

Evaluation of the choice of GP practice pilot, 2012-13

Final report: Appendices

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Appendix 1

Literature review on developments in primary health care in England

Impact of initiatives and programmes to improve patient access to, and choice of, primary and urgent care in the English NHS, 1997-2010

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Abstract

Background

There were major changes to the primary and urgent care system in the English NHS during the New Labour government, 1997-2010, aimed at delivering higher quality, more accessible and more responsive care for patients by expanding access, increasing convenience and introducing greater patient choice of provider. The government implemented ten main initiatives, including NHS Direct, primary care walk-in centres, Advanced Access to general practice, extended general practice hours and NHS 111. This review examines the impact of these initiatives on demand for, and substitution between, services, equity of access, patient satisfaction, referrals, and costs.

Methods

Initiatives were identified through policy documents published between 1997 and 2010. Studies of these were identified from electronic databases and reference lists of publications. Studies of all designs were included if they were published between 1997 and 2012, and included any data on the impacts listed above. Findings were summarised and organised into a narrative review.

Results

Eighteen studies resulting in forty papers on ten initiatives were included. Innovations often overlapped, complicating the landscape of primary and urgent care for patients. Some initiatives were poorly implemented or sited, hampering the achievement of desired outcomes. There was generally some demand for the new provision on grounds of convenience such that demand overall rose, but little sign that patients substituted new urgent care services for existing provision. Evidence on the overall impact on equity of access was unclear since schemes were likely to be used by different patient sub-groups. Patient satisfaction varied across schemes. The new services generally had high costs per visit because activity levels tended to be lower than expected. There was some evidence of duplication or confusion in onward referral pathways. There was little comparative evidence on the costs and benefits of the different forms of provision.

Conclusion

The new programmes resulted in a more complex system where new and existing providers delivered overlapping services. The evidence suggests that new provision did not induce substitution by users and was likely to have increased overall demand. Although there were gains in convenience, it was difficult to improve choice and access at low cost, especially through new forms of provision. Initiatives to improve access to existing provision (e.g. extending general practice opening hours) may have greater potential to improve access and convenience at lower marginal costs than developing entirely new forms of provision in this field.

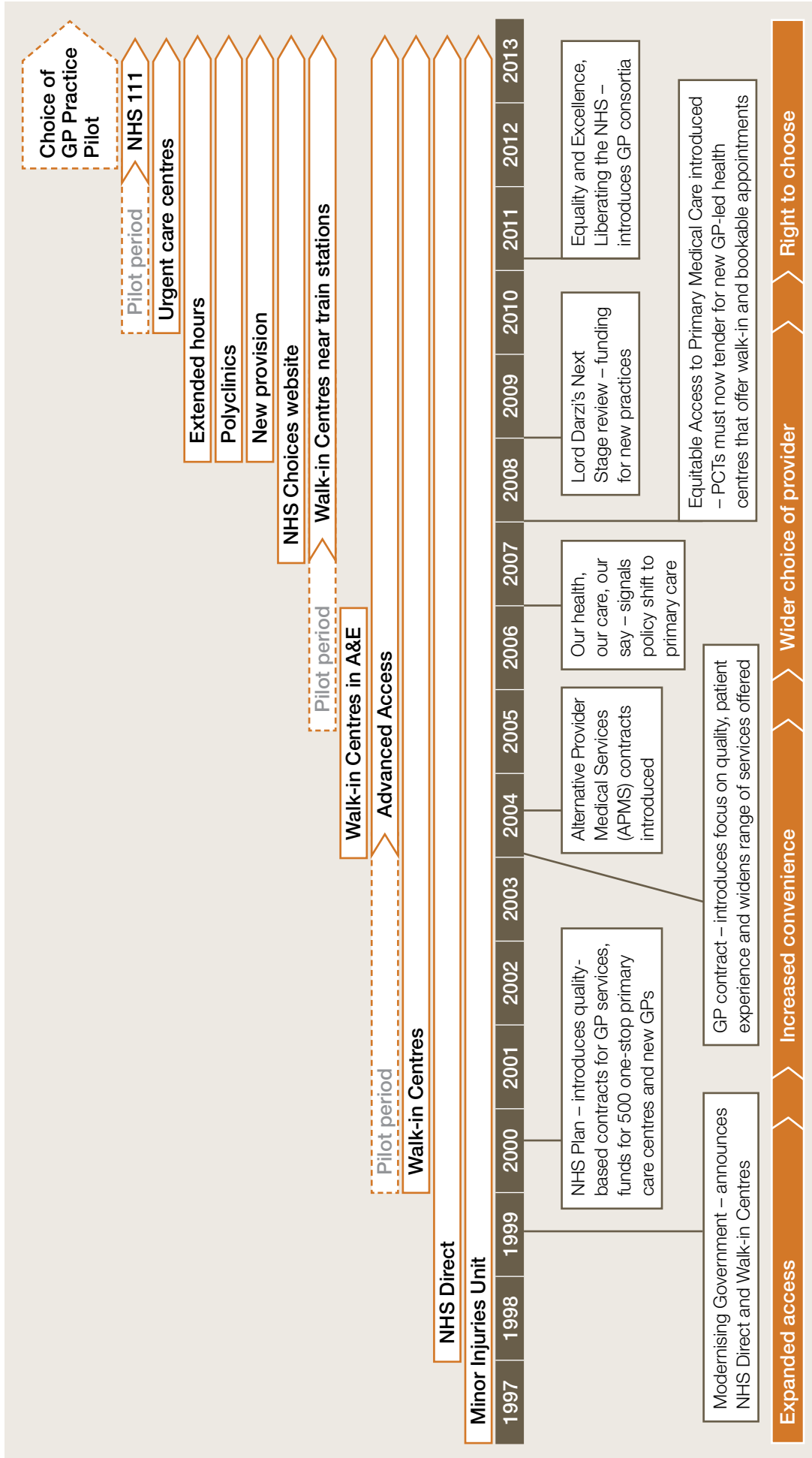


Background

After New Labour came to power in 1997, the government sought to develop better quality, more accessible and more responsive patient-centred care. Although much attention has been devoted to the quasi-market reforms in hospital care, which encouraged greater patient choice and supplier competition (Mays Dixon and Jones 2011, Mays and Tan 2012), reform also included a focus on modernising primary and urgent care. Here the focus was on correcting perceived problems in access to, and choice of, services, such as growing public concern about timely access to general practitioners (GP) during and outside clinic hours, and the perceived inflexibility of traditional general practice, despite provision for patients away from home to access a GP as a Temporary Resident or as an 'Immediate and Necessary' case. The coalition government that followed New Labour (1997-2010) has continued to focus on improving patient access to primary and urgent care, most notably through a pilot scheme in which patients can either register with, or use, general practices beyond the catchment area of their local general practices (DH 2012). Figure 1 (below) and Appendix 1 summarise the reforms from 1997-2013.



Figure 1 Initiatives to improve access and choice in urgent and primary care in the English NHS





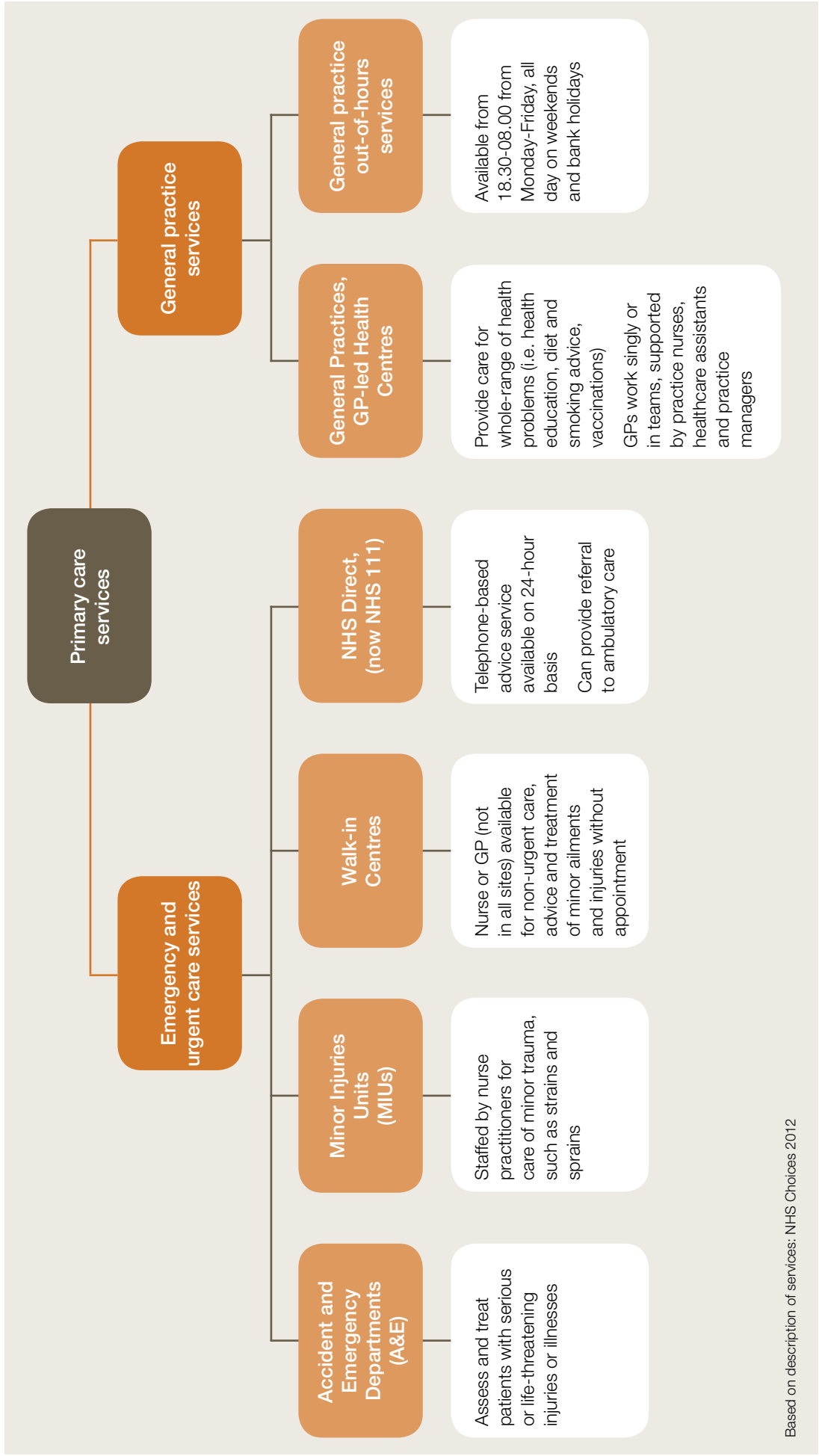
From 1997-2004, a series of initiatives was developed in response to the perceived limitations of access to primary and urgent care in the NHS. NHS Direct (1998) opened a new telephone access route for primary care advice, especially outside practice hours. NHS walk-in centres (1999) aimed to provide more convenient access to primary and urgent care without an appointment (Salisbury 2000); some were co-located with accident and emergency (A&E) departments (2004) to improve access where patients chose to attend for urgent care, and further walk-in centres were located at, or within walking distance of, commuter train stations (2005). NHS Direct and walk-in centres established new pathways for primary and urgent care, and offered a protocol-driven service for patients who could, or chose, not to access their registered GP practice. The Advanced Access scheme (2000) intended to reduce waiting times for GP appointments. There was also investment in training additional GPs and modernising existing practices in the NHS Plan (DH 2000). A new General Practice NHS contract (2004) was introduced to address issues in contracting and payment, standardise quality and modernise IT infrastructure. The new contract featured incentives to shorten waiting time for a GP appointment to 48 hours and the Quality and Outcomes Framework (QoF) which included targets relating to levels of patient satisfaction. By 2005-6, investment in primary medical care had increased by well over £2 billion when compared to the financial year ending in 2002-3.

From 2007, further policies were introduced to support and offer greater patient choice, including in primary care. The NHS Choices website and GP extended hours access scheme were introduced in 2007. The introduction of PCT tendering for new GP practices and new health centres (from 2008), polysystems (2007-9), urgent care centres (2010) and the NHS 111 service (2010), all designed to increase accessibility, or patient choice of provider, rapidly followed. The 2008 NHS Next Stage Review outlined new opportunities for patients to choose their general practice and called for the removal of practice boundaries (DH 2008). These plans have been taken forward in modified form by the coalition government through its general practice choice pilot of 2012-13 (DH 2012). Below, Figure 2 illustrates the current wide range of ways to access primary and urgent care in the English NHS.

This review assesses the initiatives designed to improve access and patient choice introduced by New Labour up to 2010 in terms of their impact on the demand for, and substitution of services, equity of access, patient satisfaction, referrals, and costs.



Figure 2 Current pattern of urgent and primary care services in the English NHS



Based on description of services: NHS Choices 2012



Methods

The review looked at initiatives to improve choice and access to primary and urgent care in the English NHS from 1997 to 2010. We searched official government documents to develop a list of the initiatives. We searched the published literature using bibliographic databases – Google Scholar, PubMed and the King’s Fund Library Database. The initial search was undertaken from June to August 2012. We used broad search terms, such as combinations of initiative names (e.g., walk-in centres or advanced access) plus English NHS. We conducted a further search using search terms “primary care reform,” “patient choice,” and “access to primary care” with English NHS in Google Scholar. Searches were performed in English for all dates without restrictions. Titles and abstracts were scanned for inclusion in the review. All studies on secondary care choice of provider, patient preferences and studies outside of the UK were excluded. Other relevant references were hand-sourced from already identified publications. A second search was conducted in November 2013 for publications from larger studies and evaluations whose final reports were available in 2012; three additional papers were identified in this search. Forty papers from eighteen studies on ten initiatives are included in this review. The review included a broad range of study types, from different disciplines, provided that the study included empirical data on the impact of any of the initiatives on demand for, and substitution of, services, equity of access, patient satisfaction, referrals, and costs. As a result, this is a narrative review.

Results

Demand and substitution effects

Demand for telephone-based services

NHS Direct, a nurse-led telephone helpline, was introduced in 1998 to address unmet demand for health services, provide referral to appropriate care and deter inappropriate attendances at A&E departments. Previously, patients needing out-of-hours care or advice called their GP practice, or the local GP cooperative – a decentralised out-of-hours telephone service that directed patients to an out of hours clinic, or arranged night visits to patients (Salisbury 2000). A national evaluation of the first wave of NHS Direct sites in Milton Keynes, Chorley and Preston, and Newcastle, North Tyneside and Northumberland, found that calls to GP cooperatives fell after the introduction of NHS Direct, but there was no reduction in A&E department attendance. During the evaluation period, March 1998-March 2001, NHS Direct became a legitimate pathway for patients to discuss urgent health issues and gain advice on appropriate treatment. NHS Direct use increased gradually after its introduction but this did not appear to be associated with any reduction in A&E attendances. Many calls to NHS direct could not be diverted to a Minor Injury Unit to avoid A&E department attendance because these Units were not widespread at that time. In fact, a survey of users found that NHS Direct was rarely used (6% in 2001) for unplanned episodes of care, defined as any contact that was not planned more than one day in advance as opposed to planned care, such as a blood pressure check or clinic visit (Munro, Nicholl et al 2000; Munro, Clancy, Knowles et al 2003).

In 2010, NHS 111 was introduced in County Durham and Darlington, Nottingham City, Lincolnshire and Luton for evaluation before nationwide roll-out. It was implemented through an ambulance-led service in County Durham and Darlington and through NHS Direct in Nottingham City, Lincolnshire and Luton. It was a new telephone-based screening service, using non-clinical advisors to help individuals seeking care to reach the most appropriate provider for urgent or non-urgent care, and was intended to replace NHS Direct. The evaluation reported mixed results on demand for services;



it found a reduction in calls to NHS Direct, but an increase in the use of the 999 emergency ambulance service. The evaluation raised concerns that NHS 111 may not reduce use of existing emergency services, despite being designed to direct callers towards more appropriate services (Turner, O’Cathain, Knowles et al, 2012).

Demand for walk-in services

Walk-in centres were established to complement NHS Direct, reduce demand on other NHS providers, especially for GP practices, and operate as an alternative to the A&E department. They were launched in January 2000; within the first year, 39 centres were opened in 30 towns and cities and were the subject of a national evaluation. The centres were located near community centres, high streets and shopping centres. All were nurse-led and staffed by a combination of nurses and nurse-practitioners. GPs were employed at a small percentage. For example, just four of the 34 that provided staffing details to the national evaluation had GP input – with just one having a whole time equivalent GP (Salisbury and Munro 2003; Salisbury, Chalder, Manku-Scott et al 2002). Demand was highly variable. By August 2001, 18 months after introduction, the average number of monthly visits at the 39 centres was 2556, or 82 per day. This figure disguises considerable site-by-site variation in the number of monthly visits, which ranged from 1004 (32 per day) to 4041 (130 per day). The evaluation did not delve into reasons for underutilisation, but suggested that there was little evidence of a formal patient and population needs-assessment during the bidding process (Salisbury, Chalder, Manku-Scott et al 2002). It is possible that centres were poorly sited or that potential demand was simply over-estimated.

An observational study sought to determine the impact of NHS walk-in centres on demand for local primary care services by comparing two Leicestershire towns, one, Loughborough with a walk-in centre and the other, Market Harborough, without. Market Harborough was selected as the control town based on geographic and demographic similarities, although it had lower levels of deprivation. Both towns were discrete communities and not part of a larger conurbation. This study found no significant difference between the daily rate of emergency general practice consultations, access to routine appointments or use of out of hours services, in the two towns, but there was a significantly higher rate of attendance at Loughborough’s Minor Injury Unit and local A&E departments after the advent of the co-located walk-in centre. This study was limited to two similar towns and small numbers of GP practices in Market Harborough. However, the findings suggest that this new provision added to use rather than inducing substitution between services. The study also showed that there is a distinct subset of patients who preferred to use walk-in centres instead of calling a telephone advice service (like NHS Direct), presenting to their local A&E department, or seeing their GP (Hsu et al 2003). The same research team also conducted a qualitative study, in Loughborough, of 23 patient’s motivations for using walk-in centres. They found two distinct user groups; the first attended with a specific goal in mind (eg, to obtain a prescription for a specific asthma medication they were familiar with), while the second group wanted professional advice or reassurance on the nature and severity of their condition, and treatment if necessary, rather than “bother” a GP, or waste NHS resources. Some interviewees noted that walk-in clinics offered practical advantages, such as a rapid but appropriate level of care for their ailment or in comparison with waiting times at A&E. The researchers suggested that open access walk-in centres led to some substitution away from GP practices, but also a new pattern of service use, because patients were not required to justify their need for an appointment as they would have been required to do with a GP practice receptionist or at A&E (Jackson, Dixon-Woods et al 2005). Maheswaran, Pearson et al (2007) conducted an ecological study using the Department of Health’s



2003-2004 Primary care 24/48 access survey from 2509 practices in 56 PCTs to examine whether exposure to a walk-in centre had an impact on a practice's ability to meet the 48-hour access target. They found no evidence that a practice's distance from a walk-in centre was associated with achievement of the 48-hour target. Their results supported Hsu et al's (2003) findings that walk-in centres do not shorten waiting times for access to primary care, although their study did not compare the characteristics of each service's users.

In 2004, eight new walk-in centres were opened in or alongside A&E departments. This new wave of walk-in centres was designed to provide health services where patients chose to present themselves, rather than trying to divert them from A&E. Patients presenting to the walk-in centre or A&E were to be triaged jointly. An evaluation compared eight co-located walk-in centres to A&E departments without a co-located walk-in centre. The evaluation team reported that the majority of sites implemented the walk in centre concept to a very limited degree compared with the first wave of walk-in centres in that few had a distinct visible presence, only three were locally known as walk-in centres and several were rebranded existing services. Most managers and doctors interviewed thought the centre was established to reduce demand on A&E, not to increase choice of urgent care, while some sites resisted the concept of providing a more convenient-walk in service at A&E because greater accessibility could increase demand. Due to the joint screening process, the evaluation was not able to compare demand for services because there was no way of differentiating between the intended destinations of each patient (Salisbury, Hollinghurst, Montgomery et al 2007). A cross-sectional questionnaire survey found that the vast majority of patients (79%) treated at the eight co-located walk-in centres had initially presented to the A&E department before being redirected to the walk-in facility through the A&E department's triage process. Of those, 55% of users were unaware that they had received treatment at a walk-in centre. This was consistent with site observations that the co-located walk-in centres had low visibility and were closely integrated with the A&E department (Chalder, Montgomery, Hollinghurst et al 2007). In practice, this initiative presented an opportunity for A&E departments to meet the 4-hour waiting time target for treatment or discharge, by redirecting non-urgent care to the walk-in centre, rather than meeting the policy's aims of increasing choice and access of provider. In some study sites, the co-located walk-in centre resulted in greater nurse-management of patients than in A&E, while in others the main change was how episodes of care were labelled. There was no evidence of a significant change in attendance rates, processes, outcomes or costs between study and control sites. The co-located centres were disbanded within two years of introduction because hospitals did not implement the concept in the way that national policy makers had hoped and because they had little effect on processes and outcomes, and did not appear to be less costly than the alternative (Salisbury, Hollinghurst, Montgomery et al 2007; O'Cathain, Coster et al 2009).

In 2005, seven new walk-in centres were located within walking distance of London Underground and rail stations primarily to suit the daily lives of, and meet unmet demand from, the commuter population revealed in market research. These differed from existing walk-in centres because they were operated by the private sector on behalf of the NHS, all had GPs, were not nurse-led, and their opening hours (7am-7pm daily) were targeted at commuters. The evaluation examined six locations; three were in London while the other three were in large cities in Northern England. A questionnaire survey revealed that most patients used this service because it was easier to get an appointment than at their own GP surgery, or because it was in a more convenient location than their registered GP surgery. However, only 12% of respondents chose

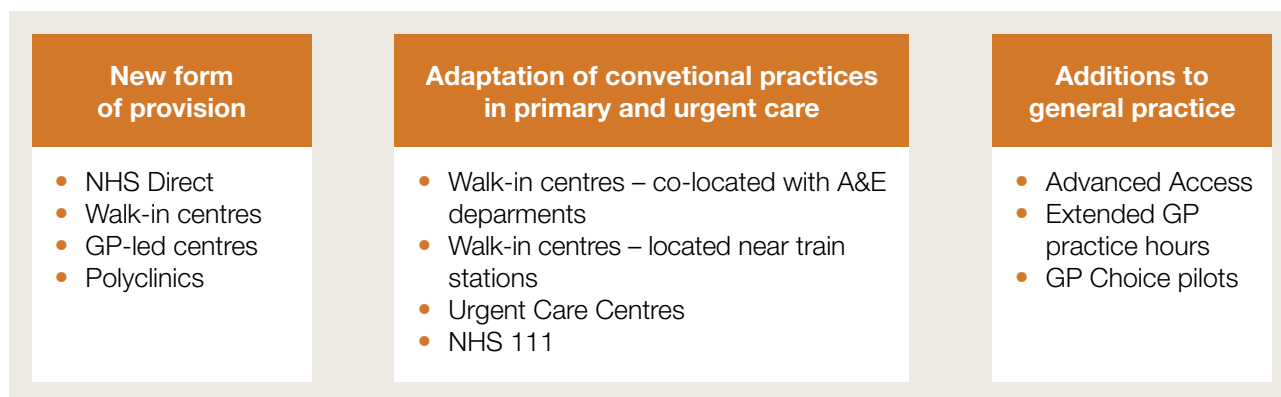


this service because they travelled to work through the particular train station (Coster, O’Cathain et al 2009). There was considerable variation in usage, attributable to location and degree of publicity. The behaviour of centre managers also played a role. One centre marketed its services directly to the local population, rather than operating solely as a hub for commuters. Usage varied widely between sites in and outside London. Outside London, half of the users were commuters, but only a sixth travelled to their place of work by train. In London, nearly two-thirds of users were commuters, 38% of whom travelled by train to work. Signage and publicity played an important role in shaping demand for the centres’ services. Users tended to work near the station (61%), but only 16% of those passed the centre directly on the way to work. Overall, centre managers reported an average of 87 visits per day between July and September 2007; the lowest site average was 33 visits per day, while the busiest site averaged 128 visits per day. The pilot evaluators found that the centres were underutilised during the research period, leading to low activity levels and high costs. They concluded that this was a costly way to meet commuter demand for primary care and suggested that walk-in centres in areas of high workplace density might be more successful than ones specifically at rail stations (O’Cathain, Coster et al 2009).

