practice		Wrythe Green	
	Year	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1
Overall knowledge of patient score	Score	55.6	55.2	52.9	54.3	57.6	56.7	51.0	55.7	58.9	60.0	43.3	48.3	48.0	56.1
	Base	111	91	111	97	108	96	89	90	112	105	54	65	91	103
Doctor's knowledge of your medical history?	Poor	*10*	*11*	*10*	*9*	*7*	*2*	*11*	*9*	*5*	*6*	*15*	*15*	*9*	*11*
	Fair	*21*	*24*	*27*	*28*	*21*	*26*	*31*	*26*	*24*	*20*	*37*	*25*	*37*	*16*
	Good	*70*	*65*	*63*	*63*	*71*	*72*	*58*	*66*	*71*	*75*	*48*	*60*	*54*	*73*
	Base	112	92	111	99	112	98	90	90	113	106	54	65	92	104
Doctor's knowledge of what worries you about your health?	Poor	*17*	*15*	*19*	*14*	*15*	*8*	*19*	*13*	*9*	*13*	*19*	*22*	*20*	*15*
	Fair	*22*	*26*	*26*	*33*	*22*	*36*	*34*	*32*	*36*	*20*	*38*	*28*	*38*	*24*
	Good	*61*	*58*	*55*	*53*	*63*	*56*	*47*	*54*	*55*	*67*	*43*	*51*	*42*	*61*
	Base	111	91	111	97	108	95	88	90	112	105	53	65	89	103
Doctor's knowledge of your work and home responsibilities?	Poor	*26*	*24*	*33*	*34*	*22*	*28*	*32*	*25*	*26*	*22*	*42*	*40*	*28*	*27*
	Fair	*24*	*34*	*21*	*27*	*30*	*27*	*33*	*30*	*24*	*25*	*33*	*31*	*41*	*30*
	Good	*50*	*42*	*46*	*39*	*49*	*45*	*34*	*45*	*50*	*53*	*25*	*29*	*31*	*43*
	Base	104	88	110	95	101	92	87	88	105	102	52	58	90	97

Table 12: Practice nursing

	%	Benhill Belmont		Cannon Hill Lane		Cheam Family		Morden Hall		Stonecot Surgery		Tod Practice		Wrythe Green	
	Year	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1
Overall practice nursing score	Scale	75.6	70.5	71.9	77.3	75.7	76.3	75.3	80.0	75.5	79.0	77.9	67.3	76.2	82.4
	Score	59	50	60	62	82	65	58	56	78	75	38	40	54	66
Have you seen a nurse in last year?	Yes	*53*	54	*54*	60	*73*	66	*61*	60	*68*	67	*70*	63	*56*	64
	No	*47*	46	*46*	40	*27*	34	*39*	40	*32*	33	*30*	37	*44*	36
	Base	115	92	112	104	114	100	97	98	115	114	54	67	98	103
How would you rate the attention the nurse gives to what you say?	Poor		4	*2*	1	*3*	2	*2*	0	*1*	1		7		0
	Fair	*8*	10	*5*	6	*3*	8	*6*	11	*9*	4	*13*	18	*4*	1
	Good	*92*	87	*94*	93	*93*	91	*92*	89	*90*	95	*88*	76	*96*	99
	Base	65	52	62	68	86	66	63	57	80	79	40	45	57	71
How would you rate the quality of care the nurse provides?	Poor	*2*	2		2	*3*	0	*2*	0		1		5	*2*	0
	Fair	*5*	10	*5*	6	*6*	9	*5*	7	*9*	1	*13*	16	*4*	1
	Good	*94*	88	*95*	92	*91*	91	*94*	93	*91*	98	*88*	80	*95*	99
	Base	65	52	62	65	87	65	63	57	81	80	40	44	56	71
How would you rate their explanations of your health problems or treatments you need?	Poor		4	*2*	2	*4*	2	*2*	2		1		9	*2*	0
	Fair	*9*	12	*15*	6	*8*	8	*3*	11	*11*	3	*10*	12	*7*	1
	Good	*91*	85	*84*	92	*88*	91	*95*	88	*89*	96	*90*	79	*91*	99
	Base	64	52	62	64	83	65	63	57	79	79	40	43	54	71

