Edith Cavell Practice
Personal Medical Services (PMS) pilot

King's Fund Evaluation Report
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Clare Jenkins
Project Officer

Richard Lewis
Visiting Fellow

Steve Gillam
Director, Primary Care Programme

King's Fund

Primary Care Programme
11-13 Cavendish Square
London
W1G 0AN
Tel: 020-7307-2689
Fax: 020-7307-2810
Email: cjenkins@kingsfund.org.uk

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Clare Jenkins, Richard Lewis, Steve Gillam
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Background

The Edith Cavell practice in Lambeth became one of only eight nurse-led Personal Medical Services (PMS) pilots in the country when it 'went live' in April 1998, and one of four first-wave PMS pilots in the Lambeth, Southwark and Lewisham health authority area. The pilot was set up and managed by Lambeth Healthcare NHS Trust (now Community Health South London NHS Trust), who had identified a gap in service provision in the Streatham Hill area, particularly for those groups of people most likely to be marginalized from mainstream primary health care, such as refugees and asylum seekers, drug users and homeless people. Taking on a PMS contract, the intention was that the practice would provide a full range of nurse-led services in order to meet the stated aims of:

- Achieving the highest standard of primary care as measured against Lambeth, Southwark and Lewisham health authority's banding criteria and performance indicators
- Delivering health gain in respect of health outcomes relevant to the registered population
- Providing access to marginalized populations currently not well served by local provision
- Providing services that offer value for money against a benchmark of the cost of conventional general practice

The practice took on the list of a co-located single handed practice, launching this as a second wave pilot in April 2000.

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

Purpose of the report

This report provides an overview of the development of the Edith Cavell practice over its first three years as a PMS pilot, and an analysis of the major themes that have emerged from the evaluation. The various data sources and collection

methods have enabled a number of different evaluation perspectives to be presented:

- The qualitative views of pilot participants, commissioners and other interested partners have been collected through 29 in-depth interviews
- The implementation of the pilot's proposals to work more collaboratively with a range of other organizations has been assessed through a focus group including pilot and key staff from a range of partnership organizations
- The views of patients have been analysed through the use of a patient satisfaction questionnaire
- The organization of the pilot and key practice characteristics have been assessed through a practice profile survey

Key findings

- The pilot, in common with seven other first-wave PMS pilots in England, set out a new model of primary care with a nurse taking on the lead role. This was a highly ambitious and innovative model, providing opportunities for enhanced professional roles for nurses, and was based on sound national and international evidence.

- The pilot was stimulated in response to identified need in one of the most deprived areas of inner London - a need that was not being met by traditional means. The pilot has succeeded, in sometimes very challenging circumstances, in creating a new practice, and the steady list growth suggests that the pilot was well targeted.

- In embarking on such an ambitious project, stakeholder interviewees felt that the pilot 'always had a mountain to climb'.

- Community trust staff felt that the pilot needed a lot of support from the health authority. However, relationships between the health authority and the pilot had not always been easy, with a general view that the health authority had not supported the pilot at the outset. Relationships improved over the lifetime of the pilot, and both the health authority and the PCG have been able to use learning from the Edith Cavell practice to influence primary care development in the area. This was particularly important as Lambeth, Southwark and Lewisham has the highest rate of PMS take-up in the country.

- Although trust input had been valuable in certain areas such as information technology and finance, staff in the pilot did not always find working under the umbrella of a larger organization easy, citing the slow response times to sort out any operational problems which arose.

- It was felt that the negotiations around the setting up of the Wave 2 pilot had complicated matters for the Wave 1 pilot, and the level of integration between the two practices was an area of confusion.

- At the outset, staff in the practice felt that the quality of care they provided was very high. The relatively small list size meant that they were able to offer long consultations to those who needed them. However, as time went on, and as list sizes grew, there was increasing concern about the practice's ability to cope with the resultant workload. Practice staff described the situation as feeling 'uncomfortable'.

- Quality of care assessed using the Practice Profile questionnaire provided variable results in comparison with PMS pilot practices taking part in the National Evaluation, and GPAS patient satisfaction scores were, on the whole, low or very low. However, the response rate to GPAS was poor, perhaps not surprisingly, given the highly mobile and socially deprived population the practice had set out to attract, making direct inter-practice comparisons problematic. The practice was unable to identify any patients who met the inclusion criteria for the Angina Audit study, but again, this was not surprising given the age and sex profile of the practice population.

- The Edith Cavell practice was set up specifically to increase accessibility for patients marginalized from mainstream primary care, and practice staff felt that the practice had been successful in this intention. They described their registered population as being 'totally different' in comparison with the patient lists of neighbouring practices. Attendees at our focus group meeting, set up to investigate further the pilot's work with refugee and drug users' organizations and hostel managers suggested that the practice was successfully providing a more responsive service for patients with high needs. However, staff turnover in the practice was mentioned as being problematic, leading to a lack of continuity for patients, and difficulties in registration protocols being followed by reception staff.

- One of the key aims of the practice was to set up links with partnership organizations working closely with specific client groups. Representatives of these organizations who attended the focus group meeting were enthusiastic about the links they had built up with the practice. However, there was some feeling from practice staff that there was the potential to strengthen these further once more immediate difficulties within the practice were addressed.

- The practice had attracted some negative feeling from neighbouring practices and from the Local Medical Committee. This was a common finding from all four PMS pilots taking part in the King's Fund evaluation, although local hostility appeared to dissipate as the pilots became more established. The relationship with the Primary Care Group similarly, was described as having improved, and by year three, the PCG were enthusiastic about the role PMS would play in the local health economy.

- One of the most problematic areas identified during the interviews in the practice was the negotiation of the respective roles of doctors, nurses and administrative staff. These difficulties were described often graphically, and in emotional terms. It did not appear that the difficulties encountered in the negotiation of doctor/nurse roles had been resolved and, by the end of year three, the distinctive nurse-led focus of the practice appeared to have been lost.

Conclusion

In year one, staff at the Edith Cavell practice assessed themselves as providing high quality care to their registered population. They felt that they had succeeded in registering the groups of high-need patients they had set out to attract, and who they saw as being marginalized from more mainstream primary care services. In years two and three, the practice list size had grown (in part due to the inclusion of a vacant list as a second wave pilot operating from within the same building) and workloads had become uncomfortably high. This led practice staff to suggest that they were losing their focus on high need groups of patients, whilst struggling to 'cope with the sheer weight of patients'. Staff at the Edith Cavell practice, set up as one of the first nurse-led practices in the country, found it very difficult to negotiate roles – whether for doctors, nurses or for administrative staff. These complications were attributed to the 'lack of vision' of the community trust and a lack of clarity about how the PMS pilot was to be run on a day-to-day basis. The difficulties were compounded by the high turnover of staff and the stresses of setting up a 'unique' and much-observed project. While the health authority felt that the pilot had confounded the 'sceptics' by proving that another practice was viable in the area, there was a feeling from within the practice that perhaps the services the pilot provided were not so very different from the traditional type of General Medical Services (GMS) they had hoped to improve upon.

Introduction to the Edith Cavell PMS pilot

Set up by Lambeth Healthcare NHS Trust (now Community Health South London NHS Trust, the Edith Cavell practice is made up of two PMS pilot practices – one first wave, and the other second-wave, based within a purpose-built trust-owned building on Streatham Hill in Lambeth. The first-wave PMS pilot, about which this evaluation report is largely concerned, was set up as one of the original ten nurse-led and nurse-partnership PMS pilots given permission to 'go live' in April 1998 in England.[1] The PMS pilot bid document described a situation in the Streatham Hill area where the local population 'is characterized by a high number of individuals who are marginalized from society and mainstream health care'.[2] Groups of individuals identified included asylum seekers, refugees, the homeless, those with mental health problems and substance users. Primary care provision in the area was described by the bid document as being 'of patchy quality and under significant pressure'.

It was envisaged from the outset that the pilot would have a different skill mix from more traditional models of general practice, and the intention was that patients would routinely see a nurse when visiting the PMS pilot, only being referred to a general practitioner if this was considered necessary. The trust felt strongly that placing a nurse in the lead clinical role within a general practice setting would be a successful model for the provision of primary care services in this deprived area of inner London. Based on their experience of providing nurse-led services to homeless people across the three boroughs of Lambeth, Southwark and Lewisham, and from literature reviews, the Trust estimated that, once the pilot was underway, no more than 20 or 30% of patients would need any direct input from the GP.

The aims and objectives of the PMS pilot were:

- Achievement of the highest standard of primary care as measured against Lambeth, Southwark and Lewisham health authority's banding criteria and performance indicators
- Delivery of health gain in respect of health outcomes relevant to the registered population
- Provision of access to marginalized populations currently not well served by local provision
- Provision of services that offer value for money against a benchmark of the cost of conventional general practice

The Edith Cavell PMS pilot was given permission by the Secretary of State for Health to go live in April 1998 – one of four PMS pilots in the Lambeth, Southwark and Lewisham health authority area. A lead nurse and two job-share GPs came into post in the summer and autumn of 1998, and the pilot opened its doors for new patient registration in September of that year. Although patient registration did not happen as rapidly as had been envisaged, by the end of the first 12 months of

[1] Lance Gardner. Nurse-led Primary Care Act pilot schemes: threat or opportunity? Nursing Times, July 8 1998.
[2] A nurse led primary care team supported and managed by Lambeth Healthcare NHS Trust: an application for a personal medical services pilot under the NHS (primary care) Act 1997. Lambeth Healthcare NHS Trust, undated.

operation, the pilot had registered 1134 new patients. In April 2000, a former single-handed practice which had been co-located within the same premises as the Edith Cavell Wave 1 pilot, was launched by the Trust as a Wave 2 pilot. As a result of this, some 2,500 additional patients joined the Edith Cavell practice, although the two lists continued to be maintained separately by the health authority.

PMS pilots in England – a brief history

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

Practice characteristics

Table 1 below shows the numbers of clinical staff working at the practice.

Table 1: Practice staffing (clinical posts)

(Wte = whole time equivalent)	**Edith Cavell (W1 and W2 pilots combined)**
No of registered patients (January 2001)	4,946
No. of GP principals (wte)	0.75
No. of vacant GP principal posts (wte)	1.85
No. of additional GPs eg registrars, assistants, retainees (wte)	Locums covering above vacancies
No. of nurse practitioners (wte)	1.00
No. of vacant nurse practitioner posts (wte)	1.00
No. of practice nurses (wte)	1.46

[3] Department of Health. Personal medical services pilots under the NHS (Primary Care) Act 1997: a comprehensive guide - second edition. London: NHSE, 1998.
[4] Jenkins C. Personal medical services pilots - new opportunities. In Lewis R, Gillam S, eds. *Transforming primary care: personal medical services in the new NHS*, pp 18-28. London: King's Fund, 1999.
[5] Department of Health press release 99/0520. 32 new pilots takes total to nearly 300: additional personal medical services pilots announced. 1999.
[6] Department of Health press release 2000/0724. Local doctors and nurses voting with their feet for reform. 2000.
[7] Great Britain. Parliament. The NHS Plan: a plan for investment, a plan for reform. London: Stationery Office, 2000.

Evaluation

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

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

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

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

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

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

Evaluation of the Edith Cavell practice PMS pilot

The King's Fund evaluation of the Edith Cavell 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 Lambeth:

• In-depth interviews	to ascertain the views of key stakeholders in the pilot and in other organisations working closely with the pilot
• 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 2: Interviews carried out at the Edith Cavell PMS pilot

	Year 1	Year 2	Year 3	Total
Practice interviews	3	5	5	13
Health authority interviews	3	1	1	5
Community trust interviews	3	2	1	6
'Other' interviews	-	3*	2*	5
Total	9	11	9	29

(* telephone interviews)

Interviewees were selected randomly from the practices, making sure that lead GPs, non-lead GPs, practice nurses, nurse practitioners, district nurses, health visitors and 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, however, in our study, the practices were asked to complete their own questionnaires. Not all practices were able to provide us with 20 patients with a diagnosis of angina – and the Edith Cavell practice was unable to provide us with any patients who fulfilled the inclusion criteria. That the practice was unable to identify any patients with angina is not an unreasonable finding when the age/sex structure of the list[10] is compared with national morbidity statistics[11] – the practice population is very young (91% aged under 40 years), and more than half of the patients (58%) are female.