Demand for primary and urgent care

Initiatives were also developed to adapt and thus improve access to existing primary care services. These initiatives are classified below in Figure 3.

Figure 3 Classification of initiatives to improve access to urgent and primary care services



The Advanced Access scheme was an organisational model strongly promoted to help practices meet the 2004 QOF target that all patients be seen by a GP within 48 hours. The National Primary Care Development Team (NPCDT) issued Advanced Access implementation guidelines to help practices meet patient demand for appointments, prepare for fluctuations in demand, and enable continuity of care between GPs and patients (Pickin, O’Cathain et al 2004; Salisbury, Banks et al 2007). Operationally, the Advanced Access scheme became conflated with the QOF target and focussed on providing rapid appointments, rather than on developing a plan to improve access and continuity equally (Pope, Banks et al 2008). By 2003, 67% of practices claimed to have implemented Advanced Access, but many did not adhere to NPCDT guidelines, focussing on rapid access by restricting advance bookings rather than managing capacity (Goodall, Montgomery et al 2006). Instead of matching appointments proportionately to demand, many practices simply held back a percentage of their appointments each day (Salisbury, Banks et al 2007). A survey of 47 practices found that general practices met the 48-hour target by withholding 30% or fewer (n=28) or up



to 50% (n=12) of their daily appointments to ensure that capacity was available for patients who had phoned or walked in (Sampson, Pickin et al 2008).

Equitable Access to Primary Medical Care (EAPMC) (2007) provided resources to expand GP practices, especially in the lowest performing quartile of PCTs and under-doctored areas. This required all PCTs to use Alternative Provider Medical Services (APMS) contracts to tender for new GP practices and when establishing GP-led health centres that featured separate walk-in services that offered bookable and walk-in appointments to registered and non-registered patients. The latter has some similarities with the 2012/13 choice of general practice pilot day patient option. APMS and the EAPMC were introduced to promote choice and competition in primary care while filling gaps in provision, especially in areas with fewer GPs. By October 2008, over 100 practices held alternative provision contracts. At a theoretical level, new provision by a wide variety of providers allowed patients greater choice in access. GP-led companies and social enterprises held the majority of these contracts; corporate providers held contracts for just ten new practices (Ellins, Ham and Parker 2009).

There is some evidence that APMS and EAPMC practices did not experience high levels of demand. Coleman, Checkland et al (2013) conducted case studies of two PCTs and their primary care commissioning processes in 2010-2011. They found that many practices struggled to grow their list size, even in under-doctored areas, suggesting that demand for new practices may have been overestimated. Interviews with PCT staff suggested that GP-led health centres over-performed on their walk-in services while struggling to recruit new registered patients and meet list size targets. Some PCT staff suggested that high use of walk-in services represented a financially “unsustainable lowering of the threshold for seeking help” rather than an expression of unmet need (Coleman, Checkland et al 2011). At one study site, the PCT conducted a survey on patient use of walk-in services at GP-led health centres and claimed that patients attended for minor ailments that they could have managed on their own (Coleman, McDermott et al 2013).

An observational study examined the effect of NHS Direct on existing NHS immediate care services during the first year of operation. It found no change in trends of use for first attendance at A&E and emergency ambulance journeys, but there was evidence that NHS Direct reduced use of, and prevented an increase in demand for, out of hours services (Munro, Nicholl et al 2000). A follow-up study used data on NHS Direct call volume and a postal survey of GP cooperatives, 999 ambulance services and A&E departments to model the estimated reduction in calls to out of hours general practice services between 1998 and 2001. This model estimated that the advent of NHS Direct was associated with a reduction in calls to out of hours services – reversing an upward trend in previous years – but had a negligible impact on the volume of demand for 999 ambulance services and hospital A&E departments. The number of patients requiring in-person consultations was constant (Munro, Sampson and Nicholl 2005).

Though a series of reforms had concentrated on improving access by developing alternative pathways for individuals to access health services, such as telephone consultations, or walk-in centres in a variety of convenient locations, evidence indicates that patients continued to present at A&E at similar rates with minor conditions best treated in primary care. Coleman, Irons and Nicholls (2001) conducted a questionnaire survey and notes review at an A&E in a large Sheffield hospital to assess the projected impact of newly developed alternatives to A&E. The survey examined why individuals triaged into the two lowest priority categories



(out of five) self-referred to A&E. The principal finding from this study predicted that MIUs and walk-in centres could have provided appropriate care to 55% of patients that had presented at A&E at the time of the study. However, based on their survey responses, just 7% of these patients were likely to attend an MIU or walk-in clinic for a non-urgent health problem. The study found a set of specific factors closely linked to patient choice of A&E over an alternative provider: belief that a radiograph was necessary; differences between professionals and patients in the perceived seriousness of health problems; previous patterns of consulting behaviour; and experience of services elsewhere versus the A&E department.

Penson, Coleman, Mason et al (2011) conducted a study at an urban A&E department in 2006 to follow up the earlier study by Coleman, Irons and Nicholls (2001) to ascertain why patients continued to present to A&E with minor health concerns. The new study discovered that A&E was not the first point of contact, or first attempt to consult health services, for the same issue, in a considerable proportion of cases. Forty seven per cent had previously sought advice from a GP or nurse-led facility and 17% had contacted NHS Direct. This corroborated the findings of the 2001 study; for example, it found that patients classify the severity and urgency of their conditions very differently from health professionals. Interestingly, the study found that those patients who had previously attended A&E and were familiar with an on-site MIU, might be encouraged to present to the MIU in the future, knowing they would be close to A&E facilities if needed (Penson, Coleman, Mason et al, 2011).

O’Cathain, Coleman and Nicholl (2008) investigated patients’ understanding and experience of the widening range of emergency and urgent care system through qualitative focus groups in different Yorkshire localities. They found patients had low awareness of the health system, limiting their options in seeking care. If patients were aware of service options like NHS Direct, walk-in centres and A&E, they were unsure which was most appropriate for their, or a family member’s, health needs.

Knowles, O’Cathain et al (2011) conducted a telephone survey of the general population to assess their experiences of the emergency and urgent care system. Most patients entered the care pathway through contact with a day time GP (59%) while 10% contacted NHS Direct and 8% visited A&E. Most patients moved to another service on the care pathway because a service provider instructed them to, while others sought alternative advice because their health issue had changed, they were dissatisfied, wanted a second opinion or because they could not access the service they wanted originally. This study found that satisfaction with care diminished as patients moved between service providers in the urgent care system.

Urgent Care Centres (UCCs) were developed in this period to provide acute care that did require specialised A&E facilities and skills. The distinction between UCCs and MIUs is not always clear, particularly not to patients. The Primary Care Foundation found that UCCs (15 sites) faced consistent demand, seeing 90-120 cases each day. The pattern of demand was predictable throughout the day, although clinicians felt that productivity (measured by typical cases seen per clinical hour) was low (Carson, Clay and Stern 2012).

Polysystems were another innovation introduced in this period to improve primary care infrastructure through the establishment of multi-disciplinary health centres with GP practice(s), community health services and elements of secondary care co-located. The evaluation of the London Polysystem, conducted from 2010 to 2011, did not find substantial changes in demand for among specific patient



groups, or changes in how patients accessed services. A patient survey at one site found that less than 5% of patients had used more than one service during a single visit, although 92% expressed a strong preference that services be co-located in polysystems rather than spread across a number of providers. At one study site, there was evidence that the polysystem paid twice for registered patients who used walk-in services as a substitute service when their preferred GP was unavailable for a booked appointment (Peckham et al 2012).

Equity of use

There was limited and hard to generalise evidence on the impact of the initiatives on equity of access to health services by age, gender, ethnicity and socio-economic status of users. In part, this is because it is difficult to study patterns of use in relation to individuals' levels of 'need' for health care.

In 2002, the National Audit Office expressed concerns that there might be inequitably low use of NHS Direct among ethnic minority groups, people with disabilities and low income groups. Some sites initiated a range of efforts to address this possibility (NAO 2002). The evidence that NHS Direct may have improved or exacerbated inequity in access to health care is limited and contradictory; this can be attributed to different study design (ecological study versus postal survey).

Two ecological studies on equity of access present similar findings. In NHS Direct South East London, Burt, Hooper and Jessopp (2003) compared call rates in Lambeth, Southwark and Lewisham with Bexley, Bromley and Greenwich, by area deprivation levels of callers' postcodes. This study found that calls rose with increasing deprivation, but fell in areas with the highest deprivation scores. Cooper et al (2005) analysed calls to NHS Direct by area deprivation levels using the ward level Index of Multiple Deprivation (IMD quintiles), age and sex of callers in West Yorkshire and West Midlands. Calls rose for working age adults (ages 15-64) with increasing deprivation, but rates fell for calls about children aged under 4 years in the most deprived areas. The studies utilised different methods to measure deprivation, but both found some reduction in use at the highest levels of deprivation, suggesting a degree of inequity in use.

Knowles, Munro et al (2006) examined longer-term patterns of use in areas where NHS Direct had been established in 1998. In 2002, they conducted a postal survey that found the following groups were less likely to utilise telephone-based services: males, 65 years or more, low levels of education, not owning their home, not having access to a car or telephone, being hearing-impaired or not being native English-speakers. This study concluded that a single-gateway service could exacerbate inequities in access in such groups. Ring and Jones (2004) conducted a cross-sectional postal survey to investigate service use among different ethnic and socioeconomic groups by sampling parents or guardians of children aged 0-5 years from a GP practice in Burnt Oak and Edgware, North London. They chose this sample because the age group is a high user of all health services and have high GP registration rates. Their study provided some evidence of inequity, defined by ethnic minority group, those whose first language is not English, lower socioeconomic group, in terms of home or car ownership, and those in ill health, but was limited by a low response rate (47%) and small study population. The study did not report how need was measured.

The national evaluation of walk-in centres found that they improved access to services for some subsets of the population while operating as an alternative form of provision



for urgent care. There was a strong relationship between time of consultation and certain age groups of patients. Young men (who are generally low users of conventional general practice) visited in larger numbers than in general practice. The highest proportion of users was aged 25-44. There were proportionately fewer younger (<24 years) and older (>45 years) patients. Consultations with children were most common in the afternoon (1500-1700), often coinciding with the end of the school day. Young adults, aged 17-35, were likeliest to visit during lunch hours (1200-1400) and older people from 1000-1200. Although walk-in centres operated from early morning into the evening (0800-2100), relatively few people used services before 0900 and after 1600. High attendance rates of young men, and the correlation between time of day and a specific age group's attendance, suggested that walk-in centres provided access to health services at a time when a specific group might find it more difficult to access their registered GP practice. It was unclear why older people particularly visited from 1000-1200 (Salisbury, Chalder, Manku-Scott et al 2002).

Commuter walk-in centres presented similar patterns of use. The majority of users were young adults (<45 years). There were few users over 65 years. Outside London, one site received more users under the age of 21, which was due to one centre manager's decision to market its services to students. The majority of users were white, although higher proportions of users came from minority ethnic groups in London (O'Cathain, Coster et al 2009).

Patient satisfaction and patients' perceptions of quality of care

There was variable evidence on patient satisfaction and perceived quality of care. The available evidence uses a variety of methods from vignettes and professional actors to questionnaires to assess user satisfaction.

The introduction of NHS Direct was accompanied by concerns about the appropriateness of advice and referrals. The evaluation found that 1 in 8 callers received advice that led to inappropriate contact with health services. There was concern over how the system could be modified to reduce that proportion, without compromising patient safety. In response, NHS Direct piloted NHS Pathways, an assessment system containing the clinical content necessary to enable the transfer of calls to ambulance dispatch services without disconnecting the patient (Munro, Clancy, Knowles et al 2003).

A rare observational study compared the quality of care in walk-in centres with NHS Direct and general practice using professional role players to portray five clinical scenarios. Standardised calls to NHS Direct could be time-consuming and often less than satisfactory; nearly a quarter of calls (25 of 99 calls) involved call backs with a mean wait of 33 minutes. Three consultations with NHS Direct were not completed due to the length of time spent waiting for call back. Walk-in centres performed particularly well for post-coital contraception and asthma when compared with general practice. Between walk-in clinics and general practice, there was little to no difference in reported quality of care for sinusitis, headache or chest pain. There was a low detection rate (1.7%) and high accuracy of portrayal (90%) from professional actors. The study concluded that walk-in centres provided adequate, safe clinical care in comparison with general practice and NHS Direct (Grant et al 2002).

The pilot evaluation of NHS 111 from 2010 to 2011 found that it performed to quality standards and was successful in directing callers to the right provider the first time. However, NHS 111 did not result in higher user satisfaction with urgent care or reduce the use of emergency services (Turner, O'Cathain, Knowles et al 2012). Coster, O'Cathain et al (2009) assessed patient satisfaction with commuter walk-in



centres using a questionnaire survey based on the instrument used in the national evaluation of walk-in centres by Salisbury, Manku-Scott, Moore et al (2002). The questionnaire used a 5-point Likert scale to assess satisfaction levels with different aspects of care, including receptionist attitude, time waited, nurse/doctor attitude, explanation given, treatment or advice and overall satisfaction. The overall satisfaction rate in this study was lower than that reported in a previous study (69% vs. 80%) of walk-in centres in England (Salisbury, Manku-Scott, Moore et al 2002). Overall satisfaction was high, but there was variation amongst centres; satisfaction was higher at pilot sites when a GP was present. The lower overall satisfaction may be attributed to dissatisfaction with nurse-led walk-in centres, which do not offer prescriptions. Waiting times received the lowest satisfaction score with just 60% reporting that they were very satisfied. This study concluded that commuter walk-in centres increased access to care for some patients. The research team suggested that the high patient satisfaction and improved access amongst patients surveyed could potentially justify continued operation despite the high per patient costs.

The Advanced Access scheme had some negative consequences for patient satisfaction. A patient survey of 12,825 patients in 47 practices participating in the Advanced Access scheme found a negative correlation between the proportion of same day appointments and patient satisfaction. Overall, there was an 8% reduction in the proportion of patients satisfied for a 10% increase in the proportion of same-day appointments. Patient satisfaction was lowest for older patients and in less deprived areas (Sampson et al 2008). Despite this, the same research team found no difference in satisfaction among patients obtaining an appointment on the day of their choice or seeing the doctor or nurse of their choice, between Advanced Access and control practices (Salisbury, Goodall et al 2007).

The GP extended hours access scheme (2007) provided financial incentives for practices to offer additional capacity outside 0800-1830 and at weekends. However, participation was voluntary and practices were free to set additional hours at their discretion. Morgan and Beerstecher (2011) used practice-level GP Patient Survey (GPPS) data in 13 PCTs to compare patient satisfaction in practices that did and did not offer any extended hours. They compared questions on satisfaction with opening hours from 2007-2008 and 2008-2009, and found some evidence that patient satisfaction increased in practices that offered any extended hours, but the difference was slight. This study was limited by its reliance on GPPS survey questions on satisfaction with opening hours as a measure of overall satisfaction with extended hours. There was no question testing patient's knowledge of the extended hours policy itself.

There was no evidence in the London Polysystems evaluation that co-location of services provided better integration or continuity of care between clinicians and community-based teams. At one study site, GPs, community nurses, other community health services and secondary care used four different IT systems, so patients were asked to provide their background to each new clinical team or community service they met. This contributed to a fragmented clinical, administrative and information system that acted as a barrier to integration (Peckham et al 2012). Arain, Nicholl and Campbell (2013) investigated patient satisfaction with walk-in services at GP-led health centres in Sheffield. They conducted a survey of patients (n=1030) presenting at two GP-led health centres in Sheffield, followed by a post-visit postal questionnaire (n=258) asking whether patients had attended another NHS service after their visit to the walk-in service. Most patients were satisfied with their visit to the service, the opening hours of the practices and convenience offered by the service. Overall satisfaction was significantly associated with patient's perception of a



convenient location. There was no significant difference between first-time and repeat service users. The postal survey found high compliance with treatment and advice received and many did not access other NHS services after their appointment at the GP-led health centre. The applicability of this study was limited; it examined just two sites operating a specific version of GP-led health centres in a single CCG area and the postal survey component had a low response rate.

Impact on referrals

New programmes can cause fragmentation to care pathways, generate adverse health outcomes from inappropriate referrals or increase inefficiency due to inappropriate or low value referrals.

The evaluation of NHS 111 reported that the majority of callers are referred to primary care (62-64%), while the remainder are referred to the ambulance service or self-care (25-27%) or A&E (7%). When necessary, NHS 111 offers to transfer callers to a clinical advisor (a nurse) or to dispatch a 999 vehicle without re-entering the triage system for ambulatory care (Turner, O’Cathain, Knowles et al, 2012).

Grant et al (2002) found that walk-in clinics and NHS Direct referred a higher proportion of patients (26% and 82% respectively) than general practice in five clinical scenarios portrayed by professional role players. The rate of referral to A&E was highest from NHS Direct (13%), lower from walk-in centres (5%) and lowest in general practice which referred no patients. The authors were unable to measure the impact of higher referrals on the workload of other health care providers, but felt it necessitated further study.

Chalder, Sharp et al (2003) matched towns with walk-in centres to towns without walk-in centres in England and assessed usage rates through time-series analysis. This study found a reduction in consultations at A&E departments and in general practice (but not at a statistically significant level), but no reduction in the use of out of hours services, in towns with walk-in centres.

Polysystems were designed to provide integrated care between community health services and primary and secondary care. In practice, the evaluation found that many services operated in silos. There was evidence at one site that GPs in polysystems did not modify their referral behaviour; for example, they continued to send patients to a hospital-based cardiology outpatient clinic instead of the community-based coronary heart disease service at the same site (Peckham et al 2012).

Staffing at UCCs was variable, ranging from several GPs to entirely nurse-led. There was no clear pattern of referral associated with UCCs; patients that presented to a rural UCC that was far from an A&E received treatment for acute care, nurses at a limited case-mix UCC treated routine cases, while at other sites patients were referred back to their GP for routine care (Carson, Clay and Stern 2012).

Costs

The first phase of primary and urgent care reform in the early 2000s was accompanied by unprecedented influxes of funds to improve performance and entry points to access care.

All the various iterations of walk-in centres were characterised by high costs and difficulty in attracting adequate levels of use. The evaluation of the first 39 walk-in centres deemed them poor value relative to the costs of setting them up and running them. Over the span of the evaluation, costs per visit fell the longer a centre was open.



The mean cost per visit for centres that had been open for one year was 20% lower with a mean cost per visit of £23.54 compared to the mean cost per visit for all centres of £30.58 and were predicted to fall more over another year of operation. The evaluation team were unable to examine cost-effectiveness or whether walk-in centres could offer value for money in the longer term (Salisbury, Chalder, Manku-Scott et al 2002).

Similarly, the evaluation of commuter walk-in centres found low activity levels and high costs. Private providers ran these centres and accurate costing data were not available. Cost estimates were based on data gathered through a mixture of site visits, interviews with users (n=28) and commissioning managers (n=6), user surveys (n=1828), and estimated mean costs for clinical and non-clinical staff at each study site. Pilot walk-in centres were designed to meet capacity of 180 (in London) and 150 (outside London) patients per day, bringing the estimated cost per visit to the NHS to £34 and £33 (in and outside London, respectively) compared with around £15 per GP visit at the time. In practice, the actual cost per attendance estimated by the evaluators was in the range of £52-£150 per episode. The evaluation suggested the following as more cost-effective modes of delivery to increase access to primary care for the working population: co-locating walk-in centres with existing GP practices in areas of high worker density; providing workplace based GPs and nurses; or expanding the roles of pharmacists (O’Cathain, Coster et al 2009).

Coleman, Checkland et al (2013) conducted qualitative case studies of EAPMC practices in two PCTS. They found that the majority of new practices in their case study sites, operated by 9 distinct providers, struggled to meet their list size targets and ran at a loss. GP-led health centres’ walk-in services were oversubscribed in comparison to demand for appointments at the same centres. It was unclear why there was higher demand for one service than the others, however one PCT officer suggested that they were unsustainable because a walk-in patient visit could earn the health centre as much as or even more than it received for a registered patient in a year. There was no research on staff motivations or preferences for walk-in versus registered patients. Some PCT and practice staff interviewed felt that APMS and EAPMC services did not represent good value for money because they over-performed on their walk-in contracts due to high demand and this was deemed financially unsustainable. One study site struggled to recruit permanent medical staff and relied heavily on locum cover, incurring higher running costs and financial penalties for not ensuring continuity of care. Despite high costs, some PCT staff noted that APMS and EAPMC services exerted a positive effect on the local health system by pushing existing providers to offer extended hours.

There were no systematic evaluations of the performance of organisations receiving contracts for the EAPMC and APMS contracts. By 2011, some corporate providers had left the NHS primary care market due to low demand for services and difficulty in making a profit, and several GP-led health centres and new practices with APMS contracts had also closed (Allen and Jones 2011; Coleman, Checkland et al, 2013; Dowler 2011; Iacobucci 2009). Ellins, Ham and Parker (2009) and Monitor (2013) found that for-profit providers had difficulties turning profits because the service delivery models required by the NHS in APMS contracts were a poor fit for their business model or that the PCT’s terms of operation were disadvantageous.

Practices received financial benefits, through an annual payment of £2.95 per registered patient, for participating in the GP extended hours access scheme. Practices could also increase their income by improving their QOF score based on



patient satisfaction with opening hours. There was no evidence that any practices benefitted from doing so. It was unclear if the GP extended hours access scheme offered value for money (Morgan and Beerstecher 2011).

Peckham et al (2012) found no evidence that polysystems in London offered value for money. However, they did not conduct a cost-effectiveness analysis due to limited comparator and costing information. There was no evidence of a reduction in avoidable use of primary or secondary care. Three polysystem sites had a UCC, integrated in the hub's A&E, as part of the GP-led health centre and available to treat out of hours patients. This did reduce A&E activity, but there were insufficient data to determine whether any cost savings had occurred. At one site, there was evidence that almost all walk-in centres and UCC patients were already registered with that polysystem's GP practice. If so, commissioners paid twice, through GMS and the walk-in centre or UCC's activity-based payment. While meeting access and choice goals was laudable, the evaluation raised concerns about the appropriateness of double funding services for some patients.

As the only entirely new service to be introduced since 2010, the evaluation team expected NHS 111 to lead to limited cost savings. The evaluation included a cost-consequences analysis (this method does not produce a single cost-effectiveness metric) to measure the cost impact of NHS 111 relative to other NHS services in pilot sites, including total activity at A&E, walk-in centres, urgent care centres, out of hours services, NHS Direct, 999 ambulance calls and 999 ambulance incidents. Pilot sites were matched to three control sites. These analyses found no statistically significant economic impact overall. There was a statistically significant cost saving in three of four pilot sites due to a reduction in NHS Direct activity, but this was offset by the cost of NHS 111 on other emergency services which rose and exceeded any savings from reduced demand for NHS Direct. The evaluation of the pilot concluded that NHS 111 is a well-performing service for urgent care, but that it is difficult to predict its costs and benefits in the long term. The evaluation team suggested that the overall benefits and consequences of shifting service use should be weighed carefully if NHS 111 does eventually replace NHS Direct, which is targeted at non-urgent and urgent care. NHS Direct also receives a different case-mix than NHS 111, which may affect future costs (Turner, O'Cathain, Knowles et al, 2012).