Table 13: Non-scaled items

	%	Benhill Belmont		Cannon Hill Lane		Cheam Family		Morden Hall		Stonecot Surgery		Tod Practice		Wrythe Green	
	Year	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1	Y 2	Y1
Was there any time the doctor didn't refer you when you needed it?	Yes	9	10	6	10	6	4	8	11	1	7	14	13	8	4
	No	91	90	94	90	94	96	92	89	99	93	86	87	92	96
	Base	110	86	108	98	108	93	91	97	112	109	51	61	95	94
Does your doctor coordinate care you receive outside the practice?	Yes	31	31	23	29	32	26	32	34	29	32	27	40	28	28
	No	7	4	4	6	5	5	3	8	4	5	8	8	4	4
	Does not apply	62	64	73	65	63	69	65	58	66	64	65	52	68	68
	Base	112	90	112	101	112	96	92	97	113	107	52	63	96	99
Would you recommend your usual doctor to your family and friends?	No*	9	14	4	10	4	5	10	6		4	8	9	6	4
	Not sure	10	8	6	6	6	2	11	14	5	4	13	12	6	4
	Yes*	81	78	89	84	90	93	79	80	95	92	79	79	88	92
	Base	117	93	114	105	115	100	92	98	115	114	52	68	98	105
All things considered, how satisfied are you with your practice?	C'pletely satisfied#	10	17	10	12	19	26	12	12	16	23	8	10	17	24
	Satisfied	75	61	70	61	70	61	64	69	73	68	71	70	66	67
	Neither#	7	10	9	15	7	9	18	10	5	7	13	12	13	6
	Diss'fied#	7	10	10	12	5	4	6	10	5	2	8	5	4	3
	C'pletely diss'fied#	1	1		1								3		
	Base	121	98	119	109	123	110	112	121	130	128	62	73	125	117

* no = definitely/probably not, yes = yes definitely/yes probably # satisfied = very/somewhat satisfied, neither = neither satisfied nor dissatisfied, dissatisfied = very/somewhat dissatisfied

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

South West London Primary Care Organization
Personal Medical Services (PMS) Pilot

Focus Group at the Nelson Hospital
Raynes Park, SW20 8DB
Tuesday 19 September, 1-3pm

Improving the provision of mental health services in primary care

Thank you for agreeing to attend our focus group. This is part of an evaluation of the South West London Primary Care Organization (SWLPCO) first-wave PMS pilot that is being carried out by the King's Fund (we are an independent health charity).

The SWLPCO first-wave PMS pilot is one of a small number of pilots established in the NHS in 1998 to look at new ways of providing primary care. One of the key aims of the SWLPCO is to improve the provision of mental health services in primary care.

The purpose of this focus group is to consider progress in meeting this 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 SWLPCO?
- How would you describe your relationships with the SWLPCO?
- How successful have you been in working together with the SWLPCO to improve patient services?
- How might your relationships and joint working with the SWLPCO 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:
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Appendix 8

South West London Personal Medical Services (PMS) Pilot
King's Fund Evaluation Feedback Meeting
Wednesday 2 June 1999

Background

The South West London Personal Medical Services (PMS) pilot bid outlined the development of a 3-year 'PMS plus' contract with Merton, Sutton and Wandsworth Health Authority. The eight practices making up the South West London Total Purchasing Project (SWLTPP) served a population of 81,000 across three boroughs. The pilot planned to extend the scope of the GMS services already provided, to extend the intermediate care project, and to take on the employment of a pharmaceutical advisor and a mental health facilitator. In particular, they hoped to coordinate services more flexibly across primary care and community services boundaries.

The objectives of the PMS pilot were as follows:

- To move practices closer together in providing 'PMS+' services through new models of primary care
- To improve the level of patient access to secondary care services
- To develop integrated care pathways for the management of chronic conditions
- To improve the integration of practice based and community based services particularly in providing services to the mentally ill and the elderly
- To reduce the level of administration in general practice

One of the practices left the PMS pilot after the first year because their practice boundary was not coterminous with the new PCG boundary.