The General Practice Assessment Survey (GPAS)

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

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

In addition, there are several non-scaled questions – these relate to referral, coordination, likelihood of recommendation of GP to family and friends, overall satisfaction and a number of socio-demographic questions. 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

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

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

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.[12]

The General Practice Assessment Survey has been used twice during our three year evaluation of London PMS pilots (see Appendix 2), 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. At the Edith Cavell practice (for both Wave 1 and Wave 2 lists), the questionnaire was sent out in September 2000 to 200 randomly selected patients, on each of the two separate lists, aged 16 and over, who had been registered for more than 12 months at the practice. A reminder letter to non-responders was sent in October. The overall response rate for the first wave patients was 11%, a very low figure in comparison with the other practices in our study and for the second wave pilot list, the response rate was 31%, again a low figure compared with the other pilots. However, it is worth remembering that the Edith Cavell practice specifically set out to register refugees and asylum seekers, many of whom would not have had English as their first language. In addition, we had previously sent GPAS to 200 randomly-selected patients registered with the co-located practice which subsequently became the Wave 2 pilot. This practice went live as a Wave 2 pilot in April 2000 and we hoped that these questionnaires would allow us to make a 'pre-PMS' comparison with subsequent patient satisfaction in the Wave 2 pilot. The questionnaires were sent out in February 2000, with a reminder to non-responders in March, and the response rate was 36%. GPAS results from the practices are given in Appendix 3.

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

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

[12] 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.

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

The Practice Profile Questionnaire was sent out to the four London PMS pilot sites taking part in the King's Fund evaluation, between November 1998 and April 1999 and again in December 2000. This was designed to provide 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 4.

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 Edith Cavell PMS pilot was to improve services for those who had previously experienced difficulty in accessing primary care, and we used this as a theme for our focus group discussion. In addition to two members of King's Fund staff, and two members of practice staff, six key stakeholders involved in providing services for refugees and asylum seekers, drug users and others living in local hostels attended the meeting. See Appendix 5 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 this questionnaire at our other three PMS pilot sites.

The Findings

The main findings from the interviews we carried out at the Edith Cavell practice in the first year have already been reported (see Appendix 6). Overall early themes were derived, in the most part, from the interview data, and included the following:

Summary of year one interview data

- Trust staff stated that the legislation for the nurse-led pilots was very last minute, which had caused difficulties in engaging the health authority at the outset. However, once they had been persuaded to support the pilot, the community trust felt that the health authority had been very supportive, albeit at a theoretical rather than a practical level.
- Staff in the practice acknowledged that they were setting out with enormous aims, using a nurse-led model for which evidence was not UK-based. While staff were enthusiastic about the opportunities to provide services in a new way and to experiment with roles, they found the short time scales and the steep learning curves 'quite frightening'.
- Because the nurse-led model was a new one, legislation had not always kept pace with developments, and staff found working up against the legal limits of nursing practice frustrating.
- The list size grew quite slowly at the beginning of the project, and staff were able to offer long consultations according to patient need. They were concerned that they would not be able to offer such a high quality service when workloads increased.
- Pilot staff felt that, by offering a very different type of service, they attracted a lot of attention from outside, not all of it positive.

By the time data collection was carried out in subsequent years, there had been a very high turnover of staff, and patient numbers had increased to just under 5000 in January 2001 (the high number is largely because of the adoption of the wave two PMS pilot list). The themes arising from the various methods of data collection in years two and three included the following topics:

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

The rest of this report considers the developments that have taken place in the PMS pilot 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. The Edith Cavell contract, at least in the first year, largely mirrored the Red Book with little evidence that the flexibilities produced under PMS had been used, a finding that was common to many first-wave pilots:[14]

> **We went for basically a Trust contract with basically a load of primary care policies attached. The reason we did that - the reason why we didn't go for start-from-scratch negotiations - was that strategic implications were more important than operational ones for us. So what we didn't want to do was to write a contract from scratch in haste, which then set a precedent which we were locked into. We went for a very fluid level of contracting and we'll negotiate different parts later. 'Red Book nouveau' we call it.... (health authority, year one)**

However, the contract did build in a number of new elements and the health authority pointed out that there are 'a long list of basics in the contract', including:

- cash-limited contracts with salary caps for PMS pilot GPs for all sites in the health authority area
- developmental targets, for example the development of a business plan by July 1998
- an entry requirement that the practice must attain at least *Band D* (in the Lambeth, Southwark and Lewisham banding structure) and move to a *Band E* as a minimum standard. The pilot was also expected to meet basic minimum standards relating to national targets
- block payment in the first year, moving to 80% block and 20% performance-related payment in the second year, dependent on achieving developmental milestones, such as banding
- the inclusion of mainstream employment practice, with posts advertised and interviews held

In year two, practice staff described the difficulties they had encountered due to a shortage of front-desk staff, and their negotiations to secure additional funding through contract variation:

> **.....we want more staffing. As the list has grown, we'd seriously underestimated admin – reception and practice management support – and we've asked for a top-up. The practice needs cover from 9am to 7pm, and we've only got one receptionist – crazy – we just hadn't thought..... (community trust, year 2)**

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[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.

...there was a lot of discussion about the contract variation and so on, I mean, there were difficulties because the practice was growing so fast and the resources were not matching the size of the practice in the end, but I'm not aware that anything really got changed (practice, year three)

The community trust put in a bid to take on the list of the single-handed practice co-located within the same building, and there was some feeling that, although running the two practices together would solve some staffing difficulties, the process of bidding for second-wave pilot status had caused some insecurity:

The Wave two issue has been around ever since we've been around, and I think that's complicated life for us (practice, year 2)

The level of integration between the two pilots was also an area of uncertainty:

...it depends a lot on whether we stay as two separate pilots completely, or whether we end up being accepted as a 'one' plus 'two'. You know, quite how that will work out.... I think that the 'wave two' one may or may not influence that, and the health authority haven't really decided whether they want us to be one or two (practice, year two)

Running two pilots in different waves added a level of confusion and uncertainty that was difficult to resolve. The team made determined efforts, including holding 'away days', to try to bring a coherence to what were two very different practices.

Quality of Care

At the outset, practice staff felt that they were providing high quality services, partly because their list size was so small:

We've been able to devote more time to our patients. We've got two highly-skilled GPs, and we did have a highly-skilled nurse practitioner and clinically, there was never any question, even if we were understaffed and overworked, there was never any question about that with regard to the patients. Because it was quite new for the admin team, we made an extra effort with the patients, to make them feel welcome and relaxed and things got done, things didn't just get put in a tray and then forgotten about because we had too much work to do, because it was all new to us. We had to remember that we had to do this, and we had to do that, so we probably gave over and above (practice, year 2)

This view that the practice was providing high quality services was confirmed by the health authority:

***(the practice)* started as an A band, but now are a D band, and *(we)* have no reasons to doubt the technical quality of care delivered (health authority, year 2)**

At the outset, in year one, staff felt that they were able to provide lengthy consultations, based on patient need:

> **....at the beginning we had time, you know, if it took an hour for an appointment with the interpreters - to ring everybody round, to sort everything out - we could do it, whereas we can't do it any more (practice, year 2)**

However, as list size increased, there was some concern that the practice would be unable to keep pace with patient demand, and would begin to lose its focus on marginalized groups as a result:

> **There is some feeling that the practice will lose some of its original focus and just try and cope with the sheer weight of patients rather than be able to spend that time with refugees, with target groups (practice, year 2)**

> **It has just begun to feel out of control in terms of numbers of patients – it's just begun to feel like that. Whereas, before the summer, you know, it was OK, now it feels that we're just holding on. We've got away with stuff without having perhaps the best administrative make-up and now we're not going to get away with it..... (practice, year 2)**

In year three, the situation was described as being 'skin of the teeth stuff, and it's not comfortable' (practice, year 3).

In addition to the self-reported views on service quality, we used two additional data collection methods to assess more objectively the quality of care provided in the practices – the Practice Profile Questionnaire and GPAS, a patient satisfaction questionnaire. We were unable to use the Angina Audit questionnaire as the practice could not identify any patients who fell within the inclusion criteria.

The Practice Profile Questionnaire

The results of the Practice Profile questionnaire are given in Table 3 below. They show that, between the two data collection rounds, the Edith Cavell practice had improved on the access scale, remained the same on the prescribing scale and had decreased scores on the organization and chronic disease management scores. However, missing data were recorded on both the organization and the chronic disease management scales, which could account for the apparent falls on these scales. 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 practice. Compared with National Evaluation data for year two, the Edith Cavell practice scored more highly on the access and prescribing scales than the national sample of PMS pilot practices, but less highly on the organization and chronic disease management scales.

Table 3: Practice Profile questionnaire results for the Edith Cavell practice

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
Edith Cavell practice	**33.3**	***0***	**75.0**	**100.0**	**80.0**	**80.0**	**72.7**	***63.6***
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

The practice profile questionnaire analysed self-reported data from the practices. The GPAS patient satisfaction questionnaire on the other hand, 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 the Edith Cavell practice (and comparator data from the Wave 2 pilot) can be found in Appendix 3. In summarising the data, Table 4 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.

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]

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

Table 4: GPAS scores for the Edith Cavell PMS pilot

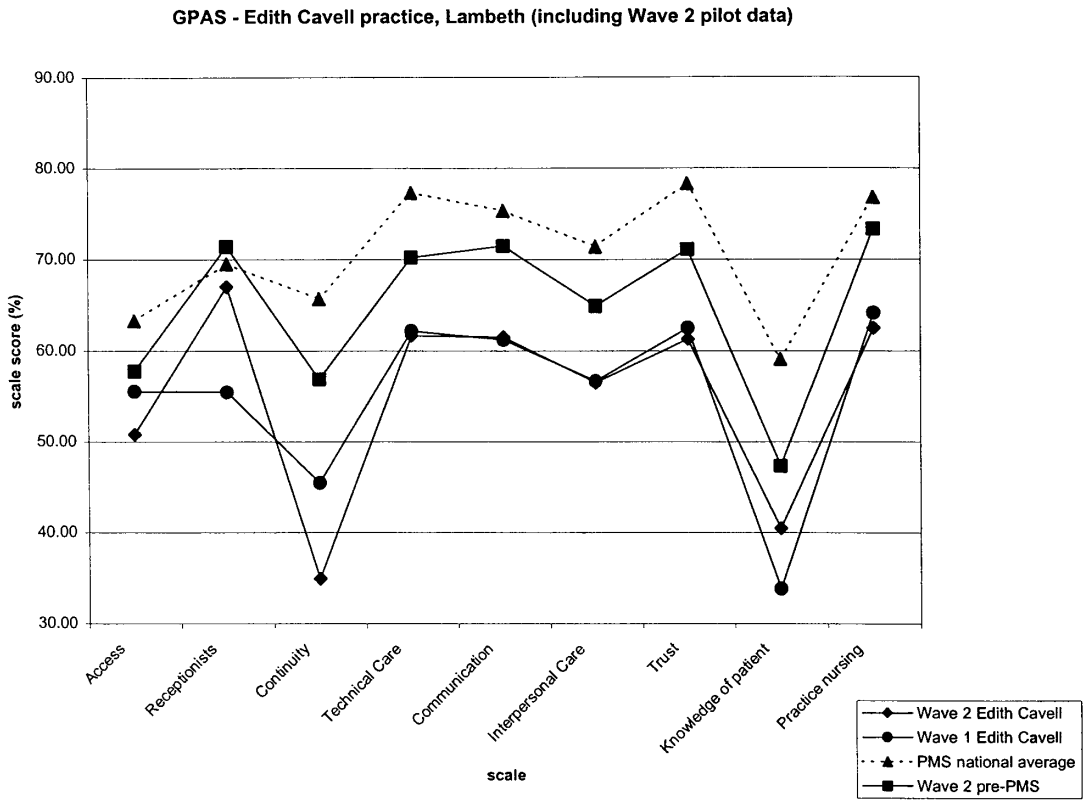
	Response rate		Access		Recept-ionists		Continuity		Technical care	
	%	N	Mean	N	Mean	N	Mean	N	Mean	N
Wave 1 Edith Cavell	11	22	55.5	22	55.5	22	45.5	22	62.2	14
Pre-PMS Wave 2	36	72	57.8	71	71.4	72	56.9	64	70.2	53
Wave 2 Edith Cavell	31	61	50.8	60	67.0	60	34.9	51	61.7	34
Nat Eval PMS pilots	64.8	2940	63.3	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
Wave 1 Edith Cavell	61.2	18	56.7	16	62.5	17	33.8	14	64.2	16
Pre-PMS Wave 2	71.4	57	64.9	57	71.1	55	47.4	49	73.3	35
Wave 2 Edith Cavell	61.5	37	56.5	37	61.3	36	40.5	35	62.5	24
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 chart above shows the GPAS results for the first and second wave Edith Cavell pilots – the second wave practice data show 'before PMS' (in February 2000) and 'after PMS' (in September 2000) results. Scores on all nine scales were lower, often markedly so, than national evaluation PMS pilots, with the exception of the receptionists scale for the pre-PMS Wave 2 pilot. Scores fell on all scales after the co-located single-handed practice became a second wave PMS pilot. Disappointingly also, for the first wave Edith Cavell practice, specifically set up as a nurse-led pilot, patient satisfaction on the practice nursing scale was lower for this practice than for any of the other eleven first-wave practices taking part in the King's Fund evaluation of London PMS pilots. It is worth pointing out however, that the response rate to the GPAS questionnaire in this practice was far lower than for any of the other participating practices, making genuine comparison with the other practices problematic.