Discussion

As far as we are aware, this is the first study systematically to review the evidence on the impact of the range of primary and urgent care reforms introduced by the New Labour government between 1997 and 2010. We found eighteen studies resulting in forty relevant papers on ten initiatives to improve patient access to, and choice of, primary and urgent care. Most papers resulted from DH commissioned studies, specifically of NHS Direct, NHS 111, walk-in centres and Advanced Access. The Polysystems evaluation was funded by NHS London. There were a handful of comparative analyses that examined quality of care or patient satisfaction between two or three programmes. The evidence was restricted to between the first and third year(s) of operation of schemes. There was little relevant research on the GP extended hours access scheme, the impact of new provision through APMS and EAPMC, and Urgent Care Centres.

The level of demand for the new programmes varied. There was some demand for walk-in centres, new provision of GP practices and GP-led health centres, Polysystems and extended practice hours. However, overall, planners struggled to



predict the level of demand for new services. In most cases it appears demand was lower than predicted, especially in the case of the new practices and GP-led health centres opened under the EAPMC scheme. Furthermore, it is difficult to ascertain how much unmet need the new services were meeting as against inducing demand through greater availability and accessibility.

There was little sign that the new forms of care were substituting for less appropriate forms of primary and urgent care. In particular, few patients were diverted from A&E departments by the availability of walk-in centres or urgent care centres. Patients were likelier to present to a new service following a prior positive experience of a similar urgent care service rather than after having used A&E. It appeared to be difficult to change patients' perceptions of the appropriate place of treatment by offering new forms of primary and urgent care. On the other hand, most of the initiatives did increase choice and convenience of urgent and first contact care even if they did not reduce demand on A&E departments.

The impact on equity of use is unclear. There was no clear evidence that equity improved for any segment of the population. Few studies examined whether equity of use improved as provision expanded; those that did varied widely in scope and methods. There was no evidence on changes in equity of use in relation to the programmes designed to improve access in supposedly underserved areas. There was little rigorous evidence on value for money compared with previous arrangements or between the new schemes. When present, cost and programme effectiveness were assessed in terms of the relative cost savings between a new programme and an existing service. It was difficult for evaluators to assess value for money, especially as the range of options in primary and urgent care expanded, since it was often unclear what the most appropriate comparator service might be. Walk-in services and new provision incurred higher costs than traditional general practice, but could be considered worthwhile if improved access or greater convenience were the main objectives of reform. Many centrally funded walk-in centres closed after their initial DH contracts expired because local PCTs chose to spend their budgets elsewhere due to their high costs per patient visit. Local health providers held mixed views on the roles of these walk-in centres, with those providers closest to walk-in centres being less opposed (Pope, Chalder et al 2004). Many walk-in services contracted through EAPMC closed or had their operating hours reduced due to high costs per visit that were comparable to a GP practice's annual payment for a registered patient.

Monitor, the English NHS economic regulator, reviewed walk-in centre closures and found that 53 of the 238 walk-in centres opened since 2000 (including the EAPMC GP-led health centres) had closed, including six of the eight commuter walk-in centres. A third of those that closed were converted to UCCs, or co-located with A&E departments. Though Monitor warned that such closures could adversely affect patients' access to primary care services, they appeared to be the result of pressures not to 'pay twice' for patient access to primary care, confusion in the division of responsibilities between CCGs and NHS England leading to commissioners not taking a system-wide view of urgent care and payment mechanisms that did not consistently encourage appropriate patient choice and competition between practices (Monitor 2013).

The evidence suggested there was high patient satisfaction with the new primary and urgent care services, however, most were underutilised hence the high per visit costs. This was generally attributed to the rapid pace of reform and the related inability to



publicise new services sufficiently to increase their use, a failure to conduct thorough community needs assessments, and poor siting. In future, it will be important for new services to demonstrate that they fill real gaps in provision (i.e. that they have a clear purpose) and be thoroughly promoted to the relevant patient sub-groups. The evidence suggests that there was an ongoing conflict between national policymakers' goals to improve choice and convenience, and clinical perspectives over the appropriate threshold for seeking beneficial care and over who in the community was most in need of better access to care.

The evidence did not extend to examining how the different stages of primary and urgent care system reform affected each other. Patients faced an increasingly complex system of primary and urgent care, and there was likely to have been some duplication between new programmes, though this was hard to quantify. For example, there was evidence that the NHS paid twice for the care of patients in polysystems (Peckham et al 2012). Increasing choice of primary and urgent care services meant patients could access multiple services for the same indication. The widening range of similar services was also likely to have complicated referral pathways, since there was no parallel integration of information systems and medical records.

Conclusion

New Labour's primary and urgent care initiatives resulted in an increasingly complex system with many overlapping initiatives. A wide range of new services were introduced to improve choice and access, but many were not well communicated to implementers or users. Overall, the evidence suggests that convenience did improve in the period, however there was little evidence that these initiatives were cost-effective compared to previous arrangements. There remain substantial gaps in the evidence, particularly on equity of access in deprived areas and the cost implications of a decade of primary care expansion. Future policy in this area should start from the knowledge that it is difficult to induce efficiency improving substitution between urgent care services and that initiatives to increase greater patient choice and improve access will increase overall use of health services as long as they add to traditional general practice. However, the value of this increased service use will be difficult to estimate. Initiatives to improve access to existing provision (e.g. extending general practice opening hours) may have greater potential to improve access and convenience at lower marginal costs than developing entirely new forms of provision. In any event, more effort needs to be made to estimate the level of demand for any new forms of NHS primary and urgent care, and their potential costs and benefits while the NHS struggles to cope in an unprecedentedly harsh financial environment.



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Table 1 Description and policy aims of initiatives and programmes to increase access and choice in urgent and primary care in the English NHS 1997-2012

Initiative	Description	Stated outcomes
NHS Direct	<ul style="list-style-type: none"> ● Increase access to health services through a telephone-based advice service staffed by nurses. ● Reduce inappropriate attendances at A&E and unmet demand for health services. 	<p>To provide “easier and faster advice and information for people about health, illness and the NHS so that they are better able to care for themselves and their families” through a “new 24 hour telephone advice line staffed by nurses.”¹¹</p>
Advanced Access	<ul style="list-style-type: none"> ● Allow GP practices to balance access with patterns of demand. ● Ensure sufficient capacity for patients to be seen on the day of their choice. ● Implementation of this scheme supported by Direct Enhanced Service on Access (DESA), National Primary Care Development Team (NPCDT) and National Primary Care Collaborative (NPCC). ● Conflated with 2004 QOF target that patients be seen by a GP within 48 hours. 	<p>To guarantee “access to a primary care professional within 24 hours and to a primary care doctor within 48 hours by 2004.”</p> <p>All practices are “required to guarantee this level of access for their patients, either by providing the service themselves, or by entering into an arrangement with another practice, or by the introduction of further NHS Walk-in Centres.”¹²</p>
Walk-in Centres	<ul style="list-style-type: none"> ● Provide rapid access, without an appointment, for first contact care. ● Operate as an alternative to the A&E department. 	<p>“Walk-in Centres will help people make better use of the NHS, help professionals make better use of their skills, and be a visible sign of the modern NHS by responding to modern lifestyles.”¹³</p>
Walk-in Centres in A&E	<ul style="list-style-type: none"> ● Provide urgent and primary health services at patient’s preferred point of access. ● Triage patients jointly with A&E attenders. 	<p>n/a</p>
Walk-in Centres near train stations	<ul style="list-style-type: none"> ● Locate Walk-in Centres within walking distance of major underground or train stations to capture unmet demand from the commuter population. ● Place services in convenient and easily accessible locations. 	<p>To “make it easier for commuters to fit seeing a GP or nurse around their daily lives. The twelve-hour opening hours and convenient location are ideal for meeting the needs of today’s patients.” To “improve access to primary care for a proportion of society that has traditionally been poorly served. They will also improve choice and convenience for patients, while adding extra primary care capacity in the areas where it is needed most.”¹⁴</p>
Alternative Provider Medical Services (APMS)	<ul style="list-style-type: none"> ● Require PCTs to tender and contract for primary care services from providers inside and outside the NHS. ● Eligible groups include GP-led cooperatives, social enterprises or commercial companies. 	<p>To present “substantial opportunities for the restructuring of services to offer greater patient choice, improved access and greater responsiveness to the specific needs of the community.” APMS “will provide a valuable tool to address need in areas of historic under-provision, enable re-provision of services where practices opt out, and improve access in areas with problems with GP recruitment and retention.” PCTs are required to ensure “transparent, non-discriminatory procedures in place for selecting a contractor to encourage competition.”¹⁵</p>

Table continued over page >



Table 1 continued Description and policy aims of initiatives and programmes to increase access and choice in urgent and primary care in the English NHS 1997-2012

Initiative	Description	Stated outcomes
<p>NHS Choices</p>	<ul style="list-style-type: none"> Website providing information on health services and conditions. Patients can provide feedback on their experiences with provider. In primary care, reviewers are invited to comment in a free-text box and rate (out of five stars) individual GP practices by telephone access, appointments, treating patients with dignity, responsiveness, involvement in decisions, and providing accurate information. 	<p>To "provide the depth and breadth of information required by patients to make full use of the extended choices available to them" through "comprehensive, easy to use information about conditions, treatment" and searchable comprehensive directories on GPs. Provide a "one-stop shop of easily accessible information... [to] assist patients and other health professionals to make informed and personalized health choices."⁶</p>
<p>Equitable Access to Primary Medical Care (EAPMC)</p>	<ul style="list-style-type: none"> Allocated funding for 152 GP-led health centres and 100 new GP practices in deprived areas or those with fewer GPs per head of population. Required GP-led health centres to be open from 0800-2000 every day and offer walk-in services. 	<p>To achieve "the visions of a fair and personalised NHS (whilst upholding the values of safe and effective primary care services)."⁷ To allocate £250m for "at least 100 new GP practices, including up to 900 GPs, nurses and healthcare assistants into the 25% of PCTs with the poorest provision" and to enable "PCTs to develop 150 GP-led health centres, situated in easily accessible locations and offering a range of services to all members of the local population."⁸</p>
<p>Urgent care centres</p>	<ul style="list-style-type: none"> Widen access to timely and immediate care for less serious illnesses and injuries. Can be 1) co-located with A&E, 2) stand-alone site offering diagnostic and clinical services or as 3) restricted case-mix sites similar to a Walk-in Centre or minor injuries unit. Staffed by multidisciplinary teams, including GPs, nurse practitioners, emergency nurse practitioners, and when necessary, consultants in emergency medicine. 	<p>To provide "more focused and appropriate response to the needs of patients currently attending accident and emergency departments (A&Es) with minor illnesses and injuries that do not require intensive or specialised care." To have the "potential to significantly improve the way urgent care is provided and to enable greater integration of the wider unscheduled care system."</p> <p>If part of a polyclinic, a UCC is "expected to deliver benefits in providing access to a broader range of primary care services, enabling co-location with community services and delivering economies of scale."⁹</p>
<p>Polyclinics</p>	<ul style="list-style-type: none"> Multi-disciplinary health centre featuring primary and community care, GP practice(s) and elements of secondary care and local government services. Intended to improve primary care infrastructure by increasing the range of services available at the local level such as antenatal and postnatal care, community mental health services, community care, social care, and specialist advice. Shift services out of hospital settings by providing outpatients with diagnostic and consulting rooms. 	<p>To improve services through "large, high-quality community services" that provides a "much-wider range of services than is currently provided by most GP practices." To bridge primary and secondary care and provide "better, more tailored healthcare closer to home for most people, whilst also delivering excellent specialised care in centralised major hospitals for those who need it"</p> <p>To increase equity and to "improve accessibility by offering extended opening hours across a wide range of services." The larger "scale is expected to provide the necessary expertise to improve accessibility for some disadvantaged groups."¹⁰</p>

Table continued over page >



Table 1 continued Description and policy aims of initiatives and programmes to increase access and choice in urgent and primary care in the English NHS 1997-2012

Initiative	Description	Stated outcomes
Extended Hours	<ul style="list-style-type: none"> Introduced financial incentives for practices to provide additional appointments outside core-contracted hours from 0800-1830 on weekdays. Practices expected to offer at least 30 minutes per week for every 1000 registered patients. Extra time should be offered in 90 minute blocks. Offered through Local Enhanced Services (LES) or Direct Enhanced Services (DES) contracts. 	<p>To improve service responsiveness through "routine access to GP services in the evening and at weekends. PCTs need to ensure that at least 50 per cent of GP practices in their area offer extended opening to their patients, with the additional opening hours based on patients' expressed views and preferences on access" based on annual GPPS survey data.¹¹</p>
NHS 111	<ul style="list-style-type: none"> Direct callers to the most appropriate provider of urgent or non-urgent care. Calls answered by a trained, non-clinical call advisor who uses the NHS pathways clinical assessment system to determine the timeframe and availability of services needed. Can dispatch ambulatory care. 	<p>To fulfil a "significant White Paper commitment to make care more accessible by introducing a single telephone number for every kind of non-emergency health care." To better understand "what people really need from different local services, 111 will help improve efficiency across the whole health care system by reducing unnecessary waste and making sure people get access to the right service, first time."¹²</p>
Choice of GP	<ul style="list-style-type: none"> Response to apparent demand for more flexibility in relation to practice boundaries and for patients to be able to use practices beyond the immediate area where they live. Allow patients greater choice and flexibility. 	<p>To allow patients in pilot areas (parts of London, Manchester, Salford and Nottingham) to register with any participating GP practice of their choice "for the first time" at the "time and place that suits them."</p> <p>To "shift the NHS to put patients' interests and desires at the heart of services."¹³</p>

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Appendix 2

International comparison literature review

Choice of primary care provider: a review of experiences in three countries

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Summary

Choice of healthcare provider has become an increasingly important feature of healthcare policy in many countries. Much of the debate has focused on choice of secondary provider, while choice in relation to primary care has received less attention. In England, following the introduction of increased choice of secondary care provider in the early 2000s, recent reform efforts foresee the implementation of free choice of GP practice following a 12-month pilot scheme during 2012 and 2013. In light of the proposed changes in England, we sought to understand choice of primary care provider as a policy issue in different health systems in Europe. A literature review was undertaken, complemented by country case studies involving document review and key informant interviews. We examined three countries, Finland, Norway and Sweden, on the basis that these had recently introduced changes to choice of primary care provider.

Our study identified a range of drivers and expectations that have contributed to the design and implementation of reforms designed to increase choice of primary care provider in Finland, Norway and Sweden

The timing and scope of choice reforms differed between the three countries. In 2001 Norway introduced the 'regular general practitioner' scheme, giving every resident the right to register with a GP of their choice anywhere in the country. In Sweden, a 2010 reform introduced the right of individuals to register with any public or private primary care practice accredited by the local county council, a practice that had already been implemented by some county councils from 2007. In Finland, since 2012, individuals have been allowed to register with a health centre of their choice, initially in the municipality of residence but, from 2014, with any centre in the country.

In all three countries, the main motivations for modifying choice in primary care were to enhance access to and improve the quality of care. In Sweden and Finland, this was to be achieved through increased competition, while in Norway the emphasis was on enabling GPs to better manage their patient load, with the expectation that this would lead to a more efficient use of resources. In Norway and Sweden, introducing choice was also seen as an opportunity to restructure care, with a particular focus on enhanced coordination between primary and secondary care. Overall, reform efforts have to be seen within the wider context of recognising the importance of patient and public preferences in decision making, with choice in healthcare being seen as part of a wider debate around choice in the public sector.

Documented evidence of the impact of reforming choice of primary care provider is scant

Whether citizens make use of increased options to choose their primary care provider can be assessed by measuring the rate of 'switching' between providers. However, the empirical evidence on patterns and trends of switching of GP or GP practice is weak, although informants in all three countries noted that choice of provider was more likely to be exercised in urban areas than in rural settings. There was an



expectation in all three countries that those most likely to choose would be active and educated, living in urban areas and better informed about the options available. The empirical evidence of the impact of other reform efforts to increase choice in primary care remains scant. Examples include enhanced access to care as measured by a change in the number and distribution of primary care providers, and there is some suggestion that new providers did enter the market in Norway and Sweden. Conversely, in Finland related impacts of the reforms were not yet visible and indeed access to primary care providers continued to pose a challenge. Overall, the evidence on outcomes of the reforms on service users, service providers and the system as a whole in each of the countries remains weak and there is a need to systematically monitor and evaluate developments and trends.

The relative lack of publicly available information presents one of the main challenges facing choice reforms

Where introducing or modifying choice of primary care provider involves permitting registration beyond administrative boundaries, this might be expected to pose challenges with regard to coordinating and following payments and in relation to financial flows. However, this was not found to be the case in the three countries studied. Indeed, key informants highlighted that local governments traditionally work collaboratively on healthcare and other public sector issues; also transfers are limited in number and value, and systems to manage flows are well established. However, informants in all three countries identified publicly available information as one of the main challenges facing the choice reforms; information that is available to patients tends to focus on basic indicators of practice size and opening hours and was regarded as limited in all three settings. Initiatives that encourage patients to post comments on the internet about their experience in primary care or that make data available on the quality of care delivered are only beginning to emerge.

Our study offers important lessons for the planned implementation of choice in primary care in the English NHS

On the basis of our findings we conclude that the implementation of policies seeking to enhance choice of primary care provider may be more straightforward in settings where transfers are limited in number and value, where it is easy to let money follow the patient, and where the existing IT infrastructure allows for easy transfer of medical records. One concern that has been identified as particularly pertinent for the three Nordic countries reviewed here is the challenge of creating choice of primary care provider in remote areas. While this poses less of a difficulty for the current GP choice pilots in England, which are focused on more populous, commuter regions, issues around remoteness will be important to consider if the scheme is to be expanded nationally. Providing choice in remote settings is challenging because of lack of sufficient market. There is a need to carefully monitor the impact of enhanced choice in primary care in order to ensure that related policies truly enhance access to and improve the quality of care and do not only benefit those who are more able to exercise choice.

Introduction

One of the main objectives of the reforms of the English National Health Service (NHS), as set out in the 2010 White Paper, *Equity and Excellence: liberating the NHS*, was to 'put patients at the heart of the NHS' (Department of Health 2010). This included a commitment to give every patient in England free choice of general practitioner (GP) practice from April 2012. Further consultation saw the introduction of a 12-month pilot scheme from the end of April 2012, permitting patients from anywhere in the country either to register with a volunteer GP practice within one of



the pilot areas or to visit a pilot practice as a day patient (Department of Health 2012). Enhancing choice of primary care provider sits within the wider choice policy agenda that has been pursued in the English NHS since the early 2000s. It can be seen to be rooted in the consumerist policies introduced under New Labour to increase the responsiveness of public services in England (Peckham, Mays et al. 2012). Introduced from 2001 with a focus on secondary healthcare provision, successive reforms saw the implementation of choice of four to five local hospitals from 2006, subsequently extended to any provider of hospital treatment nationally (2008) and becoming a patient right within the 2009 NHS Constitution (Dixon, Robertson et al. 2010).

The concept of 'choice' has become an increasingly important and widely debated feature of healthcare policy in many countries across Europe (Allen and Hommel 2006; Thomson and Dixon 2006; Bevan, Helderman et al. 2010; Or, Cases et al. 2010), particularly in systems that had traditionally limited choice of specialist care provider (Cacace and Nolte 2011). Thus, similarly to England (Peckham, Mays et al. 2012), countries such as Denmark and Sweden have sought to increase choice of hospital provider to relieve pressure on waiting times in secondary care and to increase the responsiveness of the system (Thomson and Dixon 2006). For example, patients in Denmark have been able to choose their hospital provider since 1993, a policy that was subsequently reinforced by a waiting time guarantee (2002, 2007) for patients to be seen within one month of referral by their general practitioner (Strandberg-Larsen, Nielsen et al. 2007).

Choice of primary care provider has been given less attention, possibly because most countries already offer at least some form of choice. For example, countries such as England and Denmark allow patients to switch primary care provider within defined geographical areas, although choice may be limited because of capacity limits (Ettelt, Nolte et al. 2006). In the Netherlands, patients are required to register with a general practitioner but they can in principle choose any practitioner (Schäfer, Kroneman et al. 2010); a similar system is in place in Italy (Lo Scalzo, Donatini et al. 2009). In the statutory health insurance systems of Germany and France, patients were traditionally able to see any general practitioner without prior registration, although more recently there have been attempts to promote registration with a GP to strengthen the gatekeeping and coordinating role of the primary care physician (Ettelt, Nolte et al. 2006).

It is against this background that this study seeks to better understand choice of primary care provider as a policy issue in different health system contexts in Europe. Specifically, we are interested in two aspects of the policy debate. First, we explore the motives for and drivers of choice of primary care provider among service users to better understand the (potential) 'demand' for patient choice in primary care. Second, we examine the drivers, expectations and impacts of measures to modify choice of primary care from a policy perspective in a selection of other countries in order to contribute to a better understanding of how planned developments in England to expand choice might be informed by international experience.

Methods

We first carried out a review of the literature to assess the drivers of choice of primary care provider from a service user perspective. We then undertook a detailed exploration of experiences in three countries that have recently introduced changes to choice of primary care provider, by means of a document review and interviews with key informants. Before describing these two approaches, it is necessary to operationalise the notions of 'choice' and 'primary care provider' used here.



Operationalising ‘choice’ and ‘primary care provider’

In countries that require registration, choice in primary care can principally refer to: (i) choice to register with a given GP or primary care practice; or (ii) choice of GP or family physician within a GP or primary care practice the service user is registered with. Choice can also refer to having the opportunity to choose (and availability of providers to choose from), whether or not this possibility is acted upon, and exercising choice, that is making an active selection of provider or switching from one to another.

In our study, we sought, as far as possible, to distinguish between these different uses of ‘choice’. However, frequently the literature or policy context reviewed did not permit such differentiation. This was most often the case in relation to choice of GP practice or primary care practice and choice of GP or primary care doctor; here we used choice of ‘primary care provider’ as an overarching term. Where the reviewed evidence did not permit making these distinctions, we highlight this accordingly.

Literature review

We carried out a comprehensive search of the published and grey literature, using the bibliographic databases Embase, Pubmed, Econlit and PAIS. Given the nature of the subject under study, we chose very broad search terms, using combinations (‘/’ indicating ‘OR’) of ‘patient/consumer/client’, ‘physician/doctor/general practitioner’, and ‘choice/ch*/judg*/decid*’. Searches were performed for all fields and not restricted by publication date or language. Titles and abstracts were screened for inclusion into the review. We included primary and secondary research, as well as commentaries or editorials where appropriate. Studies focusing on choice of secondary care provider or choice of health insurance were excluded unless the abstract specifically mentioned links with choice in healthcare as a broader policy initiative. Reference lists of included studies were followed up.

Country case studies

We selected three countries for detailed review: Finland, Norway and Sweden. These countries were chosen primarily because recent policy developments in each have seen changes to the system by which patients can access non-urgent care outside hospital, with modification or relaxation of requirements to register with a GP or a GP or primary care practice. Similarly to England, all three countries have a commitment to providing universal and equitable access to healthcare for their populations and operate primarily tax-funded systems. However, they differ in the overall approach to healthcare governance, with the three Nordic countries having administrative and political responsibility partly or fully devolved to local or regional authorities. In England, health policy is set nationally while the organisation of care is devolved to local healthcare organisations, with clinical commissioning groups replacing primary care trusts from 2013, overseen by a newly established national NHS Commissioning Board (Department of Health 2010).