The Interviews

The information presented below is based on a series of interviews carried out by the King's Fund last year. A total of 33 interviews were carried out in the practices, four in each: with the lead GP, with one other GP selected at random, one practice nurse (selected by the practice manager) and the practice manager in each of the eight practices. The PMS pilot project lead (Ian Ayres) was also interviewed. In addition, interviews were carried out with 3 key respondents at the Health Authority: with the project lead, with the chief executive and with the public health lead. 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, contracting issues, service provision, communication, job satisfaction and professional activities.

Health Authority interviews took place in June 1998. Practice interviews took place between May and July 1998. Our interviewing took place at a time of uncertainty in the practices – PCG boundary discussions were taking place at the same time. As one GP said:

> **(It's) a difficult time to do interview - we don't know what's happening in the Health Authority - and we can't react until we know what's going on. I personally find it hard to separate off areas - TPP, PCGs, PCAPs etc. (Lead GP)**

The following report, which is based on 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 going live. Because of this ordering, the views of some groups of respondents are more numerous at the start of the report and the comments from others tend to appear later on – this simply reflects the major involvement of different people at different stages of the project.

Initiation and setting up of the PMS Pilot

The lead GPs, who sat on the management board of the TPP, were most-well informed about the background to the setting up of the PMS pilot. The non-lead GPs were generally well-informed, although they gave less detailed responses than the lead GPs because they had been less involved in the early stages.

There was general consensus that becoming a PMS pilot was a logical extension of the work of the TPP – a natural progression. It was also seen as a way of being involved, at the cutting edge:

> **... we were very keen to, in a sense, be in there to format the rules.... (Lead GP)**
>
> **(It's) best to be in on changes early to have more control from the beginning. (GP)**
>
> **.... we wanted to direct the future, rather than being directed. (GP)**
>
> **... (we're) innovative, not tag-along people, we're actually trying to do something better, not passive - at the forefront. (GP)**

Other reasons given for setting up the PMS pilot involved improving on the Red Book, pulling GMS and HCHS budgets together and moving towards PCG status (although this didn't become government policy until later).

On one hand, becoming a PMS pilot was seen as being:

> **an exciting challenge, albeit risky in areas (Lead GP)**

but also:

> **..... it was using flexibilities we knew were there to protect ourselves against the uncertainty we knew was also there. It was a 'safe haven'. (Lead GP)**

The Project lead manager had a more strategic view:

> **(The) overarching objective (is) - to see the PMS pilot as one of the pieces of the jigsaw of becoming a primary care trust. Now, when we entered it, we didn't see it in terms of becoming a PCT, because that wasn't around, but we'd always wanted to be a single integrated organization. So that in a sense is the very high level objective. The lower level objectives of the PMS pilot are to move to practice-based contracts, move away from the medieval Red Book to something that is around purchasing quality of provision. (Practice Lead Manager)**

Respondents felt that all the practices had been in agreement about becoming a PMS pilot, there was overall consensus – although some had been more enthusiastic than others. Anxieties centred around pensions, the financial structure, what would happen if partners left, security of income, fit with the PCG and the idea that the practices may not be able to maintain their individuality.

> **Different people have different concerns..... but not really differences of view. Some are more confident than others. (Lead GP)**

Most people mentioned that the PMS pilot was a logical extension of the TPP. One GP felt that perhaps the PMS pilot wasn't radical enough, for this reason:

> **Is the PMS pilot actually radical enough? It doesn't seem terribly different to what we've been doing as a TPP and as a group. (Lead GP)**

Another wondered what difference the PMS pilot would actually make:

> **..... the future is uncertain as to how things would REALLY make a difference. (Lead GP)**

The removal of the option for unified budgets was greeted with some disappointment:

> **.... it lost some of its attraction for us. (Practice Lead Manager)**

> **It IS considerably weakened by the decision not to have unified budgets - that option was much more attractive. (Lead GP)**

Involvement of Practice Managers, nurses and other staff

It was clear that the Lead GPs on the management group of the TPP had been very involved in the decision to become a PMS pilot, and they acknowledged that although other members of staff had been party to discussions about the future of the eight practices, they had been involved very little in the decision-making process.