When comparing King's Fund evaluation results with National Evaluation results, it is worth noting that none of the National Evaluation PMS pilot sample sites were in London or the South East, although some of the non-PMS controls 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.

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



In summary, the results from the two research tools we used to assess quality showed some variability, for example, on the Practice Profile Questionnaire, access and prescribing scale scores were higher than for national evaluation PMS pilot practices, but were lower on the organization and chronic disease management scales. However, GPAS scores were low (and sometimes very low) in comparison with national evaluation PMS pilots and there was clearly a level of patient dissatisfaction with elements of care provided by the PMS pilot.

Accessibility

The Edith Cavell practice was specifically set up to provide services for those who had found difficulty accessing primary care services in the past. At the outset, at least, there was some feeling locally that the practice had been located in the wrong place, and local GPs felt that the viability of their practices would be under threat:[17]

[17] David Lowe. The Primary Care Act pilot site at Streatham Hill Primary Care Centre: recommended target areas for patient registration. 1998.

The population they were setting out to register didn't exist, and the patients they said were having problems registering weren't in Streatham Hill. The area they were talking about was in Streatham Common, a mile down the road.....That was why in the first year they only had 200 patients, and why their list size didn't increase until they took on the second wave pilot (LMC, year 3)

Despite this view, the difficulty of registering patients at other practices in the area was described graphically by attendees at our focus group, who often found themselves acting as 'brokers' on behalf of their clients, negotiating access (not always successfully) to local primary care services:

.....when I ring up and ask if they could see a client that is unwell, they first of all ask 'where is this client from?' and then I say they're an asylum seeker, and they say 'which country?' and then 'oh, we don't deal with people from Eastern European countries' (focus group, year 3)

The Edith Cavell practice felt that they were successfully registering patients who had been turned away from other practices:

We do find that a lot of people are coming to register who've been refused registration at other practices and they've been told that the lists are closed (practice, year 2)

***(The new patients)* come in downtrodden, they've been to six other doctors, nobody wanted them, and they felt very much an outcast. So that's quite positive (practice, year 2)**

However, there was some disagreement amongst focus group attendees about how easy it really was to register patients at the Edith Cavell practice, with some respondents feeling that it was a simple matter to register their clients:

....clients are taken on without any difficulties (focus group, year 3)

which contrasted with:

....often there is a barrier at *(the Edith Cavell)* reception, you can't get beyond there.... (focus group, year 3)

There was a feeling that the practice population at Edith Cavell *was* different from neighbouring practices, seeming to confirm that the practice was reaching their target groups:

I've sat in other waiting rooms in this area, you know, next door practices, and the mix in the waiting room is totally different. All the GPs will say 'well, we have refugees, we have this', but they don't have a waiting room full of non-English speaking people, day in, day out, so it is different (practice, year 2)

In response to the language needs of the registered population, practice staff described their willingness to access interpreters for their patients, despite the financial implications of this:

> **I think that what we do do is the fact that as soon as somebody doesn't speak English, we ring for an interpreter. Whereas, what I hear from the people themselves, is that in most places where they've been before, the doctor struggles, doesn't succeed, and gives them a prescription for paracetamol (practice, year 2)**

> **I mean we do get letters from time to time telling us that we're using *(Language Line)* far too much – it's very expensive – but we just throw those away! (practice, year 3)**

There was some discussion at the focus group about the ethical issues surrounding the setting up a practice for patients with often complex needs – did this make it easier for 'mainstream' practices to abdicate their responsibility to provide services for all patients, irrespective of their needs?

> **I asked *(the health advisor at the Refugee Council)* once for a 'friendly GP list' and she said, you know, that wasn't what it was about – we really had to get everybody, all GPs to kind of take responsibility as it were (focus group, year 3)**

However, the general feeling amongst practice staff was that they did see themselves as a 'mainstream' practice, albeit with some differences:

> **.....I think there are differences, and it's in terms of who we've got registered as opposed, necessarily, to what we do with them (practice, year 2)**

> **I think it's right to register refugees into a mainstream practice, it's right. So it's difficult, but it's right. Separate clinic for drug users? No, it works because they need to fit in. It's matter of rolling out the good access things for everybody (practice, year 3)**

Focus group attendees were positive about the co-location of community trust services within the same building:

> **....you've got everything under one roof (focus group, year 3)**

> **.....it provides a lot of consistency really, because you can, I mean, for us, consistency of treatment for the young people we work with is very important that we have a health visitor, we have a doctor, we have a clinic, we have all those things that are all joined together really, so that difference is a much better overall picture of everything, which is extremely helpful really (focus group, year 3)**

They were also positive about the approach that practice staff took to their client groups:

It's very tempting for us to send people down here because we know that they're going to get a really good service, we're going to get a sort of non-judgmental service (focus group, year 3)

I think this practice does offer a sort of, more understanding of the problems that come with the client group and the acceptance of that, I think (focus group, year 3)

Response rates for the GPAS patient satisfaction questionnaire at the Edith Cavell practice were low, and in the case of the first wave pilot, very low. Patient perceptions of accessibility analysed from the GPAS survey were therefore based on very small numbers of responses, which may not be representative of the full practice list. In terms of the length of time spent waiting to make an appointment, over a third (35%) of first-wave Edith Cavell respondents were able to see a particular GP on either the same or the next day (44% rated this as 'fair' or 'good'), while over two thirds (67%) were able to make an appointment with any GP within the same timescale (67% rated this as 'fair' or 'good'). However, nearly a quarter (23%) of patients registered at the first wave pilot rated the hours that the practice was open for appointments as 'poor', with half or more of respondents wanting to see the practice open for additional hours in the evening (50%) or at weekends (59%).

Partnership working

Working closely with other organizations was one of the key aims of the pilot, and, in year one, links were built up with refugee organisations and local hostels for example. Practice staff felt that one of the outstanding successes of the pilot had been the work they had undertaken in partnership with local organizations for drug users, and this view was reiterated in the focus group:

The one thing that we HAVE done, although it's a little bit more by luck than good judgement is in working with drug users.....that's the one area where I'd say we've actually got some fairly good working arrangements.... so when *(our nurse practitioner)* said 'what do we do when a methadone user comes in?' and I was able to say well, we do this and this and this and this. And we can't do that with many things! So that's one area I actually think we're moved in (practice, year 2)

Well, for me, I think the relationship we've set up has been very successful so far – we meet once a month and share our information from both sides about individuals we're working with, and that's important (focus group, year 3)

However, as the pressure of patient numbers increased, and as staffing difficulties were encountered, this outreach work stopped:

Unfortunately, when the administration started to creak *(the nurse practitioner's)* work with *(refugees and asylum seekers)* really had to go on hold and we really haven't picked it up.....We haven't lost it, I don't think

we've gone backwards from the systems that we had, but we haven't kept up contacts with the Refugee Council and refugee groups. I think with the homeless that's similar, we haven't really moved on with that.....You know, we got so far, we stopped, and we haven't moved it on because of all the management issues (practice, year 2)

Relationship with other organizations

Primary Care

At the outset, stakeholder interviewees described the antagonism they perceived from neighbouring practices, who, they felt, were worried about the impact a new practice would have on their own list sizes. The health authority described the LMC in the area as being 'positively lukewarm' about the project, a view which was confirmed by the LMC themselves:

We have very great concerns about this PMS pilot (LMC, year 2)

This local suspicion about the motives of PMS pilots, and the negative view of LMCs was a common finding in all the four PMS pilot sites taking part in the King's Fund evaluation, although, as in other pilots, dissipated as the project became more established.

The health authority

Stakeholder interviewees at the community trust described a situation, at the bidding stage of the project, where they felt they had had to 'sell the concept' of the PMS pilot to the health authority. They felt that the project had been prioritized by the Region, rather than the health authority but, once the pilot had gained approval from the Secretary of State for Health, relationships with the health authority improved. This view was confirmed by the health authority:

The health authority should have had a stronger role in defining the project. The health authority was mildly embarrassed by the project, because of the scrutiny by the LMC and other critics. I have a feeling that in the back of our minds, it was not the right thing to do. I'm not sure we really believed in it (health authority, year 3)

There was a feeling from practice staff that the health authority lacked an understanding of what they were trying to achieve, a view confirmed by the health authority themselves:

The health authority still don't know what a PMS practice is. They still refer to one of the doctors as 'the senior partner', they're still trying to work it into a GMS practice, to fit it into that little slot, rather than thinking ahead and trying to change the way they actually communicate with us, as opposed to the way that they communicate with other doctors (practice, year 2)

We can be pressurised into doing certain things, however inappropriate. We were asked to open up on a Saturday morning and we didn't believe, looking at our patients, that we needed to open up on a Saturday. This was the health authority's perception of how they could influence us – but they can't influence GMS practices this way (practice, year 2)

The Primary Care Group

From uncertain beginnings, a closer relationship with the PCG was described, attributed in part to one of the PMS pilot GPs who sat on the PCG board:

The PMS pilot hadn't been discussed by our PCG even when the second wave came up. There are three second wave round here, but it wasn't talked about at board level, it was talked about at sub-board level (practice, year 2)

...I think there was a feeling the trust were very anxious that the PCG were interfering, and I got the feeling that the trust did not want the PCG to know too much about what was going on and that kind of thing. So there was definitely a 'them' and 'us', which was odd, which I hadn't expected (practice, year 3)

By the time we interviewed in year three, the PCG were positive about the contribution they felt that PMS could play in their area, particularly since the take-up of PMS status had been so high in Lambeth, Southwark and Lewisham:

***(PMS is)* a tool for flexible development – for the first and second waves – which GMS doesn't allow. We will have, if all the third wave go ahead, 70% of patients in our PCG registered with PMS – that's a huge change. It allows us to be a driver for change and development – I see it as a way of enhancing services and recruiting in deprived areas. It's very interesting where there's a PCG-wide PMS – we're moving towards that (PCG, 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'.[18] 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 professionals, particularly nurses, 'the opportunity to be full partners and explore the better use of skill mix'.