Country case studies were informed by an initial review of the published evidence. The document review principally followed the same approach as described above, using the same search terms but combining these with ‘policies’ or ‘reform’ and the country (Finland, Norway, Sweden). The search of peer-reviewed literature was complemented by an online search for grey literature using Google, alongside a country-focused search, targeting governmental or institutional websites such as ministries of health and physicians’ associations. References of included documents were followed up. Where possible, we retrieved formal governmental documents describing relevant reform and policy changes; however, because of language constraints this additional element had to be restricted to publications in English or that contained an English summary.



We then conducted key informant interviews to enhance our understanding of the more salient issues pertaining to the context and processes of policy reform to patient choice in the three countries and to identify further (empirical) evidence and documents describing or analysing the reform effort. This was particularly important as the documented evidence identified in the peer-reviewed and grey literature provided limited insight, especially where reform efforts have been recent, such as in Finland.

Study participants were identified through a combination of purposive and 'snowball' strategies using official websites, the authors' professional networks and recommendations from study participants. We focused on a range of stakeholders involved in or acting as close observers of the policy process as it relates to patient choice in each of the three countries in order to capture different perspectives, seeking to interview three stakeholders in each.

Potential study participants were invited by letter, with an explanation of the background of the study. Interviews were undertaken by telephone, using a semi-structured interview guide that was shared with the interviewee beforehand. The interviews explored broad themes around the existing system of patient choice in primary care, the drivers behind policy changes, and expectations of the reforms and their impacts on the various stakeholders in the system, with a particular focus on providers (GPs), funders and patients, alongside other issues that the informants raised.

Interviews were undertaken by two researchers to allow for reflexive questioning (with one exception in which only one interviewer was present). Interviews lasted 30 to 60 minutes; they were audio-recorded following consent, and transcribed verbatim. Analyses of interviews were informed by the key themes guiding the interviews as described above, while also seeking to identify additional emerging themes. We interviewed a total of nine informants, representing national government (ministry of health; 1 in each country), and academia (2 in each country).

Results

Literature review: Service user motivations for choosing a primary care provider

Reasons for choosing a particular doctor within a practice most frequently include continuity of care with a given GP or primary care doctor. Thus, patients value the fact that they can see 'a physician who knows them well' (Cheraghi-Sobi, Hole et al. 2008). The value placed by patients on continuity has been quantified in a discrete choice experiment in a sample of patients from six family practices in England, which found that patients prioritise continuity over reduced waiting times (by 1 day) or more convenient appointments (Cheraghi-Sobi, Hole et al. 2008). Similarly, Rubin et al. (2006) reported on how patients from six GP practices in Sunderland, England, would trade-off shorter waiting time against seeing their own choice of doctor, in particular when they had a long-standing illness. This highlights the importance to the patient of seeing someone who knows about them and their medical history. This latter point was also reported by Turner et al. (2007), who, in a small study of a random sample of 646 community-dwelling adults in selected geographical areas in England (London and Leicestershire), found patients willing to trade waiting time against seeing a medical practitioner who knew their case. Gerard et al. (2008), in a survey of just over 1,000 general practice patients, also found that patients were willing to trade off speed of access for continuity of care, although preferences varied according to a person's gender, work and carer status.



Preference for continuity of care might explain, in part, the typically long duration of the therapeutic relationship in primary care, averaging 10.3 years in one US study (Mold, Fryer et al. 2004) and 15.6 years in the private sector in Ireland (Carmody and Whitford 2007), even in systems that provide principally free choice of any GP.

Conversely, reasons for changing primary care provider, to the extent where this is possible, typically include proximity to home or workplace, and dissatisfaction. The evidence is patchy, however. For example, one study from the early 1990s in one area in England found that where patients chose to switch, the most common reason was distance from home (41%), followed by dissatisfaction with personal care given by the GP (35%) or with practice organisation (36%) (Billinghurst and Whitfield 1993). Proximity to home was also given as the most common reason for choosing a new doctor (53%), followed by recommendation or reputation (36%) and positive expectations of service (37%). Gandhi et al. (1997), in a qualitative study of 41 patients who had changed their GP within their area of residence, found a combination of accessibility (mainly perceived as distance from home) and attitudinal problems of the treating doctor to be the most common reasons for change. Distance from home or the workplace was also reported as a main reason for changing GP in France (UNAF 2005). In Germany, where patients are generally able to consult any GP without prior registration, a 2010 survey found that about 10 per cent of patients had changed their GP during the preceding 12 months because of dissatisfaction with the services provided (FGW Forschungsgruppe Wahlen Telefonfeld GmbH 2010). The survey did not analyse the reasons for dissatisfaction that prompted an actual change of GP, and other reasons for changing GP, such as distance, were not explored, so it is difficult to compare these findings. When querying the reasons for dissatisfaction with a GP more generally, the most common problems were perceived medical error (31%), treatment not as expected (21%) and not being taken seriously (20%) (FGW Forschungsgruppe Wahlen Telefonfeld GmbH 2010).

The option of being able to choose a primary care doctor is a common preference among patients in different health systems. For example, a survey of patients in eight European countries by Coulter and Jenkinson (2005) found that between 86% (Sweden) and 98% (Germany) of respondents believed that they should have free choice of primary care doctor. There is some evidence that where patients are able to register with the primary care doctor of their own choice, they tend to report being more satisfied with the care they receive (compared to those who were assigned a doctor, for example on the basis of their employment) in settings as diverse as Norway (Lurås 2007), Estonia (Kalda, Polluste et al. 2003) and the USA (Schmittziel, Selby et al. 1997; Kao, Green et al. 1998). Choice appears to be particularly valued where it allows for selection of a primary care doctor with specific socio-demographic characteristics, such as race or ethnicity (Laveist and Nuru-Jeter 2002) or gender (van den Brink-Muinen, Bakker et al. 1994).

The degree to which people will actually exercise choice in primary care, beyond reasons of distance or dissatisfaction, is likely to be influenced, in part, by the level of information available to them. Thus Coulter and Jenkinson (2005), in their survey of patients in Europe, found that less than half of respondents felt able to make an informed choice of primary care doctor. There was also considerable variation in the extent to which patients rated their opportunities to make healthcare choices. These ranged from 30% of respondents in the UK, just under half in Sweden and Germany, and up to 73% of respondents in Spain. However, these figures relate to choice of any provider, including in secondary care; it is difficult to say whether and how they would vary in the case of healthcare choice in primary care specifically. Even where



such information is available, options to exercise choice might be limited because of supply or capacity issues (Robertson, Dixon et al. 2008).

Barnett et al. (2008), in a small qualitative study of people in southeast England, found that while participants valued the possibility of choice, there was scepticism about offering choice 'for its own sake'; that is, choice would have to be meaningful for the patient. This was most often discussed in relation to choice of secondary care provider, however, with the role of the GP seen as important in helping interpret choice options. It is unclear whether and how these findings are applicable to choice in primary care.

In summary, focusing on the service user perspective, the available evidence suggests that within practices, patients most commonly exercise choice in order to see a GP whom they know. Where patients exercise choice by switching between providers, this seems to be prompted, typically, by factors such as distance from home or the workplace as well as the perceived quality of the care provided. This evidence has to be interpreted against a background of the ability to exercise choice, which may be limited because of lack of information, or lack of supply or capacity.

Country case studies: experiences of choice reform in Finland, Norway and Sweden

In this section we trace the specific features of the approach to providing choice of primary care provider in the three Nordic countries under study.

Table 1 provides an overview of the public primary care systems in place in each of the three countries, and details the main features of choice policies. We then identify the main drivers, expectations, impacts and challenges of the different approaches to providing choice.



Table 1 Main features of the public primary healthcare system and choice of primary care provider in Finland, Norway and Sweden

	Finland ^b	Norway ^c	Sweden ^d
Population size (2010) ^a	5.39 m	4.95 m	9.45 m
GDP per capita (US \$ PPP, 2010)	37,572	56,886	41,503
Health expenditure total (% of GDP, 2010)	8.9%	9.6%	9.4%
Health expenditure per capita (US \$ PPP, 2010)	3,251	5,388	3,758
Main sources of funding for healthcare (% of total health expenditure in 2010)	Central and local (municipal) taxes (58.9), social security (15.2), VHI (2.2), OOP (20.2)	Taxation (73.3%), social security (12.1), OOP (15)	Central and local taxes (69.2%), VHI (0.3), OOP (17.8)
Annual growth rate of public expenditure on health (real terms, 2000–2009)	4.9%	4.0%	3.4%
Principles of healthcare provision outside hospital			
Administrative unit responsible for organising primary care	Municipality	Municipality	County Council
Provision of primary care	The principal unit of primary care provision is the municipal health centre; health centres comprise a range of health professionals who provide a range of services (incl. women and child health, minor surgery) ^e	The principal unit of primary care provision is the GP practice with two to six physicians	The principal unit of primary care provision is the primary health centre, comprising four to six GPs and non-medical staff (nurses, physiotherapists, psychologists, etc.)
GP gatekeeping	Yes	Yes	Varies across regions
Payment of physicians in primary care	Basic salary, capitation fee and fee-for-service payments	Capitation fee and fee-for-service payments (95% of GPs); basic salary for GPs employed by the municipality	Basic salary for individual physician; payment of healthcare centres varies across regions but in general includes a combination of capitation, payment based on visits, and performance-based payment based on meeting certain goals

Table continued over page >



Table 1 continued Main features of the public primary healthcare system and choice of primary care provider in Finland, Norway and Sweden

	Finland ^b	Norway ^c	Sweden ^d
Choice of primary care provider			
Choice of primary care provider before reform	Allocation of individuals to municipal health centres based on place of residence; some choice of physician within centre possible in some municipalities.	Allocation of individuals to GP practice based on residence.	Free choice of public primary care provider available since the early 1990s.
Changes introduced following reform	2010 Health Care Act (implemented from 2012) foresees registration with health centre of choice in municipality of residence; from 2014 choice of any centre in the country including the option to register with a second centre in the municipality of a holiday home or place of work/study.	2001 Regular General Practitioner scheme introduced the right for patients to register with a GP of their choice with no administrative or geographical limits; those not actively registering are assigned to a GP based on availability, unless they actively opt out. Patients retain the right to a second opinion from another GP.	2010 Health and Medical Services Act introduced right of individuals to register with any public or private primary care practice accredited by the local county council; those not making an active choice of primary care provider are registered passively based on last visit or geographical location (except in Stockholm county council); the 2010 Act introduced nationally the stipulations that had been implemented in some county councils from 2007.
Frequency of change permitted	Once a year.	Twice a year.	Frequency defined by county council; in theory unlimited.
Information available to patients	Information provided by municipalities includes: waiting times, patient feedback.	Information provided by the Norwegian Health Economics Administration (HELFO) includes GP list size and available spaces on the list. ^f	Information provided by the County Councils website includes: opening times, names of doctors. Information provided at the national level includes: performance indicators, waiting times and patient experience.
Mechanism for changing provider	Registration with new practice of choice by contacting old and new practice in writing. Process can take up to three weeks.	Online registration with new GP possible since 2007.	Registration with new practice of choice.
List system management	Practice lists are not publicly available. A practice may not decline a new patient wishing to register.	GP lists are publicly available. GP defines a maximum number of patients for the list. Once the number is reached, no more patients are accepted. Rejected patients are redirected to their second choice.	Practice lists are not publicly available. A practice may not decline a new patient wishing to register.

NOTE: GDP: gross domestic product; PPP: purchasing power parity; VHI: voluntary health insurance; OOP: out-of-pocket payments; **a** OECD 2012; **b** Vuorenkoski, Mladovsky et al. 2008; Ministry of Social Affairs and Health 2010; **c** Ministry of Health and Care Services 1999; Ministry of Health and Care Services 2000; Johnsen 2006; **d** Anell, Glenngård et al. 2012; **e** in addition, employed persons can access occupational health services, funded by National Health Insurance (NHI) – approximately 50% of employed persons use occupational health services; **f** HELFO 2012 and key informants.



Drivers and expectations of choice reforms

Our study identified a range of drivers and expectations that have contributed to the design and implementation of reforms of choice of primary care provider in Finland, Norway and Sweden.

A common driver among all three countries has been enhancing access to care, which poses a particular challenge for countries characterised by large geographical areas with low population density and uneven distribution of GPs, with GP shortages in remote settings in particular (Magnussen, Vrangbaek et al., 2009), alongside a perceived need to improve the quality of care provided. However, the mechanism by which choice was expected to achieve this differed in the three countries.

In Sweden and Finland, both countries that had traditionally limited choice in primary care (Magnussen, Vrangbaek et al. 2009), there was an expectation among key informants that increasing choice would promote competition among primary care providers and so enhance both access to and quality of care provided:

There was also, I think, an element of freedom of choice having an impact on the quality of [...] primary care so that there would be a competitive force that would make some health centres, some public health centres better than the others, and through this mechanism, the whole quality of the public primary care, at least somebody thought it might get better, because of the pressure from the choice by customers and patients. (Policymaker, Finland)

In order to maximise this effect, the Swedish reform included three main components: choice of practice, freedom of private primary care providers to establish new practices and payments following the patient. It was anticipated that this combination would give 'providers [an] incentive to actually respond to patients' or individuals' needs or preferences in primary healthcare' (Academic, Sweden). There was also a perception among key informants that through facilitating entry of private providers into the market the Swedish reforms had stimulated competition and increased capacity, so enhancing access to services through, for example, extended opening hours:

[Access] to primary care was very low before the reform and there was also an incentive for the provider to establish because they knew that people were fed up with having to wait too long, too much or whatever so they could sort of, address individuals by saying that we have great company hours. (Academic, Sweden)

Policymakers also voiced an expectation that private providers would be more efficient than public providers and that the resultant mix of public practices and increased number of practices operated by private providers would enhance the overall quality of care:

It is thought that private companies are good at working with processes, patient oriented ways to work and also when it comes to quality control [...] If you have a mix of private and public providers that is bound to increase efficiency. (Policy-maker, Sweden)

The 2001 reform in Norway required patients to register with a 'regular' GP. Those choosing not to participate in the regular GP scheme would have to pay higher user fees when consulting a GP (Ministry of Health and Care Services 1999). This move was explicitly aimed at improving 'the quality of the services provided by general practitioners by making it possible for everyone who so wishes to have their own regular GP' (Ministry of Health and Care Services 1999). The reform sought to enable GPs to more effectively manage their patient list and patient load, while planning and



delivering care in a more equitable manner. One key informant emphasised the notion that the reform would work through an overall more 'efficient use of resources' rather than through competition to enhance service delivery, the latter being among the main drivers behind the Finnish and Swedish reform efforts.

The Norwegian reform specifically mentions a patient's 'right' to register with a regular GP (Ministry of Health and Care Services 2000) as opposed to the previous system in which patients were seen by the first GP available in their area. This emphasis on patients' rights has been recognised as valued by the public, as argued by one policymaker, who based the following observation on a 2009/10 survey of public services (Direktoratet for forvaltning og IKT 2010):

From a citizen point of view, it was regarded an improvement to be guaranteed a certain doctor that was valued higher than being able to jump from one doctor to the other. (Policymaker, Norway)

It is important to emphasise that in Norway patients choose to register with a GP, whereas in Finland and Sweden they register with a practice, or, more specifically, a health centre.

From a policymaker's perspective, the reform in Norway was also perceived as providing the potential to restructure health services and enhance coordination and integration across primary and secondary care, so potentially reducing GP 'hopping'. This were reinforced by subsequent reforms to strengthen coordination in the healthcare system (Romoren, Torjesen et al. 2011). Similar expectations were voiced by Swedish key informants, who also noted a broader and long-standing concern about the lack of coordination between primary and secondary care, with ongoing reform efforts over the past decades seeking to transfer care from the hospital and specialised care sectors to primary care. There was a perception that for successful transfer to occur there would be a need to 'give individuals the possibility to actually have a primary healthcare [system] which they are satisfied with in order to make them go there instead of seeking care at the hospitals' (Academic, Sweden). The introduction of choice in primary care was expected to address this issue more systematically.

The notion of formally recognising the importance of patients' and the public's preferences in decision making was perceived as an important political argument by key informants in Sweden and Finland, with choice in healthcare seen to be part of a wider debate around choice in the public sector. In Sweden, for example, the reforms to enhance choice in healthcare originated in earlier efforts to increase choice in education and elderly care, and relevant measures as set out in the 2010 Health Care Act (Ministry of Health and Social Affairs 2011) built on the 2008 Act on System of Choice in the Public Sector (Swedish Competition Authority 2008). Similar observations were made by key informants in Finland, who noted that freedom of choice has been on the agenda in Finland for a while: 'It's very hard to oppose something which is in the air. I mean, this is a cultural phenomenon also [...] We cannot restrict the modern patient's rights in the way we used to' (Policymaker, Finland).

Impacts of reforming choice of primary care provider: service users

Whether citizens make use of increased options to choose their primary care provider can be assessed by measuring the rate of 'switching' between providers. We here refer to 'provider' as the unit of primary care provision that, in Norway, is the GP and in Sweden and Finland the primary health centre. Available evidence suggests that, in Norway, the proportion of people who change their GP may have risen over time.



For example, Iversen and Lurås (2011), drawing on data from the Norwegian regular GP scheme, found the annual number of switches to be 3.6 per 100 patients on a GP's list in 2001–2004. The authors considered this figure to be higher than those reported elsewhere. We were unable to identify published analyses of trends in switching; however, according to one Norwegian informant, government figures seem to suggest that rates of switching had risen over time, to between 6 and 7 per cent in 2007–2011. It is difficult, in the absence of knowledge of the underlying data, to compare this rate with that reported by Iversen and Lurås (2011) and to derive conclusions with certainty as to the drivers behind the increase. However, one informant highlighted the coincidence between the reported increase in switching rates and the introduction, in 2007, of an online system offering a simplified mechanism to change GP (see Table 1). It is possible that this new system has reduced the barriers patients might perceive when considering switching between GPs, although this hypothesis would require confirmation through further research.

Data for Sweden provide insights into the uptake of choice. For example, Glengård et al. (2011), using data from a survey in three Swedish counties conducted between 2007 and 2009, found that 61 per cent of respondents reported having made a choice of primary care provider following the introduction of free choice in their county. It is not entirely clear whether exercising choice as reported by the majority of respondents also included an actual switch between providers.

The empirical evidence on patterns of and trends in switching of GP or GP practice is weak, although informants in all three countries noted that choice of provider was more likely to be exercised in urban areas than in rural settings. This was particularly the case in those parts of the country characterised by small municipalities or county councils with a low population density:

In the north, you don't have that many options, it's not densely populated at all, there are very few people per square kilometre or whatever. So they don't have that many alternative providers to choose from. (Academic, Sweden)

Glengård et al. (2011), based on their survey in three Swedish counties, reported that there was a perception, among some respondents, that opportunities to choose would be compromised by lack of capacity, with 11 per cent of respondents highlighting the lack of alternatives. Similar issues were reported by Grytten and Sørensen (2009) for Norway, highlighting the need to distinguish between areas where there is additional capacity and those where options are limited.

Given that, in Finland, choice of primary care provider was only implemented in 2012, and that it was initially limited to choice within a given catchment area, it is difficult to assess patterns and trends of uptake of choice, although informants noted that relatively few patients have chosen to change practice so far. However, one interviewee mentioned that some people are making use of the opportunity to register with two practices, typically relating to their home and holiday residences. One potential issue of concern was raised in relation to language groups, with the Swedish speaking (about 5.5 per cent of the population) and Sami minorities less likely to be able to exercise choice because of limited availability of primary care providers offering services in these languages.

There is some limited evidence from Sweden and Norway on the characteristics of those who do exercise choice. Glengård et al. (2011) noted that those who did actively choose a new provider or GP when the possibility became available tended



to have used their primary care provider at least once during the preceding month, were older and did not work or study. Godager (2012), using revealed preference data from the introduction of the regular general practitioner scheme in Norway and focusing on the city of Oslo, showed how patients tended to register with those GPs who resembled themselves in terms of characteristics such as age, gender or marital status. There was also a preference for GPs who were Norwegian-born, with some suggestion of a preference, among some, to register with a GP near the workplace. Key informants acknowledged the relative lack of sound evidence regarding the characteristics of those who do or do not exercise choice. There was an expectation among interviewees in all three countries that those most likely to choose would be active and better-educated people, living in urban areas and better informed about the option to choose. There was also an expectation that while older people and patients with chronic conditions might be more likely to decide to register with a preferred provider, they would not want to change provider (i.e. switch).

From a policymaker and provider perspective it is notable that the analysis by Iversen and Lurås (2011) demonstrated that the ratio between expected and actual GP patient list size was associated with switching rates among patients. GPs whose actual patient list was smaller than the list they anticipated when declaring an expected list size to the health authority by at least 100 patients (conceptualised as 'patient shortage') experienced a higher rate of patients switching than those who reached the anticipated number of patients. Specifically, they found that the occurrence of patient shortage increased the proportion of patients switching physicians by 50 per cent. The authors noted that this observation confirms an earlier finding that patient shortage was related to patient dissatisfaction with several characteristics of a GP (Lurås 2007). While they did not analyse these specific characteristics further, the authors highlighted how the measure of patient shortage might reflect issues around quality such as technical quality of care provided, communication skills and waiting times.

Impacts of reforming choice of primary care provider: service providers

Overall, direct measures of the impact of reform efforts to increase choice in primary care remain scant. One crude measure in all three countries is the change in the number and distribution of primary care providers. In Sweden, for example, the phased introduction of choice in primary care from 2007 accelerated an existing growth in the share of private providers over time, with increases of between 15 per cent in Stockholm (30 new practices opening between 2008 and March 2009) and over 60 per cent in Halland county council (from 12 private providers in 2007 to 20 in 2008) (Anell 2011). Key informants confirmed that the size of the change in the 'private market' varied across county councils, but also the type of provider, with new entrants in some areas and new branches of large healthcare chains, or former specialised care providers in others.

Glenngård et al. (2011) reported that the establishment of new providers in connection with the reform was associated with a significantly increased likelihood of patients exercising choice of primary care provider, that is, registration with a primary healthcare centre of their own choice (odds ratio, OR 1.51, 95% confidence interval, CI, 1.12, 2.02). Conversely, there was no significant association between the likelihood of making a choice, i.e. registration with a primary health centre, and the number of alternative providers, suggesting, according to the authors, that 'the dynamic competition created by establishments of new providers' constituted an important (initial) factor for the system of choice to work. However, as the study by Glenngård et al. (2011) focused on only three Swedish counties, it is difficult to draw



conclusions about the impact of the reform on access to primary care provider across the entire country. We noted earlier how, as highlighted by key informants, access has also been increased by means of extending opening hours, with practices seeking to increase their competitive advantage and retain patients.

The entry of new primary care providers as a consequence of the choice reform was also reported for Norway, with an increase of 18 per cent between 1998 and 2001 (Iversen and Lurås 2011). Evidence from Norway further suggests that this increase in supply may have contributed to an enhanced geographical distribution of GPs across the country, as with excess supply in urban areas, some practitioners had moved to suburban or rural areas to achieve a financially viable patient list (Magnussen, Vrangbaek et al. 2009). Interviewees from Finland were unable to cite evidence of changes in the number and distribution of primary care providers, highlighting that access to primary care remained the ‘biggest problem’ because of a continuing ‘under-supply of primary care physicians’ (Academic, Finland).