We found this to be the case in our interviewing: Practice Managers were reasonably well informed, but most of the practice nurses we spoke to said they hadn't been involved to any great degree, and knew least about the PMS pilot. For example, when we asked how the discussion to

join the PMS pilot was initiated and discussed within the practice, the following responses were typical:

> **Don't know. (Practice Nurse)**
>
> **I haven't a clue. (Practice Nurse)**
>
> **No idea - nothing discussed with practice nurses. (Practice Nurse)**

The practice nurses felt that they hadn't been involved in the decision to enter into a PMS pilot, although several thought that their more senior nursing colleagues might have been consulted.

> **I don't think everyone UNDERSTANDS what it is - so how can you be committed? Especially initially. (Practice Nurse)**

Practice Nurses expressed concerns about losing their jobs, who they were responsible to, and what it would all mean in the long term. Practice Managers said that they had been involved in the decision to become a PMS pilot – they felt that their voices had been heard. Other administrative and reception staff were kept informed, they said, but not involved.

Approval for the PMS pilot

GPs reported consensus over the decision to become a PMS pilot – once concerns relating to getting out of Part II, pensions, staffing, income and 'the unknown future' had been resolved. One described the situation as:

> **... cautious approval, not roaring enthusiasm, though some are more enthusiastic than others (GP).**

All the GPs reported that their practices were unanimous in joining the pilot:

> **We all actively decided - not forced at all (GP)**

However, although everyone agreed that they'd had an individual choice to join the pilot, some questioned whether there really had been any choice as a group, given the direction of development the practices had set out on:

> **This is a natural evolution from fundholding - having started on that road there's no turning back. (GP)**
>
> **Linked with the TPP, fundholding has to go, (we) didn't have a choice. (GP)**
>
> **There wasn't much choice really - we had to go forward in some way - we couldn't have stayed where we were. (Practice Manager)**

Several people mentioned the risk they felt that had been taken in setting up a PMS pilot:

The Health Authority may pull the rug our from under us. Risk is on our side. The partners have really stuck their necks out and could be vulnerable. (Practice Manager)

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

For:	Advantages	Disadvantages
HA	• Reduce administration costs • Taking work off their shoulders • Look to the PMS pilot for ideas and innovations	• More work • Staffing levels threatened
Trust		• Taking their trade away
Patients	• Better level of integrated care • Greater level of care in the community • Input from pharmaceutical advisor • Practices able to target needs of community better • Real improvements for patients	
Practices	• Working with like-minded practices • More fluid boundaries between practices • Streamline bureaucracy • More freedom to do the things we want to do – more autonomy • Harder to break the group up • To preserve the initiatives of the TPP • To rewrite the Red Book • Setting quality standards • Concentrate on areas that will make a difference to our population • Potential to effect change in nursing • Improve surgery facilities	• More change and more upheaval • Insecurity – potential risks around salary, pensions • Increasing workload • Difficulties of communication in a large group • The hostility of other GPs • Erosion of independent contractor status – leading the path to salaried service • Become responsible for more difficult clinical decisions – much more the gatekeeper
Pilot staff	• Better communication • Share expertise and knowledge • Integration of management - more efficient • Personal satisfaction – we'll come out of it feeling good • Better access to training	• Worse communication • Integration of management - job losses • Difficulty of coordinating community nursing across a large area
Local GPs	• Learning lessons others can use	• The hostility of other GPs • Resentment
Others		• Expense – employment of consultants to draw up contracts

GMS vs PMS

We asked what advantages and disadvantages doctors associated with the GMS contract, and how they thought PMS would differ from GMS.