A study of nurse-led PMS pilots nationally found that hostility towards these pilots was experienced elsewhere, and not just at Edith Cavell. The negotiation of roles

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

within practices was also an issue at a number of sites, but Edith Cavell was definitely an extreme in this respect.[19] Staff at Edith Cavell reported great confusion over the negotiation of their respective roles:

> **We're still arguing about what 'nurse-led' means (practice, year 2)**

> **In terms of nurse-led – we change that every day! We're not winning on that (practice, year 3)**

This ambiguity around roles, particularly those of nurse-lead and reception staff, was felt by several respondents to be related to the community trust's lack of vision about the project:

> **The trust don't really know what they want out of it – it's got to be made explicit to the GPs who are going to be working with nurses, what it's all going to be about. That's made it difficult with locums – knocking on their door asking to get prescriptions (practice, year 3)**

> **...how *(the GPs)* view a nurse lead is sometimes quite threatening, because they say 'we're managed by a nurse', and the nurse is historically managed by the doctor, so it creates obstacles before they're even there, just because of the titles (practice, year 2)**

> **It was very blurred, one minute *(the nurse practitioner)* was a manager, the next minute she was a receptionist, the next minute she was a doctor, the next minute she was a nurse, and the next minute she was an outreach worker (practice, year 2)**

> **...(the trust) started off with wanting a manager and then turned into wanting an administrator because they viewed that the nurse could do all the management..... (practice, year 2)**

At the outset, the community trust had wanted the reception staff to be multi-skilled, so that they could carry out additional tasks, such as taking bloods. This again, proved problematic:

> **They initially wanted the admin team to be multi-disciplinary - for example, take blood, have some clinical input. Realistically, the very people that they wanted to multi-skill were the people with too much work to do anyway. But it's not realistic, and if you want her to book an appointment and use the computer and take bloods with the other hand, it doesn't really work. Patients generally need to know the boundaries of the person they're going to see – if they're used to seeing them stood behind a desk answering the phone, they're going to be a bit perturbed when they ask them to roll up their sleeve and take some blood, because that's not how it is (practice, year 2)**

[19] Richard Lewis. Nurse-led primary care: Learning from PMS pilots. King's Fund, London, 2001.

Relationships between doctors and nurses in particular deteriorated, partly in response to the confusion in their respective roles, and the difficulty of moving away from the traditional model of GP-led services. Some very strong comments were elicited:

> **...although it was supposed to be nurse-led, the power was still all in the hands of the doctors, so nothing changed really (practice, year 3)**

> ***(the nurse practitioner)* was very much treading on eggshells with the doctors because the trust's view of her role was that she would see patients first, she would be first point of contact, and she had to be very careful in whether or not she actually dealt with it as a nurse, or transferred it on to the GP. And there was always a question of 'let me just check it out', 'let me just check this out, I know I'm right, but, I just need to check it' and that was quite demoralising for her, and she felt quite de-skilled when she left..... (practice, year 2)**

> **....in terms of professions working more closely together, actually, we were doctors and nurses at war in the end, worse than in any other job I'd been in, really (practice, year 3)**

While PMS has proved a useful tool for attracting highly-qualified clinical staff into deprived areas,[20] the downside of appointing salaried practitioners is the possibility of these staff moving on. At the Edith Cavell practice, this was clearly a problem:

> **...a lot of patients have been locumed when another practice could have taken them in. Patients needing or wanting a good service have a locum – it's ironic. These patients have lost out a bit (PCG, year 2)**

> **What we've found, is that recently you've had quite a lot of locum doctors, haven't you? And we've found that a bit of a problem.... you don't get the communication, and something might slip through the net... (focus group, year 3)**

Turnover of staff was also a problem at the reception desk:

> **We're managing with a lot of temporary staff, I mean that's our problem really, that we're getting people coming in for two weeks on the desk and they don't understand the systems (practice, year 3)**

The lack of stability in staffing was reflected in the results from GPAS – 29% of Wave 1 Edith Cavell patients and 34% of the Wave 2 pilot patients said they saw their usual doctor 'never' or 'almost never'. Over a quarter (27%) of wave one patients and 41% of wave 2 pilot patients rated this as 'poor'. When patients were asked how good their doctor's knowledge of their medical history was, 44% of Wave 1 pilot and 30% of Wave 2 pilot patients rated this as 'poor'. It is likely that this lack of consistency was reflected in respondents answers to the question of whether they would be likely to recommend their GP to family and friends - only 42% of first wave

[20] Neil Hallows. Pilot schemes delivering GP freedom. BMA News Review, February 12, 2000.

patients and 58% of second wave patients would 'definitely' or 'probably' recommend their usual doctor to their family or friends.

However, it was notable that 84% of first wave patients had seen a nurse in the past year, indicating that while the pilot may not have succeeded in its intention to provide a nurse-led service, emphasis was still being placed on the importance of the nurse within the primary care team. While GPAS did not specifically seek to elicit views about nurse-led services, one of the attendees at the focus group meeting spoke enthusiastically about the nurse-led focus of the practice:

> **....I think that, for us, *(the nurse-led emphasis)* that's often very helpful actually, that our clients know that if the doctor is not available at that minute or whatever, then they can either ask to speak to *(the nurse practitioner)*, or come to see her or whatever – and that's often all it needs – because often it's like the little niggly worries that they've got because they're very young, they've got young babies – they may not need a doctor's input, but the fact that they can actually see somebody, I think, if they want some advice, and so on, it really is helpful.**

Given all the comments made above about the difficulties in negotiating roles, and the high staff turnover which resulted, it was not surprising that morale was felt to be variable:

> **There's a lot of job satisfaction, and a lot of frustration too! (practice, year 3)**

> ***(my job satisfaction is)* Zero! On a scale of one to ten, actually, between zero and minus five! It's actually quite bad, it's actually really bad. My relationship with the team is actually really good, but with regard to job satisfaction, and my own personal morale and motivation, it would be on a scale of zero, into the minus! (practice, year 2)**

> ***(There's)* not loads of job satisfaction – it's quite a grind (practice, year 2)**

> **Both nurse practitioners left on the point of breakdown. I'm outraged about this. This is to do with the health authority and the trust, both (practice, year 3)**

Workload

Practice staff found it difficult to assess whether PMS had made any impact on workload because theirs was not a steady state practice. At the outset, patient numbers were low, and the time pressures that began to be experienced later were not yet in evidence:

> **It's been awful – too many doctors seeing patients who could be seen by cheaper labour. One thousand patients to 1.1 doctors – hugely inefficient. (practice, year 2)**

However, later on, patient numbers had increased beyond a point where staff felt comfortable, and the situation was described as beginning to feel 'out of control in terms of numbers of patients':

> **At the moment, there's actually too much to do in terms of seeing patients, and that's a problem (practice, year 2)**

The high workloads which developed as the practice progressed were felt to be due in part to the types of patients the practice had set out to register:

> **They're all high-demand patients, and part of that is because they're all new and I think there is some evidence that when somebody registers newly, they actually see their doctor more often in the first year after registering, or in the first six months, or so..... (practice, year 2)**

> **....we haven't got the years of background to somebody to work out all the sorts of things that you do in general practice. I mean, nobody's been registered with us for more than a year, they can't have been... (practice, year 2)**

As well as having high levels of need, Edith Cavell patients were often highly mobile, moving on from local hostels with little or no notice:

> **It is quite difficult with the target group though, because they're quite mobile, they move around such a lot. And that in turn, means that you can do an awful lot of work, only to have it six weeks down the line, the Health Visitor will go the hostel, wherever it is they're living, in the insecure housing, to be told that they've moved on. And you know, that's quite sad. And sometimes they move back within three months, so, you know, it makes it all a bit disjointed (practice, year 2)**

> **...you put in an enormous amount of effort and three weeks later they've gone....there aren't the highs, the relationships you get with a normal caseload (practice, year 2)**

There was also some feeling that 'ordinary' patients might receive less of a service as a result of the high workloads:

> **A minus is that I've concentrated more on the 'downside' of my caseload because they need it – my 'middle of the road' *(patients)* haven't had so much of my support, for example the post natal depression mums, I haven't supported as much as I'd have liked to (practice, year 3)**

Trust-led primary care

Apart from the difficulties staff had experienced in trying to negotiate roles, a major source of frustration was that of running a general practice under the umbrella of a larger organization. While the pilot had undoubtedly benefited from its access to

trust services such as information technology and finance, the view was largely negative:

> **I mean, if we talk about being trust managed, maybe that's helpful. Some of the disadvantages of that basis of the PMS are the sort of slow reaction time to get things changed and the sort of.... yes, I mean there are advantages in the feeling that somebody else is looking after you, but the disadvantage is when they actually don't look after you, and you don't have the power to do it yourself. In a GMS set-up if something was going wrong, them somebody would obviously come and sort. As health professionals within this set up we feel that actually we're powerless to sort it because that's the trust's job and if they do it, that's fine, but if it's quite often they don't, then it's not fine for those of us working in it (practice, year 2)**

In addition, staff at the community trust who had been most involved in the initiation of the PMS had left – staff turnover had not just affected clinical staff:

> **....I did not feel that the trust were supportive, as I said, most of the key people who had thought up this PMS had left by the time I was there, or had left soon after I started, and there did not appear to be a vision within the trust of really what they were doing (practice, year 3)**

This theme of a new PMS pilot practice finding it difficult to work within the structures of a community trust was reiterated by the other trust-led pilot in the King's Fund evaluation.

Overall impact of the pilot

The Edith Cavell practice undoubtedly set out with extremely challenging objectives, a fact that was noted by many of our stakeholder interviewees:

> **....it's about accessing groups of patients that have never been accessed before using a model of delivery that's never been used before (health authority, year one)**
>
> **This was a very new model – they gave themselves quite a hard task! (PCG, year 3)**
>
> ***....(this)* is a very unique project, and they started from scratch. Whatever the shortcomings of the project, they always had a mountain to climb! (health authority, year 3)**

The fact that the pilot was one of the very few first-wave nurse-led pilots meant that staff felt that they were under the constant pressure that 'everything you do is being watched':

> **...I was very concerned that the outcome should be extra specially good, because people would look at it and say that it would be second rate**

because it was nurse-led, so I wanted to cover that, and prove that wasn't the case (practice, year 3)

There were some undoubted successes, not the least the fact that a brand new practice had been set up:

It brought one new GP into the area and some new nurses, so it helped recruitment (PCG, year 2)

It has attracted a higher quality of professional than would have been attracted to the area (LMC, year 3)

.....operating a band C/D practice by health authority criteria without having had any experience. We now have over 1000 patients and we've been open for less than a year (community trust, year 2)

However, the general tone of the interviews we carried out tended to emphasise the negative points of the project. In year two, the community trust listed the difficulties experienced by the pilot:

Hmm. It's had difficult relationships in the practice; lack of common vision; difficult to get understanding around roles; *(a)* difficult relationship with the health authority; difficulties with trust commitment; difficulties in terms of mechanisms to guide decision-making.... (community trust, year 2)

While the difficulties experienced by the pilot were sometimes described as 'hiccups' or 'teething problems', others were more negative, particularly in the practice's failure to operationalise their nurse-led aspirations:

It's been a failure, hasn't it? The single aim of a nurse doing a large amount of the work and the doctor taking on a consultancy role just hasn't happened (practice, year 2)

....I was looking forward to working in a different way, and it hasn't happened....the bit that I was looking forward to in relationship of sorting out how does a nurse work differently than a doctor, how can we work very closely together, we've just not done, we've just not done. How does the team function? How could you have somebody at the front desk doing the triage-type of system? All those things, you know, those were really exciting things to think about and they've not happened in any way at all, or any shape... (practice, year 2)

In common with the three other PMS pilots taking part in the King's Fund evaluation, the enormity of launching projects within a three year time-scale and hoping to see tangible quality improvements was described:

***(It's)* very difficult to start a practice from scratch. It's like investing in a business. You're not going to get a return on your investment for a while (health authority, year 2)**

The Edith Cavell practice was set up to provide a very different model of primary care from more traditional GMS practices. While there appeared to be agreement that the nurse-led emphasis of the pilot has failed to get off the ground, the first and second wave Edith Cavell practices now have a combined list size of just under 5,000 patients and the health authority have pointed out that the pilot has met previously unmet need locally:

> **They demonstrated to all the sceptics that there was a need for another practice (health authority, year 3)**

From anecdotal evidence, it would appear that the Edith Cavell practice is registering the groups of patients they set out to target, and good relationships have been built up with organizations, such as refugee groups, working with these patients. Levels of patient satisfaction on all but one GPAS scale were lower than National Evaluation PMS pilot practices, although it is worth noting that, not surprisingly, given the practice's target group, response rates to GPAS were very low.

In common with the other PMS pilots taking part in the King's Fund evaluation, there was disappointment that more progress had not been made, and it is worth asking whether three years may have proved too short a time frame in which to judge the ability of the pilot to achieve its very considerable objectives. Staff turnover at all levels within the pilot was very high, leading to what several interviewees called a 'lack of shared vision', and as one member of practice staff pointed out:

> **What we were doing in terms of the nurse-led thing is a very big change, and it takes a long time for things to change unless you have got very powerful people behind you... (practice, year 3)**

For a practice which set out to be very different in approach, there was a feeling that perhaps they weren't so different after all, at least in terms of the services they provided:

> **From a patient sense, I can't think of any difference at all. There have been remarkably few changes between this and GMS, actually (practice, year 2)**

Edith Cavell PMS pilot: meeting local and national objectives?