Impacts of reforming choice of primary care provider: the health system

Other measures of impact highlighted by key informants include the development of delivery models seeking to move care out of hospital and enhance coordination among providers. There was a perception, among interviewees, that initial expectations with regard to these measures may not have been met. Thus, in Sweden, the expectation that ‘there should be a greater diversity in primary healthcare compared to before the reform [...] has not happened to the extent anticipated’ (Academic, Sweden). Limited and anecdotal evidence is available from ‘early adopter’ counties in Sweden that sought to expand the role of primary care. For example, Halland county council expected that primary care centres would employ specialist providers alongside GPs and specialist nurses, thereby ensuring that the majority of outpatient visits would take place in the primary care setting (Anell 2011). This was accompanied by changes to the payment schedule, which involved financial penalties for those providers that did not meet a certain threshold for services provided in the primary care setting (80% in Halland county). According to Anell (2011), in Halland county in 2009 a proportion of primary care providers (mostly private providers) had risked not meeting the threshold, so incurring significant penalty payments. This was most likely because they sought to retain patients who might have changed provider otherwise. Other anecdotal evidence reported by Anell (2011) points to large profits made by some private providers at the expense of the quality of care provided.

Initiatives to reconfigure the care delivery model are also being pursued in Norway. From January 2013, municipalities are required to contribute 20 per cent of the costs of specialised healthcare. This move presents a substantial departure from the past, when the role of municipalities in healthcare financing was largely limited to processing payments to providers (Johnsen 2006). There is an expectation among key informants that this move will stimulate the interest of municipalities in the behaviour of GPs, ‘because it now has an economic consequence’ (Policymaker, Norway), and the placing of greater emphasis on care coordination. At the same time, there is recognition of the potential of provider competition to undermine such developments:

If you consider referrals to specialist healthcare for instance, you could argue that more competition for patients would make it more difficult to maintain a policy of efficient gate-keeping. It is felt that if a patient would like to be referred to specialist healthcare, then it would be more difficult for a GP to reject the referral if there are many other physicians who are interested in listing that particular patient. [...] But of course there is also a possibility to lean in the opposite direction. (Academic, Norway)



As noted above, the evidence on outcomes of the reforms around choice in primary care in the three countries under study remains scant and there is a need to systematically monitor and evaluate developments and trends. Recent evidence from Sweden suggests that the new 'competitive conditions' have improved technical efficiency among private and public providers, although not the quality of care provided (Anell, Glenngård et al. 2012).

Finally, it is important to note that there might have been an expectation that introducing or modifying choice in primary care, in particular as it relates to permitting registration beyond administrative boundaries, would be challenging, creating difficulties for managing financial flows and funding (Magnussen, Vrangbaek et al. 2009). However, key informants did not report any major technical or logistical issues with regard to possible administrative blockages or limitations of information technology required to coordinate and follow payment and financial flows. For example, interviewees from Norway and Finland highlighted that municipalities are used to working collaboratively on healthcare and other public sector issues that they are accountable for, because the majority of municipalities in either country tend to oversee small populations. Key informants in the three countries reported that transfers are limited in number and value, and systems to manage flows are well established, thus constituting 'a very very marginal issue in Norway' (Academic, Norway), while in Sweden it was conceded that '[it] is rather easy to let money follow the patient, so that hasn't been any problem' (Policymaker, Sweden). Interviewees from Finland highlighted the importance of functioning IT systems to allow for the transfer of medical records, noting that 'Finland is pretty far on the way to having national electronic health records[...] Two locations [...] should be able to read each other's health records' (Policymaker, Finland)). However, it was acknowledged that the further expansion of choice from 2014 will require 'smooth solutions' to facilitate transfers and information exchange (Academic, Finland).

Challenges of reforming choice of primary care provider

Informants in all three countries identified publicly available information as one of the main challenges facing the choice reforms; what is available to patients tends to focus on basic indicators of practice size and opening hours and was considered to be limited in all three settings. For example, in Norway, the Health Economics Administration makes available information on GP list sizes and the number of places available on a given GP list (HELFO 2012). While not providing direct indicators of the quality of care provided, there was an understanding among interviewees in Norway about the importance of this type of information. For example, the study by Iversen and Lurås (2011) demonstrated how the ratio between actual and expected GP patient list size was associated with switching rates among patients, based on the assumption that the most popular GPs are likely to provide higher quality of care. In Sweden, information is available at the national and county council levels, and includes details about practices such as opening hours and waiting times, alongside patient feedback (Anell, Glenngård et al. 2012). In contrast, in Finland, despite 'quite open access to information on waiting time' (Academic 2, Finland), relevant information on quality is not yet available, although plans are underway to publish performance data:

What is available these days is on a very superficial level, and doesn't really help if somebody wants to [...] compare different health centres. So it is not on a good level for the time being. (Policymaker, Finland)

Initiatives that encourage patients to post comments about their experience in primary care or that make available data on the quality of care delivered by primary care providers are just beginning to emerge. For example, in Norway, 'just in the past



couple of months there's a website that's emerging where people are invited to sort of make [available] their experiences with GPs and give them star ratings (Academic 1, Norway). In Sweden, there are private initiatives that use information provided by patients to rank individual doctors, hospitals and primary care units (Anell, Gløngård et al. 2012). Also in Sweden, Gløngård et al. (2011) found that having sufficient information was associated with a significantly increased likelihood of choosing a primary care provider (OR 3.0; 95% CI 2.15, 4.17). More recently, a governmental report in Sweden noted that 64 per cent of patients believed they had sufficient information to actively choose a primary care provider (Swedish Competition Authority 2012).

Discussion

In this study we sought to better understand choice of primary care provider as a policy issue in different health system contexts in Europe. We explored the motives and drivers of choice among service users to better understand the (potential) 'demand' for patient choice in primary care by means of a review of the literature. We found that choice is valued by patients although it may not be exercised actively and that the availability of choice, or perception of meaningful choice, may be associated with improved outcomes such as satisfaction. A core challenge in assessing and interpreting the evidence relates to the way choice in primary care has been conceptualised. We argue that, in countries that require registration, choice can principally refer to choice to register with a given GP practice or primary care practice or choice of GP or family physician within a GP or primary care practice the service user is registered with. A large share of the literature focuses on the choice of a given doctor, and existing evidence highlights how continuity of care, convenience with regards to access, and dissatisfaction with the current provider appear to be the main driving factors. This allows us to understand motivations for choosing (and changing) providers from the service user perspective.

We further investigated choice policies in primary care in Finland, Norway and Sweden with a document review and key informant interviews. We showed how the main drivers behind choice policies were to improve access to and the quality of care, although this was to be achieved by different means. In Finland and Sweden, increased choice was expected to introduce or increase competition among primary care providers and so enhance access to and the quality of care. The situation was different in Norway, however, where reform efforts and the introduction of the regular GP scheme sought to enable GPs to better manage their patient lists and thus enhance access to care. In discussing the evidence from the three countries under review, our unit of analysis was choice of GP in Norway, and choice of primary care health centre in Finland and Sweden. Conceptually, the reforms in the three countries were therefore not equivalent, which needs to be kept in mind when interpreting our findings.

However, overall it is fair to say that choice policies in the three countries can be seen to be situated in the context of a broader political agenda aimed at transforming the way health services are organised and administered. In Sweden, for example, efforts to enhance choice were accompanied by a shift towards greater private provision in the healthcare sector and the public sector more generally. In Finland and Norway, choice initiatives were embedded in the broader context of administrative reforms. Thus, in Finland, these involved an ongoing process of creating larger administrative areas through merger of municipalities in order to enhance collaboration on service arrangement and provision (Ministry of Social Affairs and Health 2012), alongside reassessment of the balance of power between national and local governments. This is important to understand since the effects of changes in choice policy may be difficult to distinguish from broader contextual changes in health or administrative systems. Similarly, the



pilot scheme in England is occurring (and will need to be understood) within a context of significant changes to commissioning and provision of services in the NHS.

Given the relative novelty of reform efforts in Sweden and Finland in particular, it is perhaps unsurprising that robust evidence of impact remains scant, with findings from systematic evaluation lacking. There is some suggestion that new providers have entered the market, and that some patients have used the opportunity to exercise choice by means of actively registering with a (new) healthcare centre. Early analyses and expert opinion from the countries studied here seem to support some of the findings of our review of the motives and drivers of choice among service users, such as distance. An important distinction was drawn between rural and urban areas, with choice of primary care provider reported to be more pertinent in urban areas, while access to care in less densely populated areas remains a challenge in all three jurisdictions.

The degree to which people will exercise choice in primary care may also be influenced by the level of information available to them (Coulter and Jenkinson 2005), although the evidence of patients making use of information to inform their choices remains patchy (Fung, Lim et al. 2008; Dixon, Robertson et al. 2010; Cacace, Ettelt et al. 2011). Key informants in all three countries confirmed that the relative lack of publicly available information to enable an informed decision has posed a challenge for the implementation of the choice reforms. Some initiatives were reported, including encouraging patients to rate their experience, but there was little evidence of systematic provision of information around quality or supply-side information beyond opening hours. Early evidence from the UK provides some insights into the potential use of patient ratings to inform organisational learning and an understanding of the quality of primary care from a different perspective (Greaves, Pape et al. 2012; Greaves, Ramirez-Cano et al. 2013).

Although the overall evidence on the impact of policies to enhance choice of primary care provider in the three countries examined here has been somewhat limited, our study provides important lessons for the planned implementation of choice in primary care in the English NHS. At the risk of simplifying an inherently complex situation, it can be concluded, on the basis of the analyses undertaken here, that implementation of policies seeking to enhance choice of primary care provider may be more straightforward where transfers are limited in number and value, where it is easy to let money follow the patient, and where the existing IT infrastructure allows for easy transfer of medical records.

In contrast to Finland, Norway and Sweden, issues of remoteness and rurality are less likely to pose a challenge to the current GP choice pilot in England, which is focused on more populous commuter regions. However, this will be an important factor to consider if the scheme is to be expanded nationally. If a driver for expanding choice is to increase access to and quality of care through competition, this is likely to have differential effects in rural and urban areas. Providing choice in remote settings is challenging because of a lack of a sufficiently large number of participants in the market. There is also a suggestion that patients in rural areas may value longitudinal relationships with primary care providers more than patients in urban areas (Farmer, Iversen et al. 2006). Although not directly related to choice of primary care provider, the question of GPs contracts and payment structures was identified as an important driver of providers' responses to reforms and this may in turn have implications for choices available to patients. This is an area not fully understood beyond anecdotal evidence, indicating the need to carefully monitor the impact of enhanced choice in primary care in order to ensure that related policies truly enhance access to and the quality of care and do not only benefit those who are more able to exercise choice.



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Appendix 3 Day patient form, for practice use

Day Patient Application Form

Section 1 – For completion by the patient

Name, Address & Date of Birth, details of current GP Practice and NHS Number

Mr Mrs Miss Ms Other – please state: _____

Male Female

Surname or Family Name: _____

First Name(s): _____

Name you are known as (if different from above): _____

Current home address: _____

Date of Birth Postcode

Are you currently registered with another GP practice in the UK?

Yes – please provide details:

Practice's or Doctor's name

or

Their address

No

NHS number: _____ (if known)

I declare that the information I have provided is true to the best of my knowledge.

Signature: _____ Print: _____ Date: __/__/__

or

Signature on behalf of applicant: _____

Your application is now complete and you may hand it in to the practice.

Guidance note

The details we are requesting here are essential for an application to be processed. Please complete this section in full to the best of your ability, and sign as appropriate.

If you are registered at another practice, details of your treatment received as an Out of Area Non-registered Patient (Day Patient) will be passed on to them. This will only be possible where you have provided details of your current practice.

If you know it, please provide your /the applicant's NHS number, this will enable us to find any records the NHS may hold about you and will ensure that your records are kept up to date and that you can continue to receive the highest possible quality of care.



Day Patient Application Form *continued*

Section 2 – For practice use

I am willing to accept the applicant whose details appear below as an Out of Area Non-registered Patient (Day Patient).

- The 'patient information leaflet' has been given to the patient.*
- The patient provided documentary evidence in support of their application. Details are as follows:*

Authorised signature (on behalf of the practice)

Print

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Practice Stamp

Practice organisational code: _____



Day Patient Application Form *continued*

Section 3 – For practice use

Today's date

Patient's sex Male Female

Patient's month and year of birth

Postcode area (first half only)

Number of times the patient has been seen, including this visit

Prescription given

Referral to a service outside the practice

Details of advice, treatment, prescriptions and/or referrals, provided to the patient

When complete, please submit to your PCT to make a claim and to ensure that details of the patient's treatment are passed on to their registered practice. Please also retain one copy of this form for your own records.



Appendix 4 Information for practice and PCT interviewees

Information sheet for practice interviews

Independent evaluation of GP practice choice pilot **PARTICIPANT INFORMATION SHEET – GP practice interviews**

Introduction

You are invited to take part in an evaluation of the GP practice choice pilot being conducted by researchers from the Department of Health-funded Policy Innovation Research Unit (PIRU). Before you decide whether to accept this invitation it is important for you to understand why the evaluation is taking place and what it will involve. Please take the time to read the following information, and feel free to discuss the evaluation with colleagues if you wish. Do not hesitate to contact us if you have any questions about the evaluation.

Context

The agreement reached with the General Practitioners' Committee (GPC) of the BMA includes piloting GP Choice in four PCT areas in England where patients, such as commuters, will be able to access a GP practice away from where they live. People able to access GP services in the pilot areas will have greater choice and flexibility about the GP practice that provides their personal care. In principle, any patient who lives within the pilot PCT areas, as well as those outside, will be able to choose a general practice that has volunteered to join the scheme. The pilots will also test new arrangements to enable patients who are away from home to use a GP surgery as a non-registered patient.

The GP contract agreed with the GPC for 2012-13 includes an agreement that the GP Practice Choice pilot scheme '... would be subjected to an independent evaluation organised by the Department of Health, with the results published and considered before further implementation.' The Department of Health has asked PIRU to undertake this evaluation with the aim of describing the uptake of the pilot scheme and its potential costs and benefits over a 12-month period.

The purpose of the evaluation

The specific objectives of this evaluation are as follows:

- To assess the scale of patient demand to take part in the pilot and how the scheme is used by pilot patients
- To understand why patients choose to receive general practice care at practices within the pilot areas, their experiences of care at the pilot and their 'home' practices, if relevant, and the perceived benefits and drawbacks to patients
- To describe the impact on commissioners of general practice services (initially, PCTs) and practices of taking part in the pilot, including the work involved to set up and run the pilots as well as the numbers of patients involved and the benefits and disadvantages to practices
- To estimate the additional costs to the NHS of offering two forms of additional patient choice of general practice together with an estimate of its value to patients.
- To put the English NHS general practice choice pilots in context by reviewing similar developments in patient choice in other countries.

Evaluation design

The evaluation covers the agreed 12 months of the GP practice choice pilot study and will report in summer 2013. The evaluation comprises:

- Analysis of administrative and clinical data of patients involved in the pilot
- Semi-structured, qualitative interviews of patients choosing one of the pilot practices; and staff (GPs, practice managers) in practices and PCTs involved in the pilot



Information sheet for practice interviews *continued*

- A web-based survey of clinical and managerial staff in all practices participating in the pilot
- A postal survey of pilot patients (this is contingent on sufficient patients participating in the pilot by late 2012 who can report on their use of GP services)

The evaluation also includes a literature review and set of interviews with policy makers involved with similar schemes in other countries that will be used to identify possible implementation issues and impacts of the pilot and thus help identify key questions for the study.

Why have I been chosen to participate?

You are being invited to take part in the evaluation because your practice is, or has been, participating in the pilot scheme. If you do agree to be interviewed, you will be offered a consent form to sign before the interview. You will be able to withdraw from the study at any time, without giving a reason.

Do I have to take part?

No. It is entirely up to you whether you participate in this evaluation or not, and if you do not wish to participate, you do not need to give a reason.

Are any risks involved?

The study has been reviewed by the British Medical Association, policy experts at the Department of Health, the relevant NHS Research and Development offices and NHS Research Ethics Committee, as well as the research ethics committee at the London School of Hygiene and Tropical Medicine. This study involves no personal risk; interviews should cause no distress or discomfort to any participant.

What will happen to me if I take part?

If you agree, we will ask you to take part in one interview with a trained researcher over the telephone or in person. The interview will last for 20-30 minutes and will be recorded so that we do not miss anything important. The interview will be arranged to take place at a time and date that is convenient for you.

In the interview you will be asked a number of questions about the pilot, including why your practice decided to participate in the pilot; what you think are the potential benefits; what systems you have in place to deal with the requirements of taking part in the pilot; how well these systems are working; any problems encountered; and whether your practice has undertaken any publicity to attract out of area patients as part of the pilot.

You may also be invited to participate in a brief follow-up interview in about six months' time. It is entirely up to you whether you participate in the follow-up interview. You can limit your participation to just one interview if you wish to.

Why should I take part?

The overall aim of this evaluation is to describe the uptake of the general practice choice pilot scheme and its potential costs and benefits. Although there may not be any immediate benefit to you from taking part in this evaluation, we believe that this evaluation will contribute to an understanding of the practical and financial issues of providing greater choice of general practice for patients and inform future planning.

Confidentiality and dissemination of data

Information derived from interviews and documents will be aggregated and used for study reports, conference presentations and articles in research journals. The study report will be submitted to the



Information sheet for practice interviews *continued*

Department of Health, and will be available to participating organisations. Findings will be reported anonymously, without identifying peoples' names, and treated as completely confidential within the research team. If interviewees agree to be tape-recorded, direct quotes may be used in the report or any research papers/ conference presentations for illustrative purposes, but this will be done in such a way that it will not identify individuals. All data will be securely stored in an anonymous form and will only be accessible to the research team. The report is likely to be available summer 2013 and will be available online www.piru.ac.uk

Who is organising the evaluation?

The evaluation is being funded by the Department of Health and is being conducted by a research team based at the London School of Hygiene and Tropical Medicine.

Who has reviewed this evaluation?

The study has been reviewed by the British Medical Association, policy experts at the Department of Health, the relevant NHS Research and Development offices and NHS Research Ethics Committee, as well as the research ethics committee at the London School of Hygiene and Tropical Medicine.

What if there is a problem?

If you have a concern about any aspect of the interviews, you can speak to the researcher who will do her best to answer your questions. During the interview, you can stop at any time and decide not to continue.

Thank you for reading this information sheet.

Nicholas Mays

**Professor of Health Policy and Director, Policy Innovation Research Unit
Principal Investigator**

If you have any questions about the evaluation or require further information, please contact us. If you phone and do not get an answer, please leave a message and we will be happy to call you back.

Contact for further information:

Elizabeth Eastmure – phone 020 7927 2775 or email elizabeth.eastmure@lshtm.ac.uk

v 25 May 2012



Information sheet for PCT interviews

Independent evaluation of GP practice choice pilot

Participant information sheet – PCT interviews

Introduction

You are invited to take part in an evaluation of the GP practice choice pilot being conducted by researchers from the Department of Health-funded Policy Innovation Research Unit (PIRU). Before you decide whether to accept this invitation it is important for you to understand why the evaluation is taking place and what it will involve. Please take the time to read the following information, and feel free to discuss the evaluation with colleagues if you wish. Do not hesitate to contact us if you have any questions about the evaluation.

Context

The agreement reached with the General Practitioners' Committee (GPC) of the BMA includes piloting GP Choice in four PCT areas in England where patients, such as commuters, will be able to access a GP practice away from where they live. People able to access GP services in the pilot areas will have greater choice and flexibility about the GP practice that provides their personal care. In principle, any patient who lives within the pilot PCT areas, as well as those outside, will be able to choose a general practice that has volunteered to join the scheme. The pilots will also test new arrangements to enable patients who are away from home to use a GP surgery as a non-registered patient.

The GP contract agreed with the GPC for 2012-13 includes an agreement that the GP Practice Choice pilot '...would be subjected to an independent evaluation organised by the Department of Health, with the results published and considered before further implementation.' The Department of Health has asked PIRU to undertake this evaluation with the aim of describing the uptake of the pilot scheme and its potential costs and benefits over a 12-month period.

The purpose of the evaluation

The specific objectives of this evaluation are as follows:

- To assess the scale of patient demand to take part in the pilot and how the scheme is used by pilot patients
- To understand why patients choose to receive general practice care at practices within the pilot areas, their experiences of care at the pilot and their 'home' practices, if relevant, and the perceived benefits and drawbacks to patients
- To describe the impact on commissioners of general practice services (initially, PCTs) and practices of taking part in the pilot, including the work involved to set up and run the pilots as well as the numbers of patients involved and the benefits and disadvantages to practices
- To estimate the additional costs to the NHS of offering two forms of additional patient choice of general practice together with an estimate of its value to patients.
- To put the English NHS general practice choice pilot in context by reviewing similar developments in patient choice in other countries.

Evaluation design

The evaluation covers the agreed 12 months of the GP practice choice pilot study, and will report in summer 2013. The evaluation comprises:

- Analysis of administrative and clinical data of patients involved in the pilot
- Semi-structured, qualitative interviews of patients choosing one of the pilot practices; and staff (GPs, practice managers) in practices and PCTs involved in the pilot



Information sheet for PCT interviews *continued*

- A web-based survey of clinical and managerial staff in all practices participating in the pilot
- A postal survey of pilot patients (this is contingent on sufficient patients participating in the pilot by late 2012 who can report on their use of GP services)

The evaluation also includes a literature review and set of interviews with policy makers involved with similar schemes in other countries that will be used to identify possible implementation issues and impacts of the pilot and thus help identify key questions for the study.

Why have I been chosen to participate?

You are being invited to take part in the evaluation because you are or have been involved in implementation of the pilot. If you do agree to be interviewed, you will be offered a consent form to sign before the interview. You will be able to withdraw from the study at any time, without giving a reason.

Do I have to take part?

No. It is entirely up to you whether you participate in this evaluation or not, and if you do not wish to participate, you do not need to give a reason.

Are any risks involved?

The study has been reviewed by the British Medical Association, policy experts at the Department of Health, the relevant NHS Research and Development offices and NHS Research Ethics Committee, as well as the research ethics committee at the London School of Hygiene and Tropical Medicine. This study involves no personal risk; interviews should cause no distress or discomfort to any participant.

What will happen to me if I take part?

If you agree, we will ask you to take part in one interview with a trained researcher over the telephone or in person. The interview will last for 20-30 minutes and will be recorded so that we do not miss anything important. The interview will be arranged to take place at a time and date that is convenient for you.

In the interview you will be asked a number of questions about the pilot including the steps taken to implement the pilot within your PCT, the costs and benefits of being involved in the pilot and any problems encountered. The questions will also help us to understand how in-hours emergency practice services are arranged for patients that have transferred their registration (where appropriate).

You may also be invited to participate in a brief follow-up interview in about six months' time. It is entirely up to you whether you participate in the follow-up interview. You can limit your involvement to just one interview if you wish to.

Why should I take part?

The overall aim of this evaluation is to describe the uptake of the general practice choice pilot scheme and its potential costs and benefits. Although there may not be any immediate benefit to you from taking part in this evaluation, we believe that this evaluation will contribute to an understanding of the practical and financial issues of providing greater choice of general practice for patients and inform future planning.

Confidentiality and dissemination of data

Information derived from interviews and documents will be aggregated and used for study reports, conference presentations and articles in research journals. The study report will be submitted to the Department of



Information sheet for PCT interviews *continued*

Health, and will be available to participating organisations. Findings will be reported **anonymously, without identifying peoples' names, and treated as completely confidential within the research team.**

If interviewees agree to be tape-recorded, direct quotes may be used in the report or any research papers/ conference presentations for illustrative purposes, but this will be done in such a way that it will not identify individuals. All data will be securely stored in an anonymous form and only accessible to the research team. The report is likely to be available in summer 2013 and will be available online www.piru.ac.uk

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What if there is a problem?

If you have a concern about any aspect of the interviews, you can speak to the researcher who will do her best to answer your questions. During the interview, you can stop at any time and decide not to continue.

Thank you for reading this information sheet.