GMS was generally felt to be secure, especially having the national negotiating committee, and reliable. GMS had been developed over time, was traditional, predictable, with some incentives to practice. The overall feeling was that "it's comfortable". As one GP said:

> **You know what you have to do to earn the money. (Lead GP)**

However, criticisms of the GMS contract were numerous:

- Bureaucratic
- Inflexible
- Reliance on counting activity
- Not evidence-based
- Perverse incentives
- Restrictive
- Confusing
- It has just evolved, with extra bits added on
- It disadvantages inner-city practices

At least initially, it was felt that the PMS contract would not differ greatly from the old GMS contract:

> **I'm not anticipating any dramatic change. (GP)**

but the plan was to change it gradually over the following months to:

- Be more flexible
- Be less bureaucratic
- Link good care with remuneration – payment related to quality and outcomes
- Be a block contract for delivery of specific services
- Develop disease-specific areas of care

Plans for the new contract were summed up by the Project Lead Manager:

> **(The) PMS pilot contract - this needs to be achieved over 3 years, we're not there yet – (we) must specify a service including quality measures and a performance framework and then rewards for delivering a service. I want to get to something that the purchasing of primary care relates to purchasing quality not quantity. The Red Book is very much about quantity. That should allow us to put the right levers in place to improve quality. Remuneration therefore follows improved quality of care. (Project Lead Manager)**

Experiences of Local Contracting

Lead GPs experiences of developing the contract varied. They said it was:

> **Frustrating... (Lead GP)**
>
> **Rushed... (Lead GP)**
>
> **Enjoyable! (Lead GP)**
>
> **It was easier than I thought – I was pleasantly surprised.... (Lead GP)**

Non-lead GPs felt that they had either not been involved, or were only peripherally involved. Practice Nurses said that they had not been involved at all. Practice Managers had read and commented on drafts of the contract:

> **The contract was done by Ian Ayres and Howard Freeman with input from GPs. We read it - our influence was on different paragraphs. As practice managers, we had more experience than GPs on the Red Book - we deal with those issues, so we did have say. (Practice Manager)**

Practice staff felt that the Health Authority had not been helpful:

> **The process was absolutely appalling. They were completely obstructive (Lead GP)**
>
> **.... all they did was to change it and destroy it.... that's what it felt like at the time. (Lead GP)**

External consultants were called in to support the practices and other advice was sought from partnership lawyers and colleagues in other pilots:

> **(We) network like mad with other projects - PMS and TPP. (We) picked the brains of other leading primary care groups. (Project Lead Manager)**

Relationship with the HA/other professionals

Practice staff we interviewed were critical of the Health Authority, and felt that their strategy for primary care had not been communicated well, if at all, to the practices.

> **We have very little contact with (the Health Authority) as a PMS - I don't know what their priorities are. You ring them up, they're busy, they don't reply. They're in limbo. They're having to go through so many changes in such a short space of time - we're giving them more headaches. They're not as proactive as they could be. (Practice Manager)**

However, some of the Lead GPs had been involved with the Health Authority in other capacities, and felt that they gained their knowledge of Health Authority strategy indirectly:

We understand them. We're a group of Gps with a huge range of experience... We understand their agenda - we are lead Gps who've seen both sides - which is unusual. (Lead GP)

The TPP is a sub-committee of the Health Authority - we're obliged to meet them regularly - we can't BUT be aware of what's going on. (Lead GP)

The financial situation at the Health Authority was perceived to overshadow everything else, and staff at the pilot felt that the Health Authority viewed them very negatively, possibly even wanting to break up the TPP. Although they wanted the Health Authority to view the pilot in a positive light:

I hope we're a feather in their cap in some senses. It ought to help them improve a wider spectrum of primary care if they choose it that way. (Practice Lead Manager)

They felt that the reality was somewhat different:

... we're a major irritant (Lead GP)

We're just a pain in the neck for them. (Practice Manager)

Its given them more work at a time when they needed this like a hole in the head (Lead GP).