Local objectives[21]	
• Achievement of the highest standard of primary care as measured against Lambeth, Southwark and Lewisham Health Authority's banding criteria and performance indicators	The practice, which had achieved 'Band D' status on Lambeth, Southwark and Lewisham health authority's banding criteria by year two, and were working towards the highest level banding of 'Band E'.

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

• Delivery of health gain in respect of health outcomes relevant to the registered population	The King's Fund evaluation did not measure health outcomes, and three years is likely to be too short a timescale to achieve tangible outcomes. The practice was unable to identify any patients who fell within the inclusion criteria of the Angina Audit.
• Provision of access to marginalized populations currently not well served by local provision	The practice believed that they had registered the groups of patients they had hoped to target, and this was confirmed by attendees at the focus group meeting.
• Provision of services that offer value for money against a benchmark of the cost of conventional general practice	We did not carry out an economic evaluation of the practice, although respondents did question whether, at the outset, staff:patient ratios were cost-effective.
Key national questions[22]	
❑ Have pilots improved *fairness* of provision by developing needs-related services, enhancing quality and improving access for disadvantaged groups?	Staff at the practice feel that they have improved access for marginalized groups. Attendees at the focus group meeting were largely positive about the ease with which they had been able to register their clients – although difficulties were identified with continuity of staff at the reception desk and the difficulties this caused in registering refugees and asylum seekers at the practice.
❑ Have pilots improved *efficiency* and value for money by making best use of staff and non-staff resources through extended roles and development of primary care staff and by ensuring a given quantity and quality of service provision at minimum cost?	Our evaluation did not include an economic analysis. Quality of care was assessed using the Practice Profile questionnaire (which showed variable results in comparison with National Evaluation PMS pilot practices) and the GPAS patient satisfaction questionnaire (in which levels of patient satisfaction were low, or very low). The Edith Cavell practice was set up specifically as a nurse-led pilot and difficulty was encountered in negotiating staff roles. While the overt nurse-led nature of the pilot appeared to have lessened, it was still the case that 84% of responders to GPAS had consulted a practice nurse in the previous 12 months.
❑ 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?	We were unable to assess whether the practice was providing high quality services (an recording data appropriately) to patients with angina – the practice could not identify any patients who fell within the inclusion criteria for the study.
❑ 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 were sought using GPAS. GPAS scores were not high, although the response rate to the questionnaire was only 11%. We did not collect any evidence of patient views being used as a basis on which to alter service provision.

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

❑ 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?	By year three, the PCG had become more positive about PMS in general acting as a 'driver for change and development', particularly in deprived areas. Attendees at the focus group were positive about the closer working relationships they had forged with the pilot.
❑ Have pilots introduced new *flexibility* in working relationships, organisational forms and employment arrangements which might improve professional morale, recruitment and retention in primary care?	One of the key difficulties identified by practice staff was the difficulty they had encountered in negotiating their own roles within the practice. This was equally the case for doctors, nurses and administrative staff. Staff turnover in the practice was high, morale was extremely variable, the 'de-skilling' of staff was mentioned, and 'outrage' was expressed at the way in which some staff members had been treated.
❑ Have pilots improved *accountability* to local communities and to health authorities?	The relationship between the practice and the health authority, and between the practice and the PCG, were described as having improved over the pilot's lifetime.

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

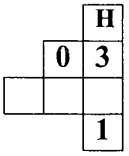
- Given your comments throughout this interview, are there any factors that you would identify as being particularly important in contributing to the success (or failure) of the pilot?

- 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

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

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

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

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

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

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

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

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

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

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

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

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

a) How quickly do you get an appointment?

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

b) How do you rate this?

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

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

a) How quickly do you get an appointment?

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

b) How do you rate this?

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

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

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

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

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

b) How do you rate this?

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

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

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

11. a) In general, how often do you see your usual doctor (not an assistant or partner)?	☐1 Always	☐2 Almost always	☐3 A lot of the time	☐4 Some of the time	☐5 Almost never	☐6 Never	
b) How do you rate this?	☐1 Very Poor	☐2 Poor	☐3 Fair	☐4 Good	☐5 Very Good	☐6 Excellent	

12. The next questions ask you about your <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	☐2	☐3	☐4	☐5	☐6
Always	Almost always	A lot of the time	Some of the time	Almost never	Never

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

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

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

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

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

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

Not at all Completely

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

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

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

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

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

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

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

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

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

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

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

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

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

26. Are you: ☐[1] Male ☐[2] Female

27. What is your date of birth?

Day Month Year

____ ____ ____

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

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

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

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

Yes ☐1 No ☐2

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

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

32. Is your accommodation.....

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

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

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

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

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

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

King's Fund

Appendix 3

Edith Cavell Practice GPAS results

Table 1: response rates

	Wave 1 Edith Cavell	Pre-PMS Wave 2	Wave 2 Edith Cavell
% overall response rate	11	36	31
base	22	72	61

Table 2: Socio-demographic characteristics of respondents

		Wave 1 Edith Cavell	Pre-PMS Wave 2	Wave 2 Edith Cavell
Sex	% male	*23*	*38*	*42*
	% female	*77*	*63*	*58*
	base	22	72	60
Age group	% 16 to 24	*14*	*4*	*7*
	% 25 to 34	*50*	*21*	*19*
	% 35 to 44	*23*	*29*	*15*
	% 45 to 54	*5*	*13*	*24*
	% 55 to 64	*9*	*13*	*15*
	% 65 to 74		*9*	*10*
	% 75 and above		*10*	*10*
	base	22	68	59
Marital status	% single	*45*	*27*	*25*
	% married/cohabiting	*45*	*50*	*53*
	% widow/er, divorced or separated	*10*	*23*	*22*
	base	20	70	60
Ethnic group	% white	*90*	*66*	*54*
	% other	*10*	*14*	*46*
	base	21	70	59
Accommodation	% owner occupied	*52*	*51*	*40*
	% rented from local authority/housing association	*14*	*25*	*47*
	% rented from a private landlord	*29*	*19*	*11*
	% under other arrangements	*5*	*6*	*2*
	base	21	69	55
Car available?	% yes	*62*	*47*	*50*
	% no	*38*	*53*	*50*
	base	21	72	56

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

		Wave 1 Edith Cavell	Pre-PMS Wave 2	Wave 2 Edith Cavell
How long have you been registered with your practice?	%1-2 years	*95*	*25*	*7*
	% 3-4 years		*17*	*13*
	% more than 4 years	*5*	*58*	*80*
	base	22	72	61
In the last 12 months, how often have you seen a doctor or nurse from your practice?	% none		*3*	*10*
	% once or twice	*36*	*19*	*25*
	% three or four times	*45*	*38*	*33*
	% five times or more	*18*	*40*	*33*
	base	22	72	61
Do you have any long-standing illness, disability or infirmity?	% yes	*45*	*38*	*51*
	% no	*55*	*62*	*49*
	base	22	71	55
How is your health in general?	% very good	*23*	*19*	*12*
	% good	*55*	*50*	*46*
	% fair	*23*	*25*	*32*
	% bad		*6*	*9*
	% very bad			*2*
	base	22	72	57

Table 4: Access

		Wave 1 Edith Cavell	Pre-PMS Wave 2	Wave 2 Edith Cavell
Overall access score	%	55.5	57.8	50.8
	base	22	71	60
How would you rate the convenience of your practice's location?	% poor		*1*	*3*
	% fair	*5*	*17*	*16*
	% good	*95*	*82*	*80*
	base	22	72	61
How would you rate the hours that your practice is open for appointments?	% poor	*23*	*11*	*7*
	% fair	*27*	*24*	*25*
	% good	*50*	*65*	*68*
	base	22	71	59
What additional hours would you like your practice to be open?	Early morning	*23*	*18*	*16*
	evenings	*50*	*29*	*18*
	weekends	*59*	*53*	*49*
How quickly do you get an appointment when you want to see a particular doctor?	% same day	*5*	*15*	*10*
	% next day	*23*	*44*	*39*
	% 2-3 days	*36*	*22*	*25*
	% 4-5 days	*5*	*4*	*5*
	% more than 5 days	*9*		*7*
	% does not apply	*23*	*14*	*14*
	base	22	72	59

Table 4: Access (contd)

		Wave 1 Edith Cavell	Pre-PMS Wave 2	Wave 2 Edith Cavell
How do you rate this?	% poor	*14*	*20*	*27*
	% fair	*32*	*20*	*25*
	% good	*36*	*47*	*34*
	% does not apply	*18*	*13*	*14*
	base	22	70	59
How quickly do you get an appointment when you want to see any doctor?	% same day	*27*	*31*	*22*
	% next day	*36*	*46*	*51*
	% 2-3 days	*23*	*16*	*17*
	% 4-5 days	*5*		
	% more than 5 days	*5*		*2*
	% does not apply	*5*	*7*	*8*
	base	22	70	59
How do you rate this?	poor	*32*	*11*	*19*
	fair	*5*	*23*	*31*
	good	*59*	*61*	*43*
	does not apply	*5*	*6*	*7*
	base	22	66	58
If you need an urgent appointment to see your GP, can you normally get one on the same day?	Yes	*41*	*49*	*36*
	no	*18*	*14*	*22*
	don't know/never needed one	*41*	*37*	*42*
	base	22	70	59
How long do you have to wait at the practice for appointments to begin?	% 5 mins or less	*5*	*15*	*6*
	% 6 to 10 minutes	*32*	*32*	*19*
	% 11to 20 minutes	*32*	*31*	*33*
	% 21 to 30 minutes	*18*	*7*	*21*
	% 31 to 45 minutes		*7*	*9*
	% more than 45 minutes	*14*	*7*	*12*
	base	22	71	57
How do you rate this?	% poor	*23*	*23*	*36*
	% fair	*36*	*36*	*41*
	% good	*41*	*41*	*22*
	base	22	70	58
How would you rate your ability to get through to the practice on the phone?	% poor	*23*	*17*	*21*
	% fair	*14*	*29*	*21*
	% good	*50*	*53*	*52*
	% don't know	*14*	*1*	*5*
	base	22	72	61
How would you rate your ability to speak to a doctor when you have a question/need medical advice?	% poor	*18*	*13*	*32*
	% fair	*18*	*13*	*13*
	% good	*5*	*14*	*13*
	% don't know	*59*	*59*	*42*
	base	22	69	60

Table 5: Receptionists

		Wave 1 Edith Cavell	Pre-PMS Wave 2	Wave 2 Edith Cavell
Overall receptionist score	%	55.5	71.4	67.0
	base	22	72	60
How would you rate the way you are treated by receptionists in the practice?	% poor	*14*		*5*
	% fair	*27*	*19*	*18*
	% good	*59*	*81*	*77*
	base	22	72	60

Table 6: Continuity

		Wave 1 Edith Cavell	Pre-PMS Wave 2	Wave 2 Edith Cavell
Overall continuity score	%	45.5	56.9	34.9
	base	22	64	51
In general, how often do you see your usual doctor (not an assistant or partners)?	% always/almost always/a lot	*43*	*62*	*21*
	% some of the time	*29*	*31*	*45*
	% never, almost never	*29*	*7*	*34*
	base	21	68	53
How do you rate this?	% poor	*27*	*9*	*41*
	% fair	*41*	*30*	*29*
	% good	*32*	*61*	*29*
	base	22	64	51

Table 7: Technical care

Thinking about the technical aspects of your doctor's care, how do you rate the following:		Wave 1 Edith Cavell	Pre-PMS Wave 2	Wave 2 Edith Cavell
Overall technical care score	%	62.2	70.2	61.7
	base	14	53	34
Your doctor's technical knowledge?	% poor		*2*	*3*
	% fair	*11*	*6*	*19*
	% good	*56*	*81*	*68*
	% don't know	*33*	*11*	*11*
	base	18	54	37
The thoroughness of your doctor's physical examination?	% poor	*6*	*5*	*11*
	% fair	*11*	*15*	*30*
	% good	*67*	*76*	*57*
	% don't know	*17*	*4*	*3*
	base	18	55	37
The arranging of tests you need when you are unwell eg blood tests, x-rays etc	% poor	*11*	*5*	*5*
	% fair		*2*	*16*
	% good	*78*	*76*	*68*
	% don't know	*11*	*16*	*11*
	base	18	55	37
Prescribing the right treatment for you?	% poor	*6*	*5*	*11*
	% fair	*6*	*4*	*14*
	% good	*72*	*86*	*68*
	% don't know	*17*	*5*	*8*
	base	18	56	37
Making the right diagnosis?	% poor	*11*	*4*	*11*
	% fair		*6*	*19*
	% good	*56*	*83*	*57*
	% don't know	*33*	*8*	*14*
	base	18	52	37