Nicholas Mays

**Professor of Health Policy and Director, Policy Innovation Research Unit
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If you have any questions about the evaluation or require further information, please contact us. If you phone and do not get an answer, please leave a message and we will be happy to call you back.

Contact for further information:

Elizabeth Eastmure – phone 020 7927 2775 or email elizabeth.eastmure@lshtm.ac.uk

v 25 May 2012



Appendix 5 Interview topic guides

Primary Care Trust topic guide

Topic Guide – Interview PCT staff

Outline for a semi-structured interview with PCT staff involved in implementation of the pilot

Interview set up:

- Introductions
- Informed consent
- 20 – 30 mins
- Interviewer to describe the approach of the evaluation

About your involvement in the pilot:

- Can you please outline your role in the PCT?
- Just briefly, can you describe your role specifically in relation to the pilot?
 - Involvement in the PCT decision to join the pilot
 - Setting up systems (e.g. to collect activity or financial data)
 - Working with stakeholders
 - Promoting the pilot

Decision of the PCT to take part in the pilot:

- Why did your PCT volunteer to take part in the pilot?
 - Advantages/disadvantages considered
 - Any remaining reservations

Implementation of the pilot (where relevant):

- Can you describe how you publicised/promoted the pilot to practices?
 - Local press
 - Established networks/arrangements
- Can you describe how the PCT recruited pilot practices?
 - Expressions of interest and sign up
- How popular has the scheme been with your practices? Why do you think this is?
 - Why specific practices signed up/didn't sign up
- Can you describe any actions required to establish the pilot practices?
 - Information flows
 - Reimbursement arrangements
- Can you describe how you publicised/promoted the pilot to patients?
 - Role of employers
 - Local press
 - other
- How many out-of-area registrations have you received?
- How does that compare with the number of day patients? Why do you think this is?
 - Any repeat day patients so far?
- Do you know anything about where the day and registered out of area patients have come from?
 - Big employers in the area



Primary Care Trust topic guide *continued*

- Do you know anything about why they chose to use the services of pilot practices?
 - Commuters
 - Specialist services
 - Access
- Can you describe how the information systems work for day patients and registered patients, respectively?
 - Details of electronic and hardcopy (including day patient form)
- Can you describe how the finance systems work for day patients and registered patients, respectively?

Communicating with 'home' PCTs in other parts of the UK (where relevant):

- Other than the day patient forms, have you communicated with 'home' PCTs in other parts of the UK about day patients?
- Can you describe the steps taken to communicate with 'home' PCTs for registered out-of-area patients?
 - Out of hours care

Being a 'home' PCT (where relevant):

- Does the PCT have any residents involved in the pilot who have gone out-of-area to receive GP care?
 - Numbers and geographic spread of patients, any patterns
- What steps have been taken to provide for residents who are Out of Area patients elsewhere?
 - Whether out of hours arrangements have been used
 - How did they work

Problems with, and benefits of, the pilot:

- Can you describe any problems that have been encountered by the PCT with implementation of the pilot?
 - PCT systems (data or finance)
 - Relations with practices
 - Support to practices
 - Relations with patients
 - "Double dipping", patients playing the system
 - Relations with home PCTs or practices
 - Relations with DH
 - Other
- Are there any disadvantages you can see with the general practice choice pilot?
- Has the pilot had any impact on existing/resident patients in pilot practices?
 - Waiting times for GP appointments
 - Referrals
 - Complaints/feedback from resident patients
- Can you describe any benefits of the pilot?
 - To the PCT
 - To practices
 - To patients
 - To others



Primary Care Trust topic guide *continued*

- Has the PCT offered any other approaches to providing out of area care in the past?
 - e.g. NHS walk in centres
- What was the PCT’s experience with these approaches?
- How do the costs and benefits of the GP pilot compare with previous approaches to meeting the needs of out-of-area patients?

About the costs of the pilot:

- Do you have a sense of where the costs of the pilot might lie (refer to grid)
- Have there been any savings (refer to grid)?
- Is the PCT collecting any data on these costs?
- Is the PCT collecting any other data from the pilot (e.g. on patients’ activity, on practices’ waiting times, etc.)?
- Do you have any ideas on how best to calculate or estimate the costs associated with the pilot?
 - Start up costs (e.g. promotion, setting up systems)
 - Running costs (e.g. information systems, administration of day patient forms, communicating with home PCTs)

Looking ahead:

- Do you foresee any potential problems if the pilot were to be rolled out to all practices in your area?
- Do you foresee any potential problems if the pilot were to be rolled out throughout the English NHS?
- Do you have any other suggestions for potential improvements to the pilot?

Close and thank you, interviewer to:

- Describe reporting of the evaluation
- Provide interviewers contact details

Costs of the GP choice Pilot

	Personnel/ salaries costs	Other direct costs	Opportunity costs	Other
<p>Start up of pilot:</p> <ul style="list-style-type: none"> • Working with Department of Health • Working with professional bodies • Agreeing financial arrangements • Promotion/recruitment of practices • Setting up patient information systems • Setting up financial systems • Promotion to patients • Other? 				



Primary Care Trust topic guide *continued*

Costs of the GP choice Pilot				
	Personnel/ salaries costs	Other direct costs	Opportunity costs	Other
Running costs: <ul style="list-style-type: none"> • Working with home PCTs • Managing patient data • Administration of day patient forms • Day to day working with practices • Responding to enquiries • Paying fees • Other? 				
Associated health care costs: <ul style="list-style-type: none"> • Referrals – secondary care • Referrals – community services • Prescriptions • Other? 				



Practice topic guide

Topic Guide – Interview GP practice staff

Outline for a semi-structured interview with GP practice staff involved in implementation of the pilot

Interview set up:

- Introductions
- Informed consent
- 20 – 30 mins
- Description of the approach to evaluation
- Check current status of pilot practice (e.g. how long they have been a pilot practice, number of patients)

About deciding to be a pilot practice:

- Reasons for taking part in the pilot
- Potential benefits they could foresee
- Did you envisage any drawbacks?
- What were the good and bad aspects of applying to be a pilot practice?

About implementation of the pilot, to describe (where relevant):

- Systems they had to put in place (e.g. practice information systems, communicating with home practices, referrals, reimbursement arrangements)
- Steps taken to publicise/promote the pilot to patients
- How the information systems work (Day patients and registered)
- How the finance systems work (Day patients and registered)

Communicating with the ‘home’ practices in other parts of England:

- Differences between day patients and registered out-of-area patients
- Managing referrals

Problems encountered with implementation of the pilot e.g.:

- Communicating with the PCT
- Communicating with ‘home’ practices
- Pilot patients (e.g. managing demand, continuity of care, emergency services, referrals, did you decide to decline any out-of-area patients? If so, why was this?)
- Existing patients
- Other

Benefits of the pilot (for the practice, patients, other)

Disadvantages of the pilot (for the practice, out-of-area patients, existing patients, other)

Costs of pilot:

- Where costs might lie
- Ideas on how to calculate/estimate costs

Looking ahead:

- Potential improvements
- Potential problems if rolled out under CCG arrangement

Close and thank you:

- Reporting
- Contact details



Local Medical Committee topic guide

Topic Guide – Interview LMC

Outline for a semi-structured interview with LMC representatives of area involved in the pilot

Interview set up:

- Introductions and consent
- 20 – 30 mins

About your involvement in the pilot:

- Can you please outline any involvement you have had in the pilot?

Providing care for people who live out of the area:

- Do you have any views in general on providing primary care for people who live out of the area?
- Prior to the pilot, has the PCT offered any other approaches to providing care for people who live out of the area?
 - e.g. NHS walk in centres
- What was the experience with these approaches?
- Do you know why the PCT volunteered to take part in the pilot?

Implementation of the pilot (where relevant):

- How popular has the scheme been with practices in the area? Why do you think this is?
- The pilot allows for either, patients to register with a practice away from where they live, eg near where they work; or for patients to retain their registration with their current practice, but to visit a practice elsewhere as a day patient.
 - Can you describe any concerns you have about either of those options?
 - Cost and funding
 - Continuity of care
 - Nature of general practice
 - “Double dipping”, patients playing the system
 - Provision of community based services
 - Do you see any potential benefits of either of those options?
 - Convenience and choice for patients
 - Improving access to care
 - Benefits to practices
- One aspect of the pilot includes providing home visits and out of hours arrangements for people who are living in the area, but are registered with practices elsewhere.
 - Do you see any potential problems that might arise with that arrangement?

Looking ahead:

- Do you foresee any potential problems if the pilot were to be rolled out throughout the English NHS?
- Do you have any suggestions for potential improvements to the pilot?

Close and thank you, interviewer to:

- Describe reporting of the evaluation
- Provide interviewers contact details



Patient topic guides

Out of area registered patient

Objectives:

In this evaluation, we are aiming to find out why patients opt to register with an out-of-area GP practice; what their experiences are; and the benefits and/or drawbacks of increased choice of GP practice.

1. Introduction

2-3 mins

Aim: To explain purpose of evaluation, introduce researcher.

- Thank interviewee for taking part in the evaluation.
- Introduce self; explain that interview will take approximately 20-30 minutes.
- Confirm that the interviewee is aware of, and consents to, the interview being taped.
- Explain purpose of evaluation:
We would like to understand why you have registered with a GP practice away from where you live, and the benefits and drawbacks you have experienced as an out-of-area patient. There are no right or wrong answers and all opinions expressed during the interview will be helpful and valid.
- Informed consent.
- Reassure patient of confidentiality and anonymity, and the right to withdraw from the interview at any time without providing a reason.
- Confirm that interviewee is comfortable with the format of this interview and subject matter.

2. Interviewee information

5 mins

Aim: To gather basic information on patient being interviewed.

- Name, age, occupation, gender, where previous GP practice was.
- Confirm whether the patient has used the new practice that they have registered with as an out-of-area patient.

3. Research topics

15-20 mins

Aim: To understand their experiences with the new GP practice.

- I. Reasons for registering with a GP practice away from where you live
 - What was the main reason you chose to register with a new GP practice?
 - Before this, have you ever tried to see a GP at this practice or in the immediate area?
 - If none, was this the first time you have used a non-local service?
 - If this service was not available, what would you have done?
 - Private GP practice?
- II. Involvement with pilot
 - How did you learn about the pilot?
 - Do you know what other GP practices, in this area, are participating in this pilot?
 - What motivated you to choose this specific practice, in this immediate area?
 - Related to your commute? Proximity to work or children's school? Opening hours? 'Home' practice inaccessible during work time?
 - Are you a care-giver to a) children under 16, or b) an adult, specifying relationship, if possible?
 - Other practice characteristics (eg languages available, specialist services)
 - Other prompts, if needed: What are your working hours like? How do you get to work? How long is your commute?
 - What information sources, if any (such as NHS Choices, PCT website, friends, family, etc), did you consult in making that decision?



Patient topic guides *continued*

III. Experience with pilot practice

- What has been your experience so far?
- How would you assess the service at your new practice?
 - Who did you see? How long was the wait to see someone? What was the outcome – referral? Did you receive a prescription?
- What difficulties, if any did you encounter in joining the practices?
 - Was it hard for you to join this practice?
- How does it compare with the service at your old GP practice?
- Can you think of any ways that the pilot can be improved?

IV. History of GP use

- How many times have you visited a GP, in any area in the past 6 months? 12 months?
- How many visits did you make to a) your previously-registered GP, b) newly-registered GP
- How long were you registered with your last GP practice, located near where you live?
- Did you have a preferred doctor at your old GP practice?
 - Were you able to see him/her within 2 days?
- Are you aware of the opening hours at your current and past GP practice (eg, early mornings, evenings, and Saturday hours)?
 - Are these convenient? How do they relate to your needs?
- It would be helpful for us to know more about the other health services you have accessed in this area.
- Can you tell me what other services you have utilised because your old GP practice was not available?
 - If prompt is needed: have you ever tried to use any of the following: pharmacist (chemist), out-of-hours service, walk-in centres, NHS direct, other out-of-hours services (eg. minor injuries unit), A&E (casualty department) for non-emergency care, or a GP in A&E

V. General views on GP Choice Pilot

- What are the benefits to you personally?
 - More convenient opening hours? Appointments easily available? Ease of referrals? Perceived quality of the new practice?
- What are the drawbacks to you personally?
 - Difficult to see the same GP?
 - Do you understand the changes to your out-of-hours care because you have registered at this new practice? Has it been explained to you?
- Can you think of any drawbacks and/or benefits for other people using a GP practice where they are registered as an out-of-area patient?

4. Summary

5 mins

Aim: To summarise conversation and what has been discussed.

- Is there anything else you would like to tell me about the scheme?
- Any remaining questions about the study and the interview data?
- Details on reporting.
- Share researcher's contact details.
- Thank and close.



Patient topic guides *continued*

Day patient

Objectives:

In this evaluation, we are aiming to find out why patients opt to make use of an out-of-area practice as a day patient; what their experiences are; and the benefits and/or drawbacks of increased choice of GP practice.

1. Introduction

2-3 mins

Aim: To explain purpose of evaluation, introduce researcher.

- Thank interviewee for taking part in the evaluation.
- Introduce self; explain that interview will take approximately 20-30 minutes.
- Confirm that the interviewee is aware of, and consents to, the interview being taped.
- Explain purpose of evaluation: we would like to understand why you have opted to make use of an out-of-area practice as a day patient and the benefits and drawbacks you have experienced in the pilot. Explain that there are no right or wrong answers and all opinions expressed during the interview will be helpful and valid.
- Informed consent.
- Reassure patient of confidentiality and anonymity, and the right to withdraw from the interview at any time without providing a reason.
- Confirm that interviewee is comfortable with the format of this interview and subject matter.

2. Interviewee information

5 mins

Aim: To gather basic information on patient being interviewed.

- Name, age, occupation, gender (if any ambiguity from name), ethnicity, where current GP practice is.
- Confirm that the patient has visited a pilot practice as a day patient.

3. Research topics

15-20 mins

Aim: To understand their experiences with the GP practice visited.

- I. Reasons for using pilot practice
 - What was the main purpose for your (most recent) visit as a day patient?
 - Who did you see?
 - How did you plan your visit?
 - Walk-in or previously-booked appointment
 - Before this, have you ever tried to see a GP at this practice or in the immediate area?
 - It would be helpful for us to know more about the other health services you have accessed in this area.
 - Can you tell me what other services you have utilised because your GP practice was not available?
 - If prompt is needed: have you ever tried to use any of the following: pharmacist (chemist), out-of-hours service, walk-in centres, NHS direct, other out-of-hours services (eg. minor injuries unit), A&E (casualty department) for non-emergency care, or a GP in A&E
 - If none, was this the first time you have used a non-local service?
 - If this service had not been available, what would you have done?
 - Private GP practice?
- II. Reasons for using pilot practice
 - How did you learn about the pilot?
 - Do you know what other GP practices, in this area, are participating in this pilot?
 - Have you visited other practices in this scheme as a day patient?



Patient topic guides *continued*

- What motivated you to choose this specific practice, in this immediate area?
 - Related to your commute? Proximity to work or children’s school? Opening hours? ‘Home’ practice inaccessible during work time?
 - Are you a care-giver to a) children under 16, or b) an adult, specifying relationship, if possible?
 - Other practice characteristics (eg languages available, specialist services)
 - Other prompts, if needed: What are your working hours like? How do you get to work? How long is your commute?
- What information sources, if any (such as NHS Choices, PCT website, friends, family, etc), did you consult in making that decision?

III. Reasons for using pilot practice

- What has been your experience so far?
- How would you assess the service at this practice?
 - How long was the wait to see someone? What was the outcome – referral? Did you receive a prescription?
- What difficulties, if any did you encounter in joining the practices?
 - Was it hard for you to join this practice?
- How does it compare with the service at the practice you are registered with?
- Would you make use of this service again?
- Did you have any further contact with health services, for the same problem, in the week after your visit as a day patient to a GP practice, which is not the one you are registered with?
- Can you think of any ways that the pilot can be improved?

IV. History of GP use

- How many times have you visited a GP in the past 6 months? 12 months?
- How many visits have you made to a) your registered GP practice, b) as day patient at the pilot practice(s)?
- How long have you been registered with your current GP practice?
- Do you have a preferred doctor at your current GP practice?
 - Can you see him/her within 2 days?
- Are you aware of the opening hours at your GP (eg, early mornings, evenings, Saturday hours)?
 - Are these convenient? How do they relate to your needs?

V. General views on GP Choice Pilot

- What are the benefits to you personally?
 - More convenient opening hours? Appointments easily available? Ease of referrals? Perceived quality of the practice? Second opinion?
- What are the drawbacks to you personally?
 - Difficult to see the same GP? GP needed information that only your registered GP had? Communication with registered practice after visit?
- Can you think of any drawbacks and/or benefits for other people using a GP in a practice away from where they live?

4. Summary

5 mins

Aim: To summarise conversation and what has been discussed.

- Is there anything else you would like to tell me about the pilot?
- Do you have any remaining questions about the study and the interview data?
- Explain details on reporting.
- Share researcher’s contact details.
- Thank and close.



Appendix 6 **Information for patient interviewees**
Sample from Westminster PCT

[Insert Name]
[Insert Address]

[Insert Date]

Dear [insert Name]

Re: SEEKING YOUR VIEWS ON THE GP PRACTICE CHOICE PILOT

I am leading an independent evaluation of the GP practice choice pilot, and would like to invite you to take part in the study. You are being invited to take part because you have attended a GP practice involved in the pilot in central London.

We would like to arrange a short (20 minutes) telephone interview with you to talk about your experience of the pilot. We would like to talk to you about why you decided to register with a GP practice outside of the immediate area where you live or to use the out-of-area walk-in service. We also would like to hear about your experiences of having greater choice of GP practice and what you think the benefits and/or drawbacks of this are. An information leaflet is enclosed to provide more information and to help answer any questions you may have.

Everything that you say in the interviews will be confidential, and we will not include any of your personal details in our reports, so you will not be identified.

If you are willing to take part, could you please fill in the attached consent form and send it back to us in the stamped addressed envelope enclosed. Our interviewer will then contact you to arrange the interview. If you have questions about the evaluation and would like to talk with someone from the research team before you decide whether to take part, please contact Stefanie Tan by phone or email (phone 020 7958 8239, email Stefanie.tan@lshtm.ac.uk).

Thank you for your time.

Yours sincerely

Nicholas Mays

Professor of Health Policy, and Director, Policy Research Unit in Policy Innovation Research
Principal Investigator, on behalf of the research team

v 25 May 2012



Information for patient interviewees *continued*

Independent evaluation of GP practice choice pilot

PARTICIPANT INFORMATION SHEET – telephone interviews

You are being invited to take part in an evaluation of the GP practice choice pilot in central London. Before you decide, it is important for you to understand what an evaluation is, why this evaluation is being conducted and what is being asked of you. Please take time to read the following information and ask us if there is anything that is not clear, or if there is more you would like to know.

What is an evaluation?

An evaluation assesses whether an intervention (such as a service, treatment, project or programme) is achieving what it set out to achieve. An evaluation measures how well this is being carried out, as well as the overall impact. The results of an evaluation can help with making future decisions and planning. The information collected can be used to make any necessary changes or improvements.

What is the purpose of this evaluation?

All UK residents are entitled to the services of an NHS GP. At present, people can register with any local NHS surgery provided they live within the catchment area of the surgery in question and the surgery has vacancies for new patients. However, in a group of people recently surveyed, three quarters of them made it clear that they wanted to be able to register with a GP practice of their choice, regardless of where it is located or where they live.

In the GP practice choice pilot, patients can use a GP practice in a different area from where they live; for example, close to work, where an elderly relative lives or a child's school. Patients can choose to either register with the second practice or visit on a walk-in basis (as a non-registered patient).

In this evaluation, we are aiming to find out why patients opt to register with a second GP practice or opt to make use of the walk-in option; what their experiences are; and the benefits and/or drawbacks of increased choice of GP practice.

Why have I been chosen?

We are seeking views from patients taking part in the GP practice choice pilot. You are being invited to take part in this evaluation because you have attended a GP practice involved in the pilot in central London. Participation in the study is voluntary and you do not have to take part. It is up to you to decide whether or not you want to take part and you can withdraw from the study at any point.

What will happen if I refuse to take part?

Nothing – you will continue to receive care from your GP practice of choice, in the normal way.

What will happen to me if I take part?

If you would like to take part in an interview, please sign the enclosed consent form and return it to the research team in the stamped addressed envelope included with this letter. If you have questions about the evaluation and would like to talk with someone from the research team before you decide whether to take part, please contact Stefanie Tan (phone 020 7958 8239, email Stefanie.tan@lshtm.ac.uk).

If you agree, we will ask you to take part in an interview with a trained researcher over the telephone.



Information for patient interviewees *continued*

The interview will last for approximately 20 minutes and will be recorded so that we do not miss anything important. The interview will be arranged at a time and date that is convenient for you.

In the interview you will be asked a number of questions so we can understand why you registered with the GP practice or visited a practice on a walk-in basis (as a non-registered patient) in the pilot. We also want to talk about how you found out about the pilot and if you had any difficulties joining the pilot. We also want to talk about the benefits and drawbacks for you, of being able to choose a GP practice away from your immediate neighbourhood.

Your GP will not know whether or not you have taken part in this evaluation, and this will not affect the care that you receive.

Why should I take part?

Although there may not be any immediate benefit to you from taking part in this evaluation, we believe that this evaluation will help people in the future by providing information that can be used to improve or discontinue the pilot.

Will my taking part in this study be kept confidential?

Yes. All information that is collected about you during the evaluation will be strictly confidential. All information about you will have your name and address removed so that you cannot be identified from it. This anonymised data will be stored in password-protected computers. Only the research team will have access to this data and they are responsible for making sure all of your information remains confidential.

What will happen to the results of the evaluation?

The results will be published in reports to the Department of Health and research papers, and shared with patients, health professionals, researchers and policy makers. All personal details will be removed so that you cannot be recognised. All general practices participating in the pilot will receive a written report of the evaluation. The report is likely to be available in Summer 2013 and will be available online on the research team's website www.piru.ac.uk.

If you wish to receive a copy of the report, let us know and we will send it to you in due course.

Who is organising the evaluation?

The evaluation is being funded by the Department of Health and is being conducted by a research team based at the London School of Hygiene and Tropical Medicine.

Who has reviewed this evaluation?

The study has been reviewed by the British Medical Association, policy experts at the Department of Health, the relevant NHS Research and Development offices and NHS Research Ethics Committee, as well as the research ethics committee at the London School of Hygiene and Tropical Medicine.

What if there is a problem?

If you have any concerns about the interviews, you can speak to the researcher who will do her best to answer your questions. During the interview, you can stop at any time and decide not to continue.



Information for patient interviewees *continued*

Thank you for reading this information sheet.

Nicholas Mays

Professor of Health Policy and Director, Policy Innovation Research Unit

Principal Investigator

on behalf of the research team.

If you have any questions about the evaluation or require further information, please contact us. If you phone and do not get an answer, please leave a message and we will be happy to call you back.

Contact for further information:

Stefanie Tan – phone: 020 7958 8239 or email: Stefanie.tan@lshtm.ac.uk



Information for patient interviewees *continued*

Independent evaluation of GP practice choice pilot
CONSENT FORM – patient interviews

Name of Researcher: Stefanie Tan

If you are happy to participate please complete and sign the consent form below, then return to the research team in the envelope enclosed.