.... the PMS pilot (is) just another burden for then to administer. (Lead GP)

(It's) dispiriting to see - quite a negative attitude from the Health Authority over the last 3-4 months. The noises I hear, responses to our plans – (they're) negative to the TPP. (GP)

One GP described the difficult position he felt PMS pilots found themselves in, not just with the Health Authority, but from other professionals:

Insecurity – (PMS is) a big risk. We don't know at the moment if its what is wanted at a national level with the movement towards PCGs. We're out on a limb with our GP colleagues. There is suspicion that we are in this to line our pockets by diverting HCHS money. We're 'scabs' for going outside GMS. There is little support from the NHSE. There is distrust of the pilots nationally - like there was with the first wave fundholders. There are a lot of downsides - what's the point? But we can see the potential. (Lead GP)

Relationship with other local groups

The staff we interviewed felt that locally the pilot was viewed with some antagonism:

We're a politically incorrect group – (we're) self-selecting, middle class, fundholding. (Project Lead Manager)

Some people have been anti our group - self-selected, better-off fundholding practices. (GP)

At the moment we're not the most popular are we? .... we're seen as a threat by local Gps. (Practice Manager)

.... (there is a) perception that we're non-sharing, exclusive and especially favoured by Health Authority and others in terms of finance and perceived lack of willingness to take part in other groupings. (Lead GP)

Some staff we interviewed felt that the pilot had become somewhat insular and didn't always present themselves in the best possible light:

We need to wheedle our way back in at a local level. We've been cocooned within the TPP, we need to find out what's happening closer to home. We don't know what's happening – (we're) in limbo. (Practice Nurse)

(There are) lots of mixed feelings about the TPP - on one hand everybody in the TPP shouts about how good they are but on the other hand what I see is that there are people who are outside the TPP look at practices in the TPP and wonder whether they're really as good as they claim to be. I think there needs to be a different pitch - there's been some really good stuff in the TPP but sometimes the way it's shouted about detracts from the benefits, detracts from people being willing to take on board the ideas. I could be wrong, but that's just a feeling. (Practice Manager)

Adverse impact on others

Several people we talked to in the practices were concerned that the PMS pilot might draw funds away from other areas and felt that the pilot shouldn't be seen to be over-resourced:

Waiting lists - will we jump ahead? I worry about inequalities developing. I worried about this with fundholding. Or will we get overloaded? People moving to us because they know we're in a PMS pilot and they'll get better care. People now have much more choice. (Practice Nurse)

..... (the) possibility of taking funding away from hospitals - will someone be denied a hip replacement if we get extra funding? (Practice Nurse)

I hope we won't have any adverse effect - I don't want us to affect anyone else badly (all 8 feel like this). We don't want to take anyone else's funding or resources. (Lead GP)

The view of the Health Authority

Although the staff we interviewed in the pilot felt that the Health Authority did not support them, the Health Authority view was different:

Obviously we support it, otherwise it wouldn't have gone through. (Health Authority Manger)

But there were some qualifications in their support:

Where is this leading - will we have an HMO in our midst? Can the Health Authority really cope with a thousand flowers blooming on its patch? They are an impressive group of GPs but we always have this problem balancing the needs of the leading edge with those of the people we really need to target. (Health Authority Manager)

The Health Authority felt strongly that locally sensitive contracts should be based on needs assessment:

Our biggest concern was that it is not geographically based. It does not fit with a public health model, is meaningless from the point of view of looking at populations. (Health Authority Manager)

The short timescale involved in setting up PMS pilots affected the response of the Health Authority to the bid:

(There) wasn't really time to say 'well, we'd like to develop a PCAP in this area' - to develop key priority areas. This'd have been ideal. (Health Authority Manager)

(It was) quite a fraught process – there was only a short timescale to develop - January to March. All supporting resources went to the PCAP who used consultants to draw up contract. We found it hard to agree as there was no time to go through clause by clause. We agreed to lots of get-out clauses for both sides - if either is not happy, we can move back to analogous GMS contract. (Health Authority Manager)

Efficiency Savings, incentives and penalties

There was general agreement amongst the GPs that the pilot would lead to efficiency savings, but that these would not happen in the short term. Areas identified where savings might occur included reducing bureaucracy and integrating management. On the PMS plus side, it was thought that the mental health work, prescribing work and intermediate care work would lead to savings. One GP pointed out though that:

(I) don't anticipate savings - but doing more from the same money. (GP)

Practice nurses saw potential areas for saving in: bulk purchasing, skill-mix and prescribing. Practice Managers thought that savings might be made on the clerical side and in terms of management staff.