Table 8: Communication

Thinking about talking with your doctor, how would you rate the following:		Wave 1 Edith Cavell	Pre-PMS Wave 2	Wave 2 Edith Cavell
Overall communication score	%	61.2	71.4	61.5
	base	18	57	37
The thoroughness of the doctor's questions?	% poor	6	4	5
	% fair	11	16	30
	% good	83	80	65
	base	18	56	37
The attention the doctor gives to what you say?	% poor	6	4	11
	% fair	22	19	16
	% good	72	77	73
	base	18	57	37
Doctor's explanations of your health problems or treatments you need?	% poor	17	4	11
	% fair	22	11	22
	% good	61	86	68
	base	18	56	37
How often do you leave the surgery with unanswered questions?	% always, almost always, some of the time	13	4	22
	% some of the time	31	25	27
	% never, almost never	56	71	51
	base	16	56	37

Table 9: Interpersonal Care

Thinking about the personal aspects of care you receive from your usual doctor, how do you rate the following?		Wave 1 Edith Cavell	Pre-PMS Wave 2	Wave 2 Edith Cavell
Overall interpersonal care score	%	56.7	64.9	56.5
	base	16	57	37
The amount of time the doctor spends with you?	% poor	19	9	11
	% fair	19	12	38
	% good	63	79	51
	base	16	57	37
Doctor's patience with your questions or worries?	% poor	19	5	8
	% fair	13	19	32
	% good	69	75	59
	base	16	57	37
Doctor's caring and concern for you?	% poor	13	7	8
	% fair	31	18	31
	% good	56	75	61
	base	16	56	36

Table 10: Trust

		Wave 1 Edith Cavell	Pre-PMS Wave 2	Wave 2 Edith Cavell
Overall trust score	%	62.5	71.1	61.3
	Base	17	55	36
I completely trust my doctor's judgement about my medical care	% disagree	*12*	*2*	*22*
	% not sure	*41*	*32*	*22*
	% agree	*47*	*66*	*56*
	Base	17	56	36
My doctor would always tell me the truth about my health	% disagree		*2*	*14*
	% not sure	*47*	*43*	*33*
	% agree	*53*	*55*	*53*
	Base	17	51	36
My doctor cares more about keeping costs down than about my health	% disagree	*35*	*61*	*44*
	% not sure	*59*	*26*	*42*
	% agree	*6*	*13*	*14*
	base	17	54	36
How much do you trust your GP	(mean score: 1=not, 10=totally)	6.8	7.9	6.8
		16	56	36

Table 11: Knowledge of patient

Thinking about how well your doctor knows you, how would you rate the following:		Wave 1 Edith Cavell	Pre-PMS Wave 2	Wave 2 Edith Cavell
Overall knowledge of patient score	%	33.8	47.4	40.5
	Base	14	49	35
Doctor's knowledge of your medical history?	% poor	*44*	*13*	*30*
	% fair	*31*	*43*	*35*
	% good	*25*	*44*	*35*
	Base	16	54	37
Doctor's knowledge of what worries you about your health?	% poor	*43*	*22*	*37*
	% fair	*21*	*33*	*34*
	% good	*36*	*45*	*29*
	Base	14	49	35
Doctor's knowledge of your work and home responsibilities?	% poor	*71*	*36*	*48*
	% fair	*21*	*28*	*27*
	% good	*7*	*36*	*24*
	Base	14	47	33

Table 12: Practice nursing

		Wave 1 Edith Cavell	Pre-PMS Wave 2	Wave 2 Edith Cavell
Overall practice nursing score	%	64.2	73.3	62.5
	Base	16	35	24
Have you seen a nurse in last year?	% yes	*84*	*63*	*65*
	% no	*16*	*38*	*35*
	Base	19	56	37
How would you rate the attention the nurse gives to what you say?	% poor	*6*		*12*
	% fair	*25*	*15*	*15*
	% good	*69*	*85*	*73*
	base	16	39	26
How would you rate the quality of care the nurse provides?	% poor	*13*		*12*
	% fair	*13*	*10*	*15*
	% good	*75*	*90*	*73*
	base	16	39	26
How would you rate their explanations of your health problems or treatments you need?	% poor	*13*		*8*
	% fair	*19*	*13*	*23*
	% good	*69*	*87*	*69*
	base	16	39	26

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

		Wave 1 Edith Cavell	Pre-PMS Wave 2	Wave 2 Edith Cavell
Was there any time the doctor didn't refer you when you needed it?	% yes	*17*	*13*	*17*
	% no	*83*	*87*	*83*
	base	18	55	35
Does your doctor coordinate care you receive outside the practice?	% yes	*32*	*46*	*41*
	% no	*11*	*7*	*16*
	% does not apply	*58*	*46*	*43*
	base	19	56	37
Would you recommend your usual doctor to your family and friends?	% definitely/probably not	*16*	*9*	*24*
	% not sure	*42*	*7*	*18*
	% definitely, probably yes	*42*	*84*	*58*
	base	19	56	38
All things considered, how satisfied are you with your practice?	% completely satisfied	*5*	*14*	*9*
	% very/somewhat satisfied	*68*	*64*	*50*
	% neither satis nor dissatis	*18*	*14*	*17*
	% very/somewhat dissatisfied	*9*	*8*	*21*
	% completely dissatisfied			*3*
	base	22	72	58

Appendix 4

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 5

EDITH CAVELL PERSONAL MEDICAL SERVICES (PMS) PILOT

FOCUS GROUP
at the
Edith Cavell Practice
Streatham Hill Primary Health Care Centre
Thursday 20th April
1:00-3:00pm

IMPROVING PRIMARY HEALTH CARE FOR TARGETTED POPULATIONS

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

The Edith Cavell PMS practice is one of a small number of pilots established in the NHS to look at new ways of providing primary care. The Edith Cavell PMS pilot has focused on meeting the needs of patients who have previously been poorly served by primary care such as refugees, asylum seekers, drug users and homeless people.

The purpose of this focus group is to consider the pilot's 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 Edith Cavell practice?
- How would you describe your relationships with the Edith Cavell practice?
- How successful have you been in working together with the Edith Cavell practice to improve patient services?
- How might your relationships and joint working with the Edith Cavell practice be improved?

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

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

Appendix 6

Edith Cavell Practice Personal Medical Services Pilot
King's Fund Evaluation Feedback Meeting
Thursday 21 October 1999

Contents

Background

The Lambeth Personal Medical Services (PMS) bid outlined the development of a brand new practice in Streatham Hill, south London. Lambeth is an inner London borough with extremely high levels of deprivation, and the population in the Streatham Hill area is characterized by high numbers of people marginalized from society and also from mainstream health care. These groups include refugees and asylum seekers, the homeless, those with mental health problems and substance misusers. The PMS pilot bid describes the level of existing primary care provision in the vicinity as 'overstretched' and details the increasing number of patient allocations in the SW16 area, and the difficulties of recruitment into deprived inner city areas. An interviewee at the Health Authority described the situation in the area in the following way:

> **....the Health Authority was aware that primary care in Streatham had problems – hostels, homelessness, and people with high needs moving in. Traditional primary care was not finding it easy to pick them up. Also, the nature of primary care provision is characterized by large numbers of single-handed practices and small practices not really working in a coordinated way together..... the result is a deficit in primary care and unmet need. (Health Authority Manager)**

This lack of communication between practices in the area is reinforced by David Lowe, an independent consultant, who carried an assessment of the proposed catchment area for the pilot:

> **There appear to be very few existing relationships and networks between practices within the area. Practice staff and GPs communicate with other practices at only a very superficial level. There appears to have been no attempt made by the Health Authority or the LMC to foster any co-operative working such as joint working arrangements or joint protocols. (David Lowe, 1998)**

Lambeth Healthcare NHS Trust (now Community Health South London), put forward a proposal for a PMS pilot, to set up a new nurse-led primary care team to be based in the Streatham area. It was proposed that the skill-mix in the new pilot would be significantly different from other models of general practice, the intention being that patients would routinely see a nurse when using the practice, and only being referred on to the GP in an estimated 20-30% of cases.

The four key objectives of the PMS pilot bid were:

- Achievement of the highest standard of primary care as measured against the Health Authority's banding criteria and performance indicators
- Delivery of health gain in respect of health outcomes relevant to the registered population
- Provision of access to marginalized populations not currently well served by local provision
- Provision of services that offer value for money against a benchmark of the cost of conventional general practice

Year 1 interviews

Interviews were carried out with nine key staff at the Community Trust, at the Health Authority and in the practice. The practice interviews were all carried out at the end of September 1998, as staff came into post. The other interviews took place in June 1998. The timing of the interviews clearly had an influence on the information we received – Health Authority staff had been involved mostly in the initiation and contracting stages of the project, while practice staff, who had only just been employed were less informed about these areas, but were instead concentrating on getting the practice up and running.

Initiation of the pilot

The PMS pilot was initiated by the Trust, and grew from previous work already underway in Lambeth with nurse-led teams for the homeless and two DoH-funded nurse-led projects working with ethnic minority groups.

> **This wasn't something that we thought of on the night of the legislation being passed, we'd been working towards nurse-led services and had a belief that we hadn't been able to enact because of the legislation, so it wasn't a new concept to us. (Trust Manager)**

It was felt that because the legislation to allow nurse-led pilots was so rushed, this led to problems of 'selling' the idea to the Health Authority.

> **The legislation for the nurse pilots was very last minute. As a Trust we knew we were immediately interested - but it was difficult to get the Health Authority to agree that nurse-led pilots were acceptable within the legislative framework - a lot of the early work was in convincing the Health Authority. Once we'd got them on our side, there was a lot of collaboration in identifying the area and how we would go about it and what the target population would be – *(it was)* very much not based on an existing list, selling a concept initially..... it's about the change in mindset. (Trust Manager)**

The Trust felt that they had had to persuade the Health Authority to support the pilot, however, once they had done so, the Health Authority had been supportive:

> **The pilot wasn't prioritized by the Health Authority, Region prioritized it. (Trust Manager)**
>
> **Once it was prioritized by Region, they were very helpful and supportive in drawing up the contract and agreeing points for the contract. (Trust Manager)**

The Health Authority felt that they had been largely supportive of the pilot:

> ***(Support is)* high, but it varies between individuals. The corporate view is one of very strong support. LSL is a big inner city area and primary care problems are recruitment and retention, quality of primary care etc. Management levers to improve these areas through the Red Book are limited. PMS gives us the flexibility we need to plug major holes in Lambeth. Its a case to be innovative. (Health Authority Manager)**

However, while the Trust felt that the Health Authority supported the project on a theoretical level, practical support had been less forthcoming:

> **I suspect they've got much, much bigger priorities on their plate at the moment, such as waiting lists, such as Trust mergers! So I think in a philosophical sense *(their support is)* high, in an actual practical sense it's very low....but I don't think that's to do with their opinion of it, but what they can allocate in terms of time. (Trust Manager)**

Support from other agencies was variable. The Regional Office were described as being 'very supportive' of the project, as was the local Refugee Outreach Team, and Lambeth Community Health Council (CHC) was 'largely supportive'. However, the Local Medical Committee (LMC) was said to be 'challenging', and a report written by David Lowe, an independent consultant, based on interviews he carried out with local GPs, suggested that they felt that the viability of their practices was 'threatened' by the siting of the new pilot in the Streatham area.