Please initial box

1. I confirm that I have read the Participant Information Sheet concerning this study and I understand what will be required of me and what will happen to me if I take part in it	
2. Any questions that I had concerning this study have been answered by Stefanie Tan	
3. I understand that at any time I may withdraw from this study without giving a reason and without this affecting my normal care and management	
4. I consent to the interview being digitally recorded	
5. I do/do not agree to quotations from my interview being included anonymously in reports about the study (delete as appropriate)	

I agree to take part in this study

Name of participant	Phone number (email)
Signature	Date

 Stefanie Tan – Researcher

 Date

1 copy for participant; 1 for researcher

v25 May 2012



Appendix 7 Practice survey

GP Patient Choice Pilot Scheme: GP Practice Survey

Introduction

The London School of Hygiene & Tropical Medicine (LSHTM) is carrying out an evaluation of the GP Choice Scheme on behalf of NHS England. We have carried out interviews with staff in all participating areas, which have included practice managers and GPs from a number of practices in each area.

We would like to get the views of all participating practices. In the time and resources available for the evaluation, it is not possible to interview all practices in person. So we hope your practice will be able to complete our on-line questionnaire.

This is your practice's chance to let NHS England and the BMA know what you think of the GP Choice Scheme, whether or not you think it should continue and potentially be rolled out across the country, and if the Scheme does continue, how you think it should be improved. We expect the evaluation report to be available to NHS England in autumn this year. We will let pilot practices know if the report is available on the web.

I can assure you that all the answers you provide will be treated in the strictest confidence, and no results or comments will be reported in a way that could identify you or your practice. The identity of participating practices and individuals will not be made available to anyone outside the LSHTM research team.

For this survey, we would like to receive a single response from your practice. Most of the survey questions can be answered by the Practice Manager. However, you may find it helpful for a GP or other member of staff in your practice to answer some of the questions, so please consult others as necessary. You can then either enter the answers yourself, or email the relevant person the link to the web questionnaire for them to answer directly.

In order for your input to be included in the evaluation report, please complete the questionnaire within the next two weeks.

Nicholas Mays

Professor of Health Policy
London School of Hygiene & Tropical Medicine

Section A: About your practice

First we would like to collect a few details about your practice.

A1 How many GPs are there at your practice?

- One, single handed practice
- Two
- Three
- Four or five
- Six or more

A2 What sorts of GPs are there in the practice?

TICK ALL THAT APPLY

- Salaried GPs
- Partner GPs
- Locum GPs
- GP Registrars



Practice survey continued

A3 What type of contract with the NHS does your practice have?

- GMS
- PMS
- APMS
- Other (please specify) _____

A4 About how many patients do you have on the practice list?

PLEASE TYPE IN

A5a In the two years before the start of the GP Choice Scheme (in April 2012), did your patient list size?

- Increase
- Decrease
- Stay about the same

A6 In what type of area is your practice located?

IF YOUR PRACTICE IS LOCATED ON MORE THAN ONE SITE, YOU MAY TICK MORE THAN ONE BOX

- Inner city
- Other dense urban area or town centre
- Suburban residential (outskirts of a city or large town)
- Rural

A7 Would you describe the demographics of your patients as 'typical' of the English population, or do you have high numbers of certain types of patients?

TICK ALL THAT APPLY

- Patient demographic is fairly typical
- High number of student patients
- High number of ethnic minority patients
- High number of deprived patients
- High number of migrant patients (including asylum seekers and refugees)
- High number of homeless patients
- High number of drug or alcohol users
- High number of visitors

A8 What are your practice's opening hours?

TICK ALL THAT APPLY

- Monday to Friday: 08.00 TO 18.30
- Monday to Friday: one or more mornings before 08.00
- Monday to Friday: one or more evenings after 18.30
- One or more hours on Saturday or Sunday
- Other (please specify) _____

A9 Do you have an agreed "outer boundary" beyond your practice's inner boundary?

- Yes
- No
- Don't know
- Other (please specify) _____



Practice survey *continued*

Section B: Deciding to be a pilot practice

B1 What were the main reasons your practice decided to become a pilot practice in the GP Choice Scheme?

B2 The next few questions are about potential benefits and concerns you had about the Scheme. The initial questions relate to your practice, followed by questions that relate to patients. At the time you decided to join the scheme, what *benefits* did you think there would be for *your practice*?

B3 And, at the time you joined, what *concerns* did you have (if any) about how the Scheme could affect *your practice*?

B4 Now, thinking of the *pilot patients*, at the time you decided to join the scheme, what *benefits* did you think there would be for them?

Please describe if you thought there would be differences between those registering as out of area patients, and those visiting as day patients.

B5 Still thinking of the *pilot patients*, at the time you decided to join the scheme, what *concerns* did you have (if any) about how the Scheme might affect them?

Please also describe if you thought there would be differences between those registering as out of area patients, and those visiting as day patients.

B6 Thinking of your *existing patients*, at the time you decided to join the scheme, what *benefits* (if any) did you think the Scheme would have for them?

B7 And, thinking of your *existing patients*, at the time you decided to join the scheme, what *concerns* did you have (if any) about how the Scheme might affect them?

Section C – omitted as no question on implementation were included

Section D: Out of Area Registrations

D1a Since the start of the Scheme, about how many patients registered with you as ‘out-of-area’ patients?

- None – go to D1b
- 1 to 4 – go to D2
- 5 to 9
- 10 to 19
- 20 to 39
- 40 to 59
- 60 or more
- Can't say

D1b Why do you think you have not had any out of area patients registering with you?

TYPE IN (THEN FILTER TO SECTION E)



Practice survey *continued*

D2 About how many of these patients were already registered with you, but became 'out of area' patients when they moved to an address outside your practice boundary?

- None
- 1 to 4
- 5 to 9
- 10 to 19
- 20 or more
- Can't say

D3 About how many of these patients first visited your practice as a 'day patient' under the GP Choice Scheme and then decided to move their registration to you?

- None
- 1 to 4
- 5 to 9
- 10 to 19
- 20 or more
- Can't say

D4a Were there any circumstances when you did not allow someone to register with your practice as an 'out-of-area' patient under the Scheme?

- Yes – go to D4b
- No – go to D5
- Don't know

D4b Why did you not allow the out-of-area registration?

D5a Did any of your out-of-area registered patients need care outside your practice's opening hours?

- None have – go to D6
- 1 or more have – go to D5b
- Don't know – go to D6

D5b Where did they go to get this care?

D5c Were you informed by the provider about this care?

D6a Did you refer any of your out-of-area registered patients to any services – whether hospital or community services - which are located outside the area you are familiar with?

- No referrals – go to D7
- 1 or more referrals – go to D6b
- Don't know

D6b How easy was it to find appropriate services outside of the area you are familiar with?

- Always easy
- Mostly easy
- Sometimes easy, sometimes difficult
- Mostly difficult
- Always difficult



Practice survey *continued*

D6c Why do you say that?

D7a During the pilot, did you have any communication with your out-of-area registered patients' home PCTs?

- Yes – go to D7b
- No – go to E1
- Don't know

D7b Generally, how well did this work?

- Very well
- Fairly well
- Not very well
- Not at all well

D7c Why do you say that?

Section E: Day patients

E1a Since the start of the GP Choice Scheme, about how many patients have you seen as day patients under the Scheme?

- None – go to E1b
- 1 to 4 – go to E2
- 5 to 9
- 10 to 19
- 20 to 39
- 40 to 59
- 60 or more
- Can't say

E1b Why do you think you have not had any day patients?

FILTER TO F1

E2 About how many day patients have visited the practice more than once?

- None – go to E4
- 1 to 4 – go to E3
- 5 to 9 – go to E3
- 10 or more – go to E3
- Can't say – go to E4

E3 About how many day patients have visited the maximum 5 times allowed under the scheme?

- None
- 1 to 4
- 5 to 9
- 10 or more
- Can't say



Practice survey *continued*

E4a Could your reception staff clearly distinguish day patients from temporary residents and from ‘immediate and necessary’ patients?

- Our reception staff had no problems with these distinctions – go to E5
- This distinction was not always clear – go to E4b
- Don’t know

E4b What sorts of problems did reception staff have with these distinctions?

E5a During the pilot, were there any particular reasons for day patient visits that your practice would discourage (e.g. a visit for a routine blood test, a visit for a flu jab, etc)?

- Yes – go to E5b
- No – go to E6
- Don’t know

E5b What reasons for day patient visits would you discourage?

E6a During the pilot, did your practice turn anyone away who wanted to visit as a day patient?

- Yes – go to E6b
- No – go to E7
- Don’t know

E6b Why did your practice turn them away?

E7a Did you offer all services and clinics available in your practice to the day patients?

- Yes – go to E8
- No – go to b
- Don’t know

E7b What didn’t your practice offer to day patients?

E8a Did your practice refer any day patients to hospital or community services?

- Yes – go to E8b
- No – go to E9
- Don’t know

E8b Did you refer these any of these day patients to services that your practice had not previously used?

- Yes: All referrals were to services that practice had not previously used
- Yes: Some referrals were to services that practice had not previously used
- No: All referrals were to services that practice had previously used
- Don’t know

E9 OMITTED FROM SURVEY



Practice survey *continued*

E10 What methods did you use for contacting the patient's home practice about their visit?

TICK ALL THAT APPLY

- Sent a letter to the patient's registered practice
- Sent a fax
- Sent an email
- Telephoned the patient's registered practice
- Other (please specify) _____

E11 Were you able to communicate with day patients' home practices within 24 hours of the consultation?

- Always within 24 hours
- Mostly within 24 hours
- Occasionally within 24 hours
- Never within 24 hours
- Don't know

E12 Did your practice ever check patient details with the patient's home practice before or during the day patient's consultation?

- Yes, for all day patients
- Yes, for most patients
- Yes, for some day patients
- No, not for any day patients
- Don't know

E13a Did you experience any problems communicating with day patients' home practices?

- Yes – go to E13b
- No – go to E14
- Don't know

E13b What problems did you have?

E14 Do you have any suggestions for improving communications with day patients' home practices?

E15a Do you think the day patient fee of £12.93 is

- Too high – go to E15b
- About right – go to E15c
- Too low? – go to E15b

E15b What do you think the day patient fee should be?

E15c Why do you say that?



Practice survey *continued*

Section F: The costs and benefits of the scheme

F1 Now that it has been about a year since the GP Choice pilot began, do you think the Scheme had any benefits for...

- | | |
|---------------------------------------|-------------------|
| a) Out of area registered patients? | Yes/No/Don't know |
| b) Day patients? | Yes/No/Don't know |
| c) Your existing registered patients? | Yes/No/Don't know |
| d) Your practice? | Yes/No/Don't know |

F2 FOR EACH YES AT F1, ASK: What benefits did it have for (FROM F1)?

F3 And do you think the Scheme had any drawbacks for...

- | | |
|---------------------------------------|-------------------|
| a) Out of area registered patients? | Yes/No/Don't know |
| b) Day patients? | Yes/No/Don't know |
| c) Your existing registered patients? | Yes/No/Don't know |
| d) Your practice? | Yes/No/Don't know |

F4 FOR EACH YES AT F3, ASK: What drawbacks did it have for (FROM F3)?

F5 Has the Scheme caused any problems for your practice in terms of...

- | | |
|------------------------------------|-------------------|
| a) Waiting times in the practice? | Yes/No/Don't know |
| b) Referrals outside the practice? | Yes/No/Don't know |
| c) Your prescriptions budget? | Yes/No/Don't know |
| d) Out of area/emergency care? | Yes/No/Don't know |
| e) Continuity of care? | Yes/No/Don't know |

F6 The next questions are about the costs of the scheme, both in terms of staff time as well as actual monetary costs. If you are not able to give precise answers, please give the best estimate you can.

First, can you please estimate the number of hours in staff time that were involved in preparing for your participation in the pilot? This covers things such as attending meetings/liasing with the PCT and professional bodies, setting up patient information and financial systems, staff training, etc.

- | |
|--|
| a) Hours of GP time? TYPE IN |
| b) Hours of practice manager and other practice staff? TYPE IN |

F7a Did you have to pay for any temporary staff to help your practice prepare for your participation in the pilot?

- Yes – go to F7b
 No – go to F8
 Don't know

F7b About how much did the use of this temporary staff cost?

TYPE IN AMOUNT IN £



Practice survey *continued*

F8 Can you please estimate the cost of day patients to your practice's budget in terms of...

(By "budget", we mean the resources available for your practices' registered patients)

Cost in £ (if none, please write in '0')

- a) Referrals to secondary care?
- b) Referrals to community health services?
- c) Prescriptions?
- d) Tests, scans etc?
- e) Other ongoing costs (e.g. for claiming day patient fees)?

Section G: Overall views of the scheme and the way forward

G1 Now that the GP Choice Scheme has been piloted for 1 year, what suggestions do you have for improving the Scheme if the government decides it should to continue?

G2a How likely is it that your practice would stay in the Scheme if the government decides to let it continue and if participation is entirely voluntary?

- Very likely
- Fairly likely
- Fairly unlikely
- Very unlikely
- Depends/only if the Scheme were altered
- Don't know

G2b Why do you say that?

G3a Can you foresee any problems if the Scheme continues under the new CCG arrangements in your area?

- Yes – go to G3b
- No – go to G4
- Don't know

G3b What are these problems?

G4a Do you think the GP Choice Scheme should be rolled out throughout England?

- Yes, and it should be compulsory for all practices to participate
- Yes, but it should be voluntary so practices can decide for themselves
- No, it should not be rolled out
- Don't know

G4b Why do you say that?

G5-7 Omitted

G8 About how many out-of-area registrations would your practice be willing or able to accept?

TYPE IN APPROXIMATE NUMBER



Practice survey *continued*

G9 If you accept a large number of out-of-area registrations, what effect, if any, would this have on potential new patients who move within your current practice boundaries?

G10a Are there any of your practice's current services that you think should not be offered to out-of-area registered patients?

- Yes – go to G10b
- No, they should have access to all our services
- Don't know

G10b What services should they not be able to access?

G11 If you were to have a large number of day patients, what effect, if any, would this have on your appointment system and waiting times?

G12a Currently, a day patient can only make 5 visits as a day patient per year. Do you think it is sensible to set a maximum number of visits per day patient per year?

- Yes – go to G12b
- No – go to G12d

G12b Is 5 the right number, or would you have a different maximum number?

- 5 is right for maximum number of day patient visits – go to G13
- The maximum number of day patient visits should be lower than 5 – go to c
- The maximum number of day patient visits should be higher than 5 – go to c
- Don't know

G12c What should the maximum number be?

G12d Why do you say that?

G13a Are there any of your practice's current services that you think should not be offered to day patients?

- Yes – go to G13b
- No, they should have access to all our services
- Don't know

G13b What services should day patients not be able to access?

G14 If there are any other comments you would like to make about the GP Choice Scheme – either in relation to the pilot, or whether it should continue, or how it could be improved – please do so here.

G15a Would you like to be informed when the evaluation report is available on the web?

- Yes – go to G15b
- No – go to G16

G15b Please provide an email address for us to contact your practice about the final report

G16 Thank you very much for completing this questionnaire.



Appendix 8

Out of area registered patient postal survey



Ipsos MORI

THE NHS PATIENT CHOICE SCHEME SURVEY

The NHS Patient Choice Scheme allows patients to register with a participating GP surgery even if they live outside the surgery’s catchment area. These patients are called “out-of-area patients”. We understand that you have registered as an “out-of-area patient” with a participating GP surgery under the Patient Choice Scheme, and we would like to ask about your experiences and views of this scheme. **Please answer all questions in relation to the GP surgery you registered with since April 2012.**

Please answer the questions below by putting an ✕ in ONE BOX for each question unless more than one answer is allowed (these questions are clearly marked). We will keep your answers completely confidential.

Reference: 1234567890

REGISTERING WITH A GP SURGERY UNDER THE NHS PATIENT CHOICE SCHEME

Q1 How or where did you first hear about the NHS Patient Choice Scheme?

Please ✕ all the boxes that apply to you

- NHS Choices Website
- Primary Care Trust (PCT) website
- GP surgery website
- News report (newspaper, TV, radio)
- Leaflets, booklets, posters (including those in GP surgery)
- The GP surgery told me about it when I called or visited
- From other health professionals (such as a walk-in centre, another surgery, etc)
- From friends / family members
- I can't remember how or where I first heard about it
- I don't recall ever hearing about the NHS Patient Choice Scheme
- Other (please write in) _____

Q2 How important are the following aspects of a GP surgery to you...?

Please ✕ one box for each statement

	Very important	Fairly important	Not very important	Not at all important	Not applicable	Don't know
Able to make appointments at a time I want.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being able to see the same GP at each visit.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being convenient to where I live.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being convenient to where I work or study.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convenient opening hours.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friendly / helpful staff.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good reputation or recommended by others...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of hospitals in the area.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of the service.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short waiting times for appointments.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specialists or facilities available in the surgery...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Out of area registered patient postal survey *continued*

Q3 Please write in below anything else that is important to you when choosing a GP surgery.

Please write in _____

Q4 Why did you leave the last GP surgery you were registered with?

Please *✗ one box for the main reason only*

- I wanted specialist care / advice that my last surgery did not provide
- It was not easy to get an appointment at my last GP surgery
- My last doctor retired or died
- My last GP surgery did not have convenient opening hours
- My last GP surgery was not conveniently located
- Waiting times to see or speak to a GP were too long at my last GP surgery
- I was not satisfied with the quality of the service at my last GP surgery
- I just moved to the area
- I haven't changed GP surgery since April 2012
- Other (please write in) _____
- Don't know / can't remember

Q5 And what was the main reason you chose the particular surgery you are currently registered with?

Please *✗ one box for the main reason only*

- Being able to see the same GP on every visit
- Convenient location for my home
- Convenient location for my work or place of study
- I can make appointments at times that are convenient for me
- I liked the services, specialists or facilities available at the surgery
- I moved house but didn't want to change my GP surgery
- It has convenient opening hours
- It was recommended by friends and / or family members
- It was recommended by another doctor / health professional
- Other members of my family were already registered there
- The surgery provides access to other local services or facilities I like (such as hospitals)
- There are short waiting times for appointments
- Other (please write in) _____
- Don't know / can't remember

Q6 Did you try to find out anything about the surgery before you registered there?

- Yes.....Go to Q7
- No.....Go to Q8
- Don't know/ can't remember.....Go to Q8

Q7 What did you do to find out about the surgery?

Please *✗ all the boxes that apply*

- I asked family members about the surgery
- I asked friends about the surgery
- I looked at the surgery's website
- I looked at other websites (such as NHS Choices)
- I visited or phoned the surgery and asked questions
- Other (please write in) _____
- Don't know / can't remember



Out of area registered patient postal survey *continued*

MAKING AN APPOINTMENT

Q8 When making an appointment, is there a particular GP you usually prefer to see or speak to?

- Yes
- No
- There is usually only one GP in my surgery

Q9 Last time you wanted to see or speak to a GP or nurse from your GP surgery:

What did you want to do?

- See a GP at the surgery
- See a nurse at the surgery
- Speak to a GP on the phone
- Speak to a nurse on the phone
- Have someone visit me at my home
- I didn't mind/ wasn't sure what I wanted

Q10 And when did you want to see or speak to them?

- On the same day
- On the next working day
- A few days later
- A week or more later
- I didn't have a specific day in mind
- Can't remember

Q11 Were you able to get an appointment to see or speak to someone?

- YesGo to Q12
- Yes, but I had to call back closer to or on the day I wanted the appointmentGo to Q12
- NoGo to Q15
- Can't rememberGo to Q17

Q12 What type of appointment did you get? I got an appointment...?

- ...to see a GP at the surgery
- ...to see a nurse at the surgery
- ...to speak to a GP on the phone
- ...to speak to a nurse on the phone
- ...for someone to visit me at my home

Q13 How long after initially contacting the surgery did you actually see or speak to them?

- On the same day
- On the next working day
- A few days later
- A week or more later
- Can't remember

Q14 How convenient was the appointment you were able to get?

- Very convenient..... Go to Q17
- Fairly convenient..... Go to Q17
- Not very convenient..... Go to Q15
- Not at all convenient..... Go to Q15

Q15 If you weren't able to get an appointment or the appointment you were offered wasn't convenient, why was that?

- There weren't any appointments for the day I wanted
- There weren't any appointments for the time I wanted
- I couldn't see my preferred GP
- I couldn't book ahead at my GP surgery
- Another reason

Q16 What did you do on that occasion?

- Went to the appointment I was offered
- Got an appointment for a different day
- Had a consultation over the phone
- Went to A&E / a walk-in centre
- Saw a pharmacist
- Decided to contact my surgery another time
- Didn't see or speak to anyone

Q17 Overall, how would you describe your experience of making an appointment?

- Very good
- Fairly good
- Neither good nor poor
- Fairly poor
- Very poor

SEEING A GP OR NURSE

Q18 When did you last see or speak to a GP from your GP surgery?

- In the past 3 months
- Between 3 and 6 months ago
- Between 6 and 12 months ago
- More than 12 months ago
- I have never seen a GP from my surgery

Q19 When did you last see or speak to a nurse from your GP surgery?

- In the past 3 months
- Between 3 and 6 months ago
- Between 6 and 12 months ago
- More than 12 months ago
- I have never seen a nurse from my surgery



Out of area registered patient postal survey *continued*

LAST GP APPOINTMENT

Q20 Last time you saw or spoke to a GP from your GP surgery, how good was that GP at each of the following?

Giving you enough time

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Doesn't apply

Listening to you

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Doesn't apply

Explaining tests and treatments

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Doesn't apply

Involving you in decisions about your care

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Doesn't apply

Treating you with care and concern

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Doesn't apply

Q21 Did you have confidence and trust in the GP you saw or spoke to?

- Yes, definitely
- Yes, to some extent
- No, not at all
- Don't know / can't say

LAST NURSE APPOINTMENT

Q22 Last time you saw or spoke to a nurse from your GP surgery, how good was that nurse at each of the following?

Giving you enough time

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Doesn't apply

Listening to you

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Doesn't apply

Explaining tests and treatments

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Doesn't apply

Involving you in decisions about your care

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Doesn't apply

Treating you with care and concern

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Doesn't apply

Q23 Did you have confidence and trust in the nurse you saw or spoke to?

- Yes, definitely
- Yes, to some extent
- No, not at all
- Don't know / can't say



Out of area registered patient postal survey *continued*

OPENING HOURS

Q24 How satisfied are you with the hours that your GP surgery is open?

- Very satisfied
- Fairly satisfied
- Neither satisfied nor dissatisfied
- Fairly dissatisfied
- Very dissatisfied
- I'm not sure when my GP surgery is open

Q25 Is your GP surgery currently open at times that are convenient for you?

- Yes.....Go to Q27
- No.....Go to Q26
- Don't know.....Go to Q26

Q26 Which of the following additional opening times would make it easier for you to see or speak to someone?

Please **x** all the boxes that apply to you

- Before 8am
- At lunchtime
- After 6.30pm
- On a Saturday
- On a Sunday
- None of these

OVERALL EXPERIENCE

Q27 Overall, how would you describe your experience of your GP surgery?

- Very good
- Fairly good
- Neither good nor poor
- Fairly poor
- Very poor

Q28 Would you recommend your GP surgery to someone else?

- Yes, would definitely recommend
- Yes, would probably recommend
- Not sure
- No, would probably not recommend
- No, would definitely not recommend
- Don't know

MANAGING YOUR HEALTH

Q29 Do you have a long-standing health condition?

- Yes
- No
- Don't know / can't say

Q30 Which, if any, of the following medical conditions do you have?

Please **x** all the boxes that apply to you

- Alzheimer's disease or dementia Go to Q31
- Angina or long-term heart problem ... Go to Q31
- Arthritis or long-term joint problem ... Go to Q31
- Asthma or long-term chest problem ..Go to Q31
- Blindness or severe visual impairment Go to Q31
- Cancer in the last 5 years Go to Q31
- Deafness or severe hearing impairment Go to Q31
- Diabetes Go to Q31
- Epilepsy Go to Q31
- High blood pressureGo to Q31
- Kidney or liver disease Go to Q31
- Learning difficultyGo to Q31
- Long-term back problem Go to Q31
- Long-term mental health problemGo to Q31
- Long-term neurological problemGo to Q31
- Another long-term condition Go to Q31
- None of these conditions Go to Q32
- I would prefer not to say Go to Q32

Q31 In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)?