Respondents at the Health Authority felt that savings could potentially be made by the pilot:

As they improve quality of primary care - they might make savings there. Using the same amount of money, but more effectively. Possible reductions in referrals and prescribing. (Health Authority Manager)

All the Gps we spoke to were sure that the Health Authority would be seeking efficiency savings from the pilot.

Influence on clinical behaviour

When asked whether incentives or penalties would alter clinical behaviour, there was agreement amongst GPs that incentives should be linked to good practice rather than financial benefits.

All the lead GPs felt that being part of the PMS pilot was likely to influence their clinical behaviour:

- Force one's behaviour re guidelines and protocols
- Greater liaison with secondary care providers
- Intermediate care scheme
- Prescribing
- Clinical management pathways
- Mental health facilitator
- Clinical standard setting

Non-lead GPs weren't so sure about this, although most thought (or hoped) that their clinical behaviour would change for the better.

Practice nurses were undecided whether involvement in the PMS pilot would affect their clinical behaviour, although one felt that she would now be more aware of ordering supplies.

Quality of care in the practices

All the practice staff we interviewed felt that the group of eight practices provided a very high level of clinical service:

Very high - within the top 10% of general practice. These are high quality practices. (Lead GP)

Absolutely excellent service - we're always available for patients, we work extremely hard - we couldn't work harder. Very committed. (Practice Nurse)

It's brilliant, absolutely brilliant. 8am till 8pm, we don't shut our doors, doctors are running surgeries all day long, we don't stop. Gps are accessible all day, with a very low level of nights. Patients have TOTAL access to us. Diploma of Management Studies survey of 400 patients is to be repeated this year - clinical services absolutely excellent! (Practice Manager)

They also felt that the other seven practices were of a uniformly high standard, although several people said they had no knowledge of them clinically.

In terms of non-clinical services, the main improvements suggested were in premises. Lack of space was felt to stifle development in some practices – preventing development in minor surgery, chronic disease management and physiotherapy for example. Other areas where improvements were suggested were ethnic care provision, out-of-hours care and implementing new guidelines for treatment. Several GPs and Practice Nurses felt that it was difficult to balance the number of appointments with patient demand.

There was agreement that the PMS pilot would lead to better standards in the delivery of care – by improving the service itself, but also increasing the breadth of services provided. However, when we asked whether PMS was likely to alter the quality of service provided, one of the practice nurses said that she felt that the practices were already working to extremely high standards, and she found it hard to think about quantifying improvements for patients when standards were already so high:

> **I honestly don't know – this is the hardest thing to be able to clarify or justify (Practice Nurse)**

Roles

There was a general feeling amongst the doctors that their own roles would not change that much as a result of being part of the PMS pilot – although one or two GPs felt that increasingly they would:

> **The PMS pilot will lead to increasing integration with the practices involved. Organization will be based around the pilot, not the individual practice. Increasingly I'll come out of practice into the pilot. (Lead GP)**

> **Yes, I'll go into more supervisory management as well as clinical roles. (GP)**

The doctors thought that the roles of practice managers and nurses might change as a result of increasing integration of the management structure and nursing team development in the integrated nursing team.

Practice nurses were uncertain whether their roles would change – some thought they would, others thought not. However, they thought that some of the other nurses' roles had already changed as a result of the integrated nursing team. One nurse mentioned the fears of redundancy at the practice management level and worried that:

> **... (we) may not have daily access to practice manager for questions, queries, complaints. (Practice Nurse)**

Many of the practice managers felt that the centralization of the management function would mean that the practice manager's role was likely to become a lesser one within the practice.

Job Satisfaction

Morale amongst lead and non-lead GPs was generally reported to be 'high' or 'good' although the discussions around the setting up of geographical boundaries for the local PCG had upset and unsettled some. In general, morale amongst practice nurses was high, although in practices where staffing levels had changed, this was less so:

> **A bit under pressure at the moment. (Practice Nurse)**

> **Very up and down. (Practice Nurse)**

Practice managers also described their morale as being high, although they expressed the highest levels of uncertainty about the long-term effects on job security of joining the PMS pilot.