There appeared to be a great deal of enthusiasm for the pilot amongst the staff we interviewed at the practice, at the Health Authority and at the Trust. While the Trust were enthusiastic about the opportunity it gave them to explore the role of the nurse in primary care, the Health Authority were keen to improve primary care provision in the area:

> **I guess the reason that *(the HA)* supported it was that it falls in with their priority for improving provision in an area where it was very poor and badly serviced. I personally don't think that they bought into it on any other agenda than that - I don't think that they saw it as a way of experimenting with nursing leadership or with partnership arrangements. (Trust Manager)**

Setting up the pilot

Practice-based staff were enthusiastic about the opportunity to experiment with new roles, to work within a different management structure, and to offer a high quality service to groups of people who hadn't traditionally been able to access health care.

> **It seemed like the job I'd always wanted. (Practice)**

> ***(It's)* a lot more team-based approach than traditional general practice. (Practice)**

> **You can do things that are difficult – you don't have necessarily to bring the money in. You can reach out to other groups. (Practice)**

> ***(It's about) b*elonging to something that is bigger. (Practice)**

However, they did acknowledge that the short timescales between the bid being accepted and 'going live', meant that practice staff were recruited relatively late on, which caused difficulties:

(There is) **a major difficulty of coming in to something only 2 months before it's operational... we've got to deliver on promises that other people have made. (Practice)**

The two months before the practice opening were described as 'manic', and staff were anxious to get everything in place before the practice started to register their first patients in October 1998:

If we manage to have the basics for day 1, that'd be good. (Practice)

The newness of everything, particularly for those practice staff who hadn't worked in general practice before, and the balance between enthusiasm for the project and worry surrounding the setting up an entirely new practice from scratch was summed up in the following way:

For me, it's all one great learning exercise, in some respects quite frightening, in some respects quite exciting. (Practice)

It was generally acknowledged by all those we interviewed that the pilot was setting out with enormous aims, using a nurse-led model for which evidence wasn't UK based.

....it's about accessing groups of patients that have never been accessed before, using a model of delivery that's never been used before. (Health Authority Manager).

At the moment, we don't even know who's going to walk in through the door. (Practice)

Working ahead of the legislation as a nurse-led pilot was proving problematic:

The really, really difficult thing for us has been how you get round the current legal limits of nursing practice....and influencing, in a sense, the central policy agenda for nursing, to allow that to happen. I think that's pretty unique about nurse-led pilots, and I mean, in that context, we've had a lot of support from nurses in government, from the Department nurses and the NHSE, so it's not that they've not been supportive, it's that it takes time to make these changes. (Trust Manager)

Apart from all the things coming up where people don't know what's allowed because you're PMS or not, the real issues at the moment are GP and nurse cover with the MDU and what you can and can't do. It'd probably be really nice to come across as a second or third wave when all these things have been ironed out. It's not a disbenefit for patients – we're all trying to ensure that they get the best possible care. For us it's just a frustration around learning how things work, where there aren't rules, making them, learning all the time. (Practice)

Practice staff pointed out that knowledge of PMS amongst other people was limited, and responses to the project were often quite negative.

There are so many politics around PCAPS – if you think up front that first of all everyone is going to say 'no', and they're all against you, it's almost easier..... (Practice)

It's very negative to get so many 'no's, maybe's, not sure's'. (Practice)

We're between the devil and the deep blue sea – between the Health Authority and the Trust. Later on, maybe when people in the Trust know what PCAPS stands for, it could be easier.... *(it's)* as clear as mud. Some things we can't access because you're part of the Trust, some things you can't have because you're not GMS. (Practice)

As well as a lack of understanding about the PMS pilot, staff in the practice felt that being a pilot, and a nurse-led pilot in particular, made them unique in many ways, and that this attracted a lot of attention from outside:

Everything you do is being watched – you could get paranoid! (Practice)

The timing of the launch of PMS pilots, it was felt, was often overtaken in the crowded agenda to set up Primary Care Groups (PCGs), and the achievements of the pilot's first year overshadowed perhaps by the setting up of the second wave pilot.

Respondents were asked to list the potential benefits and disbenefits of PMS for particular groups, and these are given in the table below:

For:	Benefits	Disbenefits
HA	• Meet unmet need in a weak area • To help improve quality • To let us know what the cost is • Learning about contracting for PCGs • Learning about different ways of providing primary care • A test bed of thinking of how to manage pressures in general practice • A knock-on effect to other practices	• Make relationships with LMC and other GPs more difficult • Encroaches on vertical integration • Possibility of 'Fundholders syndrome' – developing services in a way the HA don't necessarily agree with • Intensive work, tight timescale • The need to monitor contracts closely • Concern over list, if project fails

Trust	• To integrate primary and community services • To share management expertise • Raises a wider range of options for future primary care delivery • Closer working relationships • Looks at different ways of teamworking • To be seen as part of primary care provision • Develops an evidence base around nurse-led care • Raises the profile of the Trust	• The potential disadvantages of managing GPs • Added time implications • Relationship with local GPs • Potential that the Trust could be out of pocket
For patients	• In terms of quality – longer surgery hours, new services, prescribing, referrals • More time on clinical skills • A more flexible service – choice of seeing a nurse or a GP • Easier for marginalized groups to access, reduced barriers of access • Two female GPs • Highly developed team work • Access to a greater range of specialist services in primary care	• Salaried GPs may not have the same incentives as GMS • There may be difficulties when patients move to a different practice • There is a sense in which patients are taking part in a research project • Nurses currently can't prescribe • Seeing a nurse rather than a GP, and then possibly having to make another appointment to see the GP • Being under the spotlight
For individuals within the pilot	• Being part of a genuine team • The security of having a major employer, guaranteed income, training opportunities • Less admin for GPs • Nurses more able to use skills • Reduction in isolation for nurses • The opportunity to experiment with roles • Takes the urgency away from the payment of things • Time to consider social care as well as 'the medical bit'	• Being under the spotlight. • Feeling isolated • Being expected to toe the 'party line' • Being corporate players • Problems around nurse certification • Uncertainty around GP terms and conditions
For others	• Closer working with community groups • Closer working with voluntary organizations • Benefit to the nursing profession in developing nursing contribution in primary care	• May be income disadvantages for other GPs in the area. • Concerns amongst professional groups around skill-mix

GMS vs PMS

We asked our interviewees to assess the advantages and disadvantages of General Medical Services (GMS) and PMS. GMS was largely felt to be a known entity leading to independence and clinical freedom. With the national contract, the Exeter system is updated centrally, allowing data to be analysed nationally. The freedom of independent contractors to speak out was described by one respondent:

> *(Independent contractors)* **don't have to buy into the government view in quite the same way as the Trust does, and can be the grit in the system more readily than those with a direct line of command and control. (Trust Manager)**

The criticisms of GMS were that it was bureaucratic, complex and archaic, and bore little relation to modern-day needs. It was felt that GMS did not allow for definitions of quality, had perverse incentives and had led to unevenness of basic quality in primary care. In a deprived inner city area, it failed to allow resources to be targeted and there was little flexibility in terms of a multi-skilled primary health care team model. A major criticism of GMS, especially in relation to the PMS pilot, was that it assumed a single model of practice, which may be too medically dominated.

The PMS pilot contract

Although, at least initially, the PMS pilot contract largely reflected the outcomes as set out in the Red Book, the Health Authority, who led on the contracting, described the process as:

> *(It)* **needed a lot of detailed care and attention....a huge amount of detail. (Health Authority Manger)**
>
> **We didn't want to rush into one inflexible system with another. (Health Authority Manager)**
>
> **We went for a very fluid level of contracting and we'll negotiate different parts later. 'Red Book nouveau', we call it. (Health Authority Manager)**

The new areas, distinct from GMS, which it was anticipated the PMS contract would cover included:

- Mainstream employment practice – posts advertised, interviews held.
- Salary caps for all sites.
- Training and professional development built in.
- Emphasis on joint working and collaboration.
- Taking the views of patients seriously.
- Developmental contracts, with developmental targets eg production of business plan, minimum banding achievement.

Efficiency Savings, incentives and penalties

Opinions varied as to whether the PMS pilot would lead to efficiency savings. It was felt that comparing the PMS pilot with other GMS practices was not comparing like with like:

> **....it's like comparing apples and oranges. (Health Authority Manager)**

Two areas where respondents felt there was the potential to make savings was in prescribing and improving patient information which could reduce repeat visits.

Practice staff were doubtful whether the nurse-led model would be cheaper to run than a traditional GMS practice:

> **I think *(the Health Authority)* think that by using nurses rather than doctors they'll save money, if that's what efficiency means. I'm not sure that they're right, because I'm not sure that nurses are that cheap actually. They think that a nurse-led service will be cheaper. (Practice)**

> **It's generally agreed that nurses could see 50% of a GPs patients, and that's a conservative estimate. Nurses cost half as much as a GP, but spend twice as long. I'm not sure it's entirely evident up front. I believe nurses are better at getting patient compliance and understanding, but I'm not sure how this will affect our group. (Practice)**

While respondents disagreed whether the Health Authority would be actively seeking efficiency savings, it was thought that the Health Authority would, quite rightly, be looking for value for money from the pilot.

Performance related pay and penalties hadn't been built in to the contracts.

> **...we don't have any incentives for the clinical staff – we don't expect to pay people an incentive to work at this Trust, we expect everybody to work well – and that's part of the basic deal! (Trust manager)**

Clinical staff in the practice differed as to whether they thought being in a PMS pilot would have an impact on their clinical behaviour.

> **Everything you do is affected by it. (Practice)**

> **I think that when it's one to one with the patient, we'll do the same thing. (Practice)**

New roles and workloads

New roles were being introduced in the pilot. The practice nurse was to take on some of the management of the practice, and it was planned that the reception staff would be multi-skilled to allow them to take blood samples, for example. Multi-skilling of district nurses and health visitors and an integrated nursing team had been discussed. In addition to the new roles in the pilot, a number of the staff taken on at the practice had not worked in general practice

before, so this was new to them too. Learning new skills in a short space of time was necessary, and graphically described:

> **It's just learning at the moment, just an education. I've got learning curves coming out of my ears at the moment! (Practice)**

Practice staff were enthusiastic about working in new ways:

> **I'd really like a flat team, with no lead. I'd like different members of the team to deal with particular problems and for this not to be the doctors all the time. (Practice)**

However, there was some concern about staffing levels:

> **At the moment we've got a purely skeleton staff. GPs don't have much overlap time. We need to meet regularly as a team. (Practice)**

All practice staff we spoke to felt that their workload would increase over time as the practice list grew:

> ***(It will)* increase as the patient list develops and as we look at more and more structuring the service to patient needs and offering more services. (Practice)**

Patients had not yet begun to register at the practice when we interviewed, so it remained to be seen how they would react to the nurse-led aspects of the pilot. One of our respondents commented that the CHC had been concerned that a nurse-led service might mean a second-class service, and a member of staff in the practice said that:

> **Just watching a patient come in and routinely see a nurse – I think we're going to have real problems with that at the beginning. The perception *(is that)* people generally feel short changed seeing a nurse. (Practice)**

The particular needs of the expected practice population, it was felt, complicated the nurse-led issue:

> **In my experience in the past, people are often quite happy to see the nurse because they feel they don't want to waste the GPs time, or they feel the nurse can deal with it, but we're dealing with a group who may not know how to differentiate services. I think if we had a standard population it wouldn't be a problem, but it might just be the case that they expect to see a doctor all the time anyway. (Practice)**

Improving accessibility for marginalized groups

One of the chief aims of the PMS pilot was to improve access for marginalized groups in the area. The timing of our interviews meant that patients had not yet started to register at the practice, so it was not clear whether this aim would be fulfilled. However, the practice was taking steps to make registration simpler for particular groups of patients:

Hopefully *(it'll be)* a lot more accessible, with two boundaries, recognising the need to extend the boundary – one boundary for the general population, an outer boundary for the high need populations. We won't turn people away if they're refugees, and we'll try and help them more. (Practice)

It was planned that user views of the new service would be collected via the existing complaints and procedures policy, although it was envisaged that, in future, practice literature would need to be translated into a number of different languages.

Emerging themes from year two interviews

Interviewing for year two is still underway in the pilot. As a result, the themes outlined below relate to five interviews already undertaken.

1. Achievements in Year One

- There was a general sense of satisfaction that an entirely new practice had been set up from scratch and had already reached a Health Authority quality banding level that many practices in the area had failed to achieve.
- Patient turnover was reported to be low, and no complaints from patients had been received.
- However, there was a feeling perhaps that the achievements of year one had been clouded by the negotiations around the wave two pilot – that this had got in the way of concentrating on the wave one practice.

> **The wave 2 issue has been around ever since we've been around, and I think that's complicated life for us. (Practice)**

2. Registering Marginalized populations/Access

- There was a perception that the practice had been successful in registering marginalized groups, although data is not available to support this supposition. It was suggested that perhaps the practice was seen as a 'dumping ground' for patients other practices didn't want to register. However, this was seen as a positive thing, as patients who hadn't previously been able to access primary care services were now being given the opportunity to do so.
- It was felt that the patients who had registered **were** different from those in a standard GMS practice. A high proportion of patients from ethnic minority groups had registered and there was a high demand for translation services (access to these was problematic, especially for some languages).

> **All the GPs will say 'well, we have refugees, we have this', but they don't have a waiting room full of non-English speaking people, day in, day out, so it is different. (Practice)**

> **I think that what we do is the fact that as soon as somebody doesn't speak English, we ring for an interpreter. Whereas what I hear from the people themselves, is that in most places where they've been before, the doctor**

struggles, doesn't succeed, and gives them a prescription for paracetamol. (Practice)

- Newly-registered patients were felt to increase workload as it was reported that they consulted more frequently, generally, than patients who had been registered for some time. The caseloads of the health visitors were felt to be different from the average practice.
- In addition to the high numbers of refugees and asylum seekers, another large group of patients included the student/young/professional/mobile/commuter population.

3. Working in a different way/Working across agencies

- Interviewees in the practice reported that they had, at least initially, been able to devote more time to their patients, to have made an extra effort with patients, and to have carried out outreach work.

> **We've been able to offer more to people who need longer. (Practice)**

> **... we made an extra effort with the patients, to make them feel welcome and relaxed and things got done, things didn't just get put in a tray and then forgotten about.... (Practice)**

- A particular success was felt to be in improving services for drug users.
- However, there was a feeling that perhaps the practice wasn't necessarily working in a different way, but rather working in a standard way with people who hadn't been able to access services before.

> **.... I think there are differences, and it's in terms of who we've got registered as opposed, necessarily to what we do with them. (Practice)**

> **.... I don't think our links have been very much different than a good general practice.... at the of the day, the only service we offer that is different is the fact that we don't have as many patients. (Practice)**

4. Roles

Roles within the practice

- The initial enthusiasm about working in new ways had given way to a sense of failure, particularly around the nurse-led aspects of the pilot. It was felt that the nurse-led approach had not been developed.

> **It's been a failure hasn't it? The single aim of the nurse doing a large amount of work, and the doctor taking on a consultancy role just hasn't happened. (Practice)**

> **We're still arguing about what nurse-led means..... (Practice)**

- There were tensions in the power relationship between the doctor and nurse roles, with the GPs being uncertain whether to 'guide and direct' or to 'get involved'. The nurse role had not been felt to impact on GP workload.
- There had been a lack of clarity over the management/leadership role which meant that the nurse clinical lead role had not developed as anticipated.

> ***(the nurse lead role)*** **was very blurred, one minute she was a manager, the next minute she was a receptionist, the next minute she was a doctor, the next minute she was a nurse, the next minute she was an outreach worker.... it was very difficult for her.... (Practice)**

- Understaffing was reported to be a problem. The nurse practitioner had left; there was no recognized practice manager; the receptionist's contract specified very long hours, and there was no secretarial support.
- It was questioned what being a salaried GP 'really meant'. The balance between contracted hours and responsibility for patients was felt to be an area where there needed to be a lot more reflection.

> **I certainly feel very torn as a salaried person about how involved I should or shouldn't be... (Practice)**

- Multi-skilling of reception staff had not occurred.

Between the practice and the Trust

- It was felt that there were disbenefits of being Trust managed, particularly in the slow reaction times.

> **.... procurement against standing financial requirements – this takes four weeks. (Practice)**
>
> **... as professionals we feel powerless. (Practice)**

- Uncertainty surrounding the involvement of the GPs in the management of the practice had led to an uneasy balance between 'who is managing the doctors?' and 'they're not actually involving us in anything'. The clinical staff in the practice had not been involved in re-negotiating the contract, and therefore had limited knowledge of it.
- Senior staff at the Trust who had been heavily involved in the PMS pilot had left, so in-depth knowledge of the pilot at a senior level had been lost.

Between the HA and the practice

- The Trust had not always been seen as having effective negotiations with the HA.
- Levels of support for the pilot from the Health Authority were, at least initially, reported to be low. Although the situation had improved slightly, it was still reported that the HA didn't understand the PMS pilot, and that the HA had tried to force

changes on the pilot (for example, Saturday opening) that they could not have influenced a GMS practice about.

- HA support in helping the pilot to network with similar pilots in the area had, it was felt, been minimal.
- Around the contract, it was felt that, although the pilot had some of the same targets as a GMS practice, the HA had forced changes on them.
- The Health Authority view was not that they did not support the pilot, but accepted that pressure around early outcomes might have been too high.

5. Workload and morale

- There was a feeling that with the increasing list size, workload had now reached a point where it threatened the pilot's focus on priority groups. Workload for managers was felt to have increased, but for the GPs, at least initially, this had not been the case. The GPs felt that they had to take less work home than they had in previous jobs, and they did not do on-call. Currently, however, with patient numbers standing at around 1400, it was commented that:

> **It has just begun to feel out of control in terms of patient numbers. (Practice)**

- Frustration was expressed, with variable levels of job satisfaction and morale linked to the sense of 'failure' of the pilot to live up to its original aims.

> **I was looking forward to working in a different way, and it hasn't happened. (Practice)**

6. Impact on clinical roles

- GPs did not feel that their clinical behaviour had changed as a result of working within a PMS pilot. There was confusion about how different PMS really was from GMS.

> **I really cannot get my head around what the difference between PMS and GMS is.... we are still asked for cervical cytology numbers, we are still asked for immunisation rates.... OK, when we do contraceptive service I don't have to get an FP1001 to be signed, but *(at my previous practice)* we were already linked, so we didn't need to do that anyway... I don't think that it changes my practice in any way, though. (Practice)**

- In other areas of their work, the GPs felt that the nurse role had not had any impact on their workload, they felt a reduced sense of power, and that there was less impetus (and time) to take part in continuing medical education.

7. Relationship with the wider health service

- There were mixed messages around the level of commitment of the PCG to the PMS pilot. At Board level, there was felt to be little discussion about the pilot, although the PCG was felt to be committed to it.

The PMS pilot hasn't been discussed by our PCG even when the second wave came up. There are three second wave round here, but it wasn't talked about at Board level, it was talked about at sub-board level. (Practice)

- Working in a small practice was felt to be potentially isolating – a situation that was made worse by the lack of support and suspicion from local practices.

  I think that whole kind of feeling of being isolated is very much there. (Practice)

  Lack of support from the HA, and the loss of senior-level staff from the Trust added to the sense of isolation. In addition, there was intense interest generated by the pilot, which led to a sense of being constantly observed.

Main Messages

The pilot has succeeded, in sometimes very challenging circumstances, in creating a new practice that is meeting the needs of a growing patient list. While data has not yet been collected on patient views of the service, the practice itself feels that it is able to devote time to meeting the multiple needs of its patients and has developed good links with a number of other agencies working in the area. It has been reported that patient turnover is low and that patients are choosing to switch to the pilot from neighbouring practices. There have been no complaints so far. However, as one might expect, some difficulties have been experienced. In some cases these can be deemed serious, as judged by their impact on pilot members.

A number of key messages are beginning to emerge from the evaluation (although it must be recognised that not all second round interviews have been undertaken and other research methods have yet to be employed).

A lack of a common vision within the practice team and between the practice and trust has been detected. In particular, this has concerned the mutual expectations of practice staff and the Trust. One of the perceived advantages of salaried employment as opposed to independent contractor status is the managerial infrastructure provided by the Trust that allows clinical staff to concentrate on patient care without wider responsibilities. From the staff members point of view, this can be seen as a trade off between autonomy and control on the one hand and protection from the labours of management and responsibility on the other. In practice this trade off has not been wholly satisfactory.

The inability of pilot staff to initiate and implement change within the practice has proved a source of frustration; the support offered by the Trust has been perceived to be insufficient and bureaucratic. While much of this frustration may be due to teething troubles that any new practice might experience, the conceptual point – which responsibilities lie within the practice and which within the Trust? – needs to be clarified. The lack of practice staff involvement in (and knowledge of) the contract specification, for example, was surprising.

It is generally accepted within the practice and the trust that teamwork has not been as effective as it could have been. At its heart this issue appears to be one of role confusion

regarding management, leadership and clinical responsibilities. The pilot has a prime objective to deliver innovation in patient care in the shape of 'nurse-led services', yet to date this has not successfully been achieved. The practice and the trust recognise that greater clarity over the definition of 'nurse-led services' is required. The lack of clarity within the team has caused morale and job satisfaction to diminish.

While practice members accept that the objective of 'nurse-led services' has not yet been delivered it would be helpful to reflect on why this is the case. There may be a number of competing explanations: difficulties in managing the implementation; a lack of shared 'vision' or commitment to the concept of 'nurse-led services' within the team, or a problem with the concept itself (i.e. it is not, in practice, implementable).

Another clear theme emerging from the interview data is the perception within the practice that the health authority has been unsupportive to the practice. This is not the health authority's view, although the authority does recognise that it may have demanded too much, too early in terms of pilot outputs (especially patient registration levels). While there is a general perception that pilot-authority relations have improved over time, it may be important to consider what an appropriate level of support from the health authority might be.

The relatively low list size has been a distinguishing feature of the pilot and has allowed a satisfying degree of responsiveness to patients in general and priority client groups in particular. Signs are emerging that this responsiveness is now being compromised as the list continues to grow. Given the apparent needs of the practice population (particularly if the practice is accepting patients refused elsewhere) a high doctor-patient ratio may be appropriate in the long-term. However, at a PCG or authority level, this raises important issues of equity. Other GMS practices may well have equal needs and yet do not have access to the same remedy. This might be a strong argument in favour of PMS pilots generally, however, the affordability of low-list pilots might be questioned if they were extended more generally.

Interviewees have suggested that in many ways the pilot is no different to what one might have expected under GMS. This similarity has been presented as a 'failure'. Notwithstanding the (so far) unfulfilled desire to initiate nurse-led services, this raises the question of how one might judge the success of PMS - is 'success' synonymous with innovation? Success can be measured both in terms of 'output' and 'process' and, to date, the pilot has concentrated on process changes such as salaried practice. The result has be characterised by some within the practice as good, traditional general medical services. While further goals are still being pursued, this might represent a satisfactory staging post halfway through the lifetime of the pilot. However, this underlines the need for the pilot to agree a shared success criteria for both process and outcomes to assist in the further development of the scheme.

Evaluation

Interviewees have identified a wide range of issues that they feel it would be advantageous to evaluate. These include:

- the range and quality of services
- nurse-led services
- the population served

- patient views
- the impact on the wider health service
- the impact on health
- the impact of competition on health care

The King's Fund evaluation will not be able to answer all the questions that might be raised and it is important to be clear what evaluation tools are planned and what outputs can be expected.

To date, a great deal of effort has been directed towards semi-structured interviews that will yield important data from the perspective of participants and other stakeholders. This will be used to 'tell the story' of the pilot as well as determining its impact on those involved.

The King's Fund evaluation has a number of other strands (see attached timetable):

Clinical Audit	An audit of heart disease and diabetes using medical records of 20 patients drawn randomly from disease registers
General Practice Assessment Survey (GPAS)	A random survey of the views on service quality of 200 patients
QUASAR	A survey, with follow-up, of a package of practice-based quality indicators
Focus Group	Discussion with 'external' stakeholders to determine the impact of the pilot on priority patient groups (suggest refugee and asylum seekers)
Population Analysis	Analysis of population registered with practice together with the associated workload.
Registration Analysis	Analysis of movements in and out of the pilot and surrounding practices, together with basic information about registered population.

Steve Gillam
Clare Jenkins
Richard Lewis
October 1999

Appendix 7

King's Fund PMS publications

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Jenkins C, Lewis R, & Gillam S. 2000. (in press). Two years on: Personal Medical Services pilot projects in London. British Journal of Health Care Management.

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