There was a general level of optimism overall that being in the PMS pilot would increase job satisfaction by reducing paperwork and giving the practices more freedom. However, practice nurses were more divided as to whether job satisfaction would increase – some said it would, others said it wouldn't.

> **It could do - it could work both ways. Positive and motivating if we push things forward and nurses have a voice. Or demoralising if we don't feel we own it. Effects depend on the way it's managed. (Practice Nurse)**

Workload

Responses from GPs varied when asked if the PMS pilot would increase their workload – some said yes, others no. The overall feeling was 'watch this space'!

Practice nurses felt that there were a number of clinical roles they could take on, although they acknowledged that they had finite time, limited space in the practices and some might need additional training. The new roles mentioned were: counselling, suturing, telephone triaging, chronic disease management and prescribing.

Practice managers too, were uncertain about the effect of the PMS pilot on their workload, largely because of their uncertainties about the centralization of management.

Patient views on service provision

We asked the Practice Managers whether they currently employed any means of identifying patient views on service provision. All the practices had tried a range of different ways of collecting patient views – comments and suggestions, competitions, health days, health fairs, questionnaires, newsletters, patient participation groups, involvement of the Community Health Council. Almost all practice managers thought that the PMS pilot would alter the ways in which patients were asked for their views, although they were doubtful about response rates. As one said:

> **I'm willing to try anything ..... we've tried so much already. (Practice Manager)**

Specific areas to be included in the PMS pilot

Mental health

Perceptions of the care provided for long-term severely mentally ill were best described as 'patchy' – partly, it was felt, because the catchment area of the TPP stretched from the inner city to the suburbs. The appointment of the proposed mental health facilitator was seen as being a way to integrate services, and to coordinate between the pilot and providers. Strong links with community mental health teams were reported.

Prescribing

Previous contact with a community liaison pharmacist at the local trust was described as helpful in influencing GP prescribing. The overall feeling was that this post would be useful.

> **We think we'd get a lot of value out of this. Contact previously with liaison pharmacist (was) very useful in improving prescribing. (Lead 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:

- Is the project up and running?
- Improving satisfaction with the quality of care
- Structural changes – advisors in post, rationalization of practice management
- Streamlining of bureaucracy
- Progress with developing contract
- Developing postgraduate education
- Just deriving measurables and a plan for the future
- To work within budget
- Job satisfaction
- Do nursing teams make a difference?
- Improvements in communication
- Value for money
- Impact on public health
- Impact on other agencies eg social services

Long term:

- Staff morale
- Proven gains – influence on referrals, prescribing,
- Influence on wider community/PCG
- Quality standards to exceed national standards

- Improving primary/secondary interface
- Financial savings – value for money
- Development of specialties in the practice
- Improvements in access for patients

Pace of change

There was only 11 months from submission of expressions of interest to the Health Authorities to actually going live, and the obvious time constraints were mentioned by both the Health Authority and the PMS pilot – in terms of the bidding process, drawing up the contract and having detailed discussions with other groups. Several people felt that after the rush to become a PMS pilot, tangible changes had been slow to follow:

> **Not sure yet - haven't seen any changes on the ground. Nothing since 01 April has changed our way of practising. (GP)**

> **Big flurry of activity - rewriting Red Book – a rush to sign. Afterwards nothing has really happened..... (It's) business as usual at the front end. (Practice Manager)**

It was suggested that, in this PMS pilot, unlike some others, changes might not happen straight away:

> **We're different from other PCAPS, lots of them start with a blank sheet. (Practice Lead Manager)**

> **PMS goes into trough of not being visible for a year or so - but it'll come back with PCTs. (Practice Lead Manager)**

> **For us, unlike some others, PMS pilots are a small thing. Managing the project is easy - rewriting the Red Book is difficult. We're relatively unique - It's a different type of project to some of the others. I think we'll get off to a slower start than some of the smaller ones, but will deliver more eventually. I'll just be pleased to get things off the ground in Year 1, but by the end of Year 3 should see some improvements in the quality of service provision. (We) don't want short-term deliverables, (we) want longer-term achievement..... (Practice Lead Manager).**

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June 1999

Appendix 9

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