Please think about all services and organisations, not just health services

- Yes, definitely
- Yes, to some extent
- No
- I haven't needed such support
- Don't know/ can't say

Q32 How confident are you that you can manage your own health?

- Very confident
- Fairly confident
- Not very confident
- Not at all confident



Out of area registered patient postal survey *continued*

OUT OF HOURS

These questions are about contacting an out-of-hours GP service. Do not include NHS Direct, NHS walk-in centres or hospital A&E.

Q33 When you registered with your current GP surgery, did the surgery explain that they were not responsible for providing you with out-of-hours care?

By out of hours care, we mean services that require the GP to leave the surgery area such as home visits or hospital after care. These services should be provided in the area where you live.

- Yes
- No
- Don't know / can't remember

Q34 Has the NHS sent you a letter about who to contact for an out-of-hours GP service?

- Yes
- No
- Don't know / can't remember

Q35 Since registering as an out-of-area patient with this GP surgery, have you tried to call an out-of-hours GP service when the surgery was closed?

- Yes, for myself.....Go to Q36
- Yes, for someone else.....Go to Q36
- NoGo to Q39

Q36 How easy was it to contact the out-of-hours GP service by telephone?

- Very easy
- Fairly easy
- Not very easy
- Not at all easy
- Don't know / didn't make contact

Q37 How do you feel about how quickly you received care from the out-of-hours GP service?

- It was about right
- It took too long
- Don't know / doesn't apply

Q38 Overall, how would you describe your experience of out-of-hours GP services?

- Very good
- Fairly good
- Neither good nor poor
- Fairly poor
- Very poor

OTHER NHS SERVICES

Q39 Since registering as an out-of-area patient with this GP surgery, which, if any, of the following NHS services has a GP referred you to?

No information collected in this survey will be passed on to any third parties. It will be used by the project teams at Ipsos MORI, the London School of Hygiene and Tropical Medicine, and the NHS for statistical purposes only.

*Please **✗** all the boxes that apply to you*

- For x-rays or other tests (including blood tests)
- Child health / mother and baby clinic
- Midwife/ antenatal clinic
- Physiotherapist
- Counsellor
- Podiatrist / chiropodist
- Dietician
- Drug and alcohol services
- Sexual health services
- Obesity clinic
- Minor surgery clinics
- Sports injuries
- Mental health services
- Complementary and alternative medicines (such as homeopathy, acupuncture etc)
- None of these

DAYPATIENT SERVICES

Q40 Under the NHS Patient Choice Scheme, GP patients can seek treatment as an unregistered 'daypatient' at participating surgeries. Daypatients can attend a participating surgery during the day for treatment but will remain registered with their current surgery.

As far as you can remember, have you attended a GP surgery as a 'daypatient' since April 2012?

- Yes, at the GP surgery I am currently registered with
- Yes, at another GP surgery
- No
- Don't know/ can't remember



Out of area registered patient postal survey continued

SOME QUESTIONS ABOUT YOU

The following questions will help us to see how experiences vary between different groups of the population. We will keep your answers completely confidential.

Q41 Are you male or female?
 Male Female

Q42 How old are you?
 Under 18 35 to 44 65 to 74
 18 to 24 45 to 54 75 to 84
 25 to 34 55 to 64 85 or over

Q43 What is your ethnic group?
A. White
 English/ Welsh/ Scottish/ Northern Irish/ British
 Irish
 Gypsy or Irish Traveller
 Any other White background

↳ Please write in

B. Mixed / multiple ethnic groups
 White and Black Caribbean
 White and Black African
 White and Asian
 Any other mixed / multiple ethnic background

↳ Please write in

C. Asian / Asian British
 Indian
 Pakistani
 Bangladeshi
 Chinese
 Any other Asian background

↳ Please write in

D. Black / African / Caribbean / Black British
 African
 Caribbean
 Any other Black / African / Caribbean background

↳ Please write in

E. Other ethnic group
 Arab
 Any other ethnic group

↳ Please write in

Q44 Which of these best describes what you are doing at present?

If more than one of these applies to you, please ✕ the main ONE only

- Full-time paid work (30 hours or more each week)Go to Q45
- Part-time paid work (under 30 hours each week)Go to Q45
- Full-time education at school, college or university.....Go to Q45
- UnemployedGo to Q47
- Permanently sick or disabled.....Go to Q47
- Fully retired from work.....Go to Q47
- Looking after the home.....Go to Q47
- Doing something else.....Go to Q47

Q45 In general, how long does your journey take from home to work (door to door)?

- Up to 30 minutes
- 31 minutes to 1 hour
- More than 1 hour
- I live on site

Q46 If you need to see a GP at your GP surgery during your typical working hours, can you take time away from your work to do this?

- Yes
- No

Q47 Are you a parent or a legal guardian for any children aged under 16 living in your home?

- Yes
- No

Q48 Do you look after, or give any help or support to family members, friends, neighbours or others because of either:

•long-term physical or mental ill health / disability, or

•problems related to old age?

Don't count anything you do as part of your paid employment

- No
- Yes, 1-9 hours a week
- Yes, 10-19 hours a week
- Yes, 20-34 hours a week
- Yes, 35-49 hours a week
- Yes, 50+ hours a week



Out of area registered patient postal survey *continued*

YOUR STATE OF HEALTH TODAY

Q49 By placing a ✕ in one box in each group below, please indicate which statements best describe your own health today.

Mobility

- I have no problems in walking about
- I have slight problems in walking about
- I have moderate problems in walking about
- I have severe problems in walking about
- I am unable to walk about

Self-care

- I have no problems washing or dressing myself
- I have slight problems washing or dressing myself
- I have moderate problems washing or dressing myself
- I have severe problems washing or dressing myself
- I am unable to wash or dress myself

Usual activities (e.g. work, study, housework, family, or leisure activities)

- I have no problems doing my usual activities
- I have slight problems doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities

Pain / Discomfort

- I have no pain or discomfort
- I have slight pain or discomfort
- I have moderate pain or discomfort
- I have severe pain or discomfort
- I have extreme pain or discomfort

Anxiety / Depression

- I am not anxious or depressed
- I am slightly anxious or depressed
- I am moderately anxious or depressed
- I am severely anxious or depressed
- I am extremely anxious or depressed

Q50 Have your activities been limited today because you have recently become unwell or been injured? *By 'unwell or injured' we mean anything that only lasts for a few days or weeks, e.g. a bad cold or broken leg*

- Yes, limited a lot
- Yes, limited a little
- No

OVERALL EXPERIENCE OF NHS PATIENT CHOICE SCHEME

Q51 Overall, compared with your last GP surgery, how would you rate your current GP surgery? Is it...

- Much better
- Somewhat better
- About the same
- Somewhat worse
- Much worse
- Better in some ways, worse in others
- Haven't changed surgery
- Can't say

Q52 If there is anything else you'd like to tell us about what you like or don't like about the NHS Patient Choice Scheme, please do so by writing in the box below

Thank you for your time.
Please return this questionnaire in the reply paid envelope provided or send it to the address given in the letter that came with this questionnaire.

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Appendix 9 Day patient postal survey



THE NHS PATIENT CHOICE SCHEME SURVEY: DAY PATIENTS

The NHS Patient Choice Scheme allows patients to seek treatment at a participating GP surgery even if they live outside the surgery’s catchment area. Since the patient stays registered with their current surgery, these patients are called “day patients” when visiting a surgery they are *not* registered with. We understand that you were a “day patient” with the GP surgery listed on the letter accompanying this questionnaire. **Please answer all questions in relation to the visit you made to that GP surgery.**

Please answer the questions below by putting an **X** in ONE BOX for each question unless more than one answer is allowed (these questions are clearly marked). We will keep your answers completely confidential.

Reference: 1234567890

VISITING A GP SURGERY AS A “DAY PATIENT”

How important are the following aspects of a GP surgery to you...?

Q1 Please **X** one box for each statement

	Very important	Fairly important	Not very important	Not at all important	Not applicable	Don't know
Able to make appointments at a time I want.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being able to see the same GP at each visit.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being convenient to where I live.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being convenient to where I work or study.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convenient opening hours.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doctors having ready access to my medical records.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friendly / helpful staff.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good reputation or recommended by others.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of hospitals in the area.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of the service.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short waiting times for appointments.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specialists or facilities available in the surgery...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q2 Please write in below anything else that is important to you when choosing a GP surgery.

Please write in _____

Q3 How or where did you first hear about the NHS Patient Choice Scheme?

Please **X** all the boxes that apply to you

- | | |
|---|---|
| <input type="checkbox"/> NHS Choices website | <input type="checkbox"/> Leaflets, booklets, posters (including those in GP surgery) |
| <input type="checkbox"/> Primary Care Trust (PCT) website | <input type="checkbox"/> From other health professionals (such as walk-in centre, another surgery, etc) |
| <input type="checkbox"/> GP surgery website | <input type="checkbox"/> From friends/ family members/ co-workers |
| <input type="checkbox"/> News report (newspaper, TV, radio) | <input type="checkbox"/> I can't remember how or where I first heard about it |
| <input type="checkbox"/> The GP surgery told me about it when I called or visited | <input type="checkbox"/> I don't recall ever hearing about the NHS Patient Choice Scheme |
| <input type="checkbox"/> Other (please write in) _____ | |



Day patient postal survey *continued*

Q4 Since April 2012, approximately how many times have you visited a surgery as a “day patient”? Please include all surgeries you have visited as a day patient since April 2012.

- | | |
|--|---|
| <input type="checkbox"/> Once...go to Q6 | <input type="checkbox"/> 4 times...go to Q5 |
| <input type="checkbox"/> 2 times...go to Q5 | <input type="checkbox"/> 5 times...go to Q5 |
| <input type="checkbox"/> 3 times...go to Q5 | <input type="checkbox"/> 6 times or more...go to Q5 |
| <input type="checkbox"/> I can't remember...go to Q5 | |

Q5 Have all your visits as a “day patient” been to the same GP surgery or have you visited more than one surgery as a “day patient” since April 2012?

- All my “day patient” visits have been to the same surgery
- I have visited more than one surgery as a “day patient”

Q6 Thinking about the last GP surgery you visited as a “day patient”: What was the main reason why you visited this surgery as a “day patient” rather than the surgery you are registered with?

Please **x** one box for the main reason only

- I would have had to take (more) time off work to visit my registered surgery
- This surgery has more convenient opening hours than my registered surgery
- Waiting times to visit a GP at my registered surgery are too long
- It was not easy to get a convenient appointment at my registered surgery
- I prefer this surgery to my registered surgery
- I work or study closer to this surgery than my registered surgery
- I was away from home
- I wanted to get a second opinion from another GP
- This surgery has specialist care / advice that my registered surgery does not provide
- I did not want to bother my GP
- I am not satisfied with the quality of the service at my registered surgery
- I am not registered with a GP
- Other (please write in) _____
- Don't know/ can't remember

Q7 Did you try to find out anything about the surgery before you visited it as a “day patient”?

- Yes.....Go to Q8
- No.....Go to Q9
- Don't know.....Go to Q9

Q8 What did you do to find out about the surgery?

- I asked family members about the surgery
- I asked friends/ co-workers about the surgery
- I looked at the surgery's website
- I looked at other websites (such as NHS Choices)
- I visited or phoned the surgery and asked questions
- Other (please write in) _____
- Don't know/ can't remember

Q9 Before your visit to this surgery as a “day patient”, did you first try to make an appointment at your registered surgery?

- No, I did not try to make an appointment
- Yes, I tried, but did not make an appointment with my registered surgery
- Yes, and I did visit my registered surgery



Day patient postal survey *continued*

MAKING AN APPOINTMENT

Q10 When did you last see a GP as a “day patient”?

- In the past 3 months
- Between 3 and 6 months ago
- Between 6 and 12 months ago
- More than 12 months ago
- I have never seen a GP as a “day patient”

Q11 When did you last see a nurse as a “day patient”?

- In the past 3 months
- Between 3 and 6 months ago
- Between 6 and 12 months ago
- More than 12 months ago
- I have never seen a nurse as a “day patient”

Q12 Thinking about the last time you visited a GP or nurse as a “day patient”:

- Who did you see?
- I saw a GP at the surgery
 - I saw a nurse at the surgery

Q13 Did you make an appointment to see the GP or nurse?

- YesGo to Q14
- NoGo to Q19
- Can't rememberGo to Q19

Q14 How long after initially contacting the surgery did you actually see them?

- On the same day
- On the next working day
- A few days later
- A week or more later
- Can't remember

Q15 How convenient was the appointment you were able to get?

- Very convenient.....Go to Q18
- Fairly convenient.....Go to Q18
- Not very convenient.....Go to Q16
- Not at all convenient.....Go to Q16

Q16 If the appointment you were offered wasn't convenient, why was that?

- There weren't any appointments for the day I wanted
- There weren't any appointments for the time I wanted
- I couldn't see my preferred GP
- I couldn't book ahead at my GP surgery
- Another reason

Q17 What did you do on that occasion?

- Went to the appointment I was offered
- Got an appointment for a different day

Q18 Overall, how would you describe your experience of making an appointment as a “day patient” at that surgery?

- Very good
- Fairly good
- Neither good nor poor
- Fairly poor
- Very poor

Q19 What was the main reason for your last visit as a “day patient”?

Please ✗ one box for the main reason only

- To get a repeat prescription
- To get advice/ treatment for a long-term condition
- To get advice/ treatment for an infection
- To get advice/ treatment for a short-term condition (such as flu or a cold)
- To get a referral for a test/ treatment
- It was a follow-up to a previous visit (for example, to get a test result)
- Other (please say what) _____



Day patient postal survey *continued*

LAST GP/ NURSE APPOINTMENT AS A “DAY PATIENT”

Q20 Still thinking about the last time you visited as a “day patient”, how good was that GP/ nurse at each of the following?

Giving you enough time

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Doesn't apply

Listening to you

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Doesn't apply

Explaining tests and treatments

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Doesn't apply

Involving you in decisions about your care

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Doesn't apply

Treating you with care and concern

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Doesn't apply

Q21 Did you have confidence and trust in the GP/ nurse you saw or spoke to?

- Yes, definitely
- Yes, to some extent
- No, not at all
- Don't know / can't say

ACCESS

Q22 At the surgery you visited as a “day patient”, were there any services you wanted to access but were told were not available to “day patients”?

- Yes.....Go to Q23
- No.....Go to Q24
- Can't remember.....Go to Q24

Q23 What services were not available for you to use as a “day patient”?

Please write in _____

Q24 When you visit a surgery as a “day patient”, the GP or nurse does not have access to your medical history. Thinking about the reason for your “day patient” visit, how important would it have been for the surgery to have seen your medical history?

- Very important
- Fairly important
- Not very important
- Not at all important
- Can't say

Q25 Do you know if the surgery you visited as a “day patient” has told the surgery you are registered with about the advice or treatment you received as a “day patient”?

- Yes, the surgery I am registered with has been told about my visit to another surgery as a “day patient”
- No, the surgery I am registered with has not been told
- I am not registered with a GP surgery
- Don't know

OVERALL EXPERIENCE

Q26 Overall, how would you describe your experience of the GP surgery you visited as a “day patient”?

- Very good
- Fairly good
- Neither good nor poor
- Fairly poor
- Very poor



Day patient postal survey *continued*

REGISTERING AS A PATIENT

- Q27** Did you know you could register as a patient with the surgery you visited as a “day patient”?
- Yes
 No
 Don't know/ can't remember
- Q28** Would you consider registering as a patient with this GP surgery?
- Yes.....Go to Q30
 No.....Go to Q29
 Don't know.....Go to Q31
 I have already registered with this surgery.....Go to Q31
- Q29** Why would you not consider registering?
- Please write in
- _____
- _____
- _____ **Go to Q31**
- Q30** Why would you consider registering?
- Please ~~x~~ all the boxes that apply**
- The surgery is convenient to where I work or study
 The surgery is convenient to where I live
 I can make appointments at a time convenient to me
 The surgery has convenient opening hours
 You don't have to wait too long to see a GP
 The surgery provides specialist services that meet my health care needs
 I like the GPs or other staff at the surgery
 The surgery has a good reputation
 I prefer this surgery to my current/previous surgery
 Other (please write in) _____
- Q31** If you were not able to visit this GP surgery as a “day patient”, what would you have done instead?
- Visited my registered surgery
 Visited A&E/ NHS walk-in centre/ NHS urgent care centre
 Called out-of-hours GP service
 Other (please say what) _____
 Don't know

OPENING HOURS AT YOUR REGISTERED GP SURGERY

- Q32** Now, thinking of the GP surgery you are registered with: How satisfied are you with the hours that your GP surgery is open?
- Very satisfied
 Fairly satisfied
 Neither satisfied nor dissatisfied
 Fairly dissatisfied
 Very dissatisfied
 I'm not sure when my GP surgery is open
 I'm not currently registered with a GP surgery.....Go to Q35
- Q33** Is your GP surgery open at times that are convenient for you?
- Yes.....Go to Q35
 No.....Go to Q34
 Don't know.....Go to Q34
- Q34** Which of the following additional opening times would make it easier for you to see or speak to someone at your GP surgery?
- Please ~~x~~ all the boxes that apply to you**
- Before 8am
 At lunchtime
 After 6.30pm
 On a Saturday
 On a Sunday
 None of these
 Not relevant/ not planning to visit this surgery again
- Q35** Which, if any, of the following services have you ever used?
- Please ~~x~~ all the boxes that apply**
- NHS Direct/ NHS 111 service
 NHS walk-in centre
 Minor injuries unit
 Hospital accident & emergency (A&E)
 Out-of-hours GP service
 NHS Urgent care centre



Day patient postal survey continued

MANAGING YOUR HEALTH

Q36 Do you have a long-standing health condition?

- Yes
- No
- Don't know / can't say

Q37 Which, if any, of the following medical conditions do you have?

Please **x** all the boxes that apply to you

- Alzheimer's disease or dementia Go to Q38
- Angina or long-term heart problem ... Go to Q38
- Arthritis or long-term joint problem ... Go to Q38
- Asthma or long-term chest problem ..Go to Q38
- Blindness or severe visual impairment Go to Q38
- Cancer in the last 5 years Go to Q38
- Deafness or severe hearing impairmentGo to Q38
- DiabetesGo to Q38
- Epilepsy Go to Q38
- High blood pressureGo to Q38
- Kidney or liver diseaseGo to Q38
- Learning difficultyGo to Q38
- Long-term back problemGo to Q38
- Long-term mental health problemGo to Q38
- Long-term neurological problemGo to Q38
- Another long-term condition Go to Q38
- None of these conditions Go to Q39
- I would prefer not to sayGo to Q39

Q38 In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)?

Please think about all services and organisations, not just health services

- Yes, definitely
- Yes, to some extent
- No
- I haven't needed such support
- Don't know/ can't say

Q39 How confident are you that you can manage your own health?

- Very confident
- Fairly confident
- Not very confident
- Not at all confident

SOME QUESTIONS ABOUT YOU

The following questions will help us to see how experiences vary between different groups of the population. We will keep your answers completely confidential.

Q40 Are you male or female?

- Male
- Female

Q41 How old are you?

- Under 18
- 18 to 24
- 25 to 34
- 35 to 44
- 45 to 54
- 55 to 64
- 65 to 74
- 75 to 84
- 85 or over

Q42 What is your ethnic group?

A. White

- English/ Welsh/ Scottish/ Northern Irish/ British
- Irish
- Gypsy or Irish Traveller
- Any other White background

Please write in

B. Mixed / multiple ethnic groups

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed / multiple ethnic background

Please write in

C. Asian / Asian British

- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background

Please write in

D. Black / African / Caribbean / Black British

- African
- Caribbean
- Any other Black / African / Caribbean background

Please write in

E. Other ethnic group

- Arab
- Any other ethnic group

Please write in



Day patient postal survey continued

Q43 Which of these best describes what you are doing at present?

If more than one of these applies to you, please ✕ the main ONE only

- Full-time paid work (30 hours or more each week)Go to Q44
- Part-time paid work (under 30 hours each week)Go to Q44
- Full-time education at school, college or university.....Go to Q46
- UnemployedGo to Q46
- Permanently sick or disabled.....Go to Q46
- Fully retired from work.....Go to Q46
- Looking after the home.....Go to Q46
- Doing something else.....Go to Q46

Q44 In general, how long does your journey take from home to work (door to door)?

- Up to 30 minutes
- 31 minutes to 1 hour
- More than 1 hour
- I live on site

Q45 If you need to see a GP at your GP surgery during your typical working hours, can you take time away from your work to do this?

- Yes
- No

Q46 Are you a parent or a legal guardian for any children aged under 16 living in your home?

- Yes
- No

Q47 Do you look after, or give any help or support to family members, friends, neighbours or others because of either:

- long-term physical or mental ill health / disability, or
- problems related to old age?

Don't count anything you do as part of your paid employment

- No
- Yes, 1-9 hours a week
- Yes, 10-19 hours a week
- Yes, 20-34 hours a week
- Yes, 35-49 hours a week
- Yes, 50+ hours a week

YOUR STATE OF HEALTH TODAY

Q48 By placing a ✕ in one box in each group below, please indicate which statements best describe your own health today.

Mobility

- I have no problems in walking about
- I have slight problems in walking about
- I have moderate problems in walking about
- I have severe problems in walking about
- I am unable to walk about

Self-care

- I have no problems washing or dressing myself
- I have slight problems washing or dressing myself
- I have moderate problems washing or dressing myself
- I have severe problems washing or dressing myself
- I am unable to wash or dress myself

Usual activities (e.g. work, study, housework, family, or leisure activities)

- I have no problems doing my usual activities
- I have slight problems doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities

Pain / Discomfort

- I have no pain or discomfort
- I have slight pain or discomfort
- I have moderate pain or discomfort
- I have severe pain or discomfort
- I have extreme pain or discomfort

Anxiety / Depression

- I am not anxious or depressed
- I am slightly anxious or depressed
- I am moderately anxious or depressed
- I am severely anxious or depressed
- I am extremely anxious or depressed



Day patient postal survey *continued*

OVERALL EXPERIENCE OF NHS PATIENT CHOICE SCHEME

Q49 Overall, compared with the GP surgery you are registered with, how would you rate the GP surgery you visited as a “day patient”? Is the surgery you visited as a “day patient”...

- Much better than your registered surgery
- Somewhat better than your registered surgery
- About the same as your registered surgery
- Somewhat worse than your registered surgery
- Much worse than your registered surgery
- Better in some ways, worse in others
- Can't say
- I am not registered with a GP surgery

Q50 Under the NHS Patient Choice Scheme, people are allowed to visit a surgery as a “day patient” a maximum of 5 times in one year? Do you think this number of yearly visits to a surgery as a “day patient” is...

- Too many
- About right
- Too few
- Don't know

Q51 In general how worried, if at all, are you about receiving advice or treatment from a GP or nurse who does not know your medical history or have access to your medical records?

- Very worried
- Fairly worried
- Not very worried
- Not at all worried
- It depends on the reason for the visit
- Don't know

Q52 We may want to contact you again about taking part in a telephone interview about your experiences as a “day patient”. Would you be willing for a member of the research team to contact you?

- Yes.....Go to Q53
- No.....Go to Q54

Q53 Could you please provide a contact telephone number? _____
 Could you please also provide a contact email address? _____@_____

Q54 If there is anything else you'd like to tell us about what you like or don't like about visiting a surgery as a “day patient” or about the NHS Patient Choice Scheme, please do so by writing in the box below.



Thank you for your time.
 Please return this questionnaire in the reply paid envelope provided or send it to the address given in the letter that came with this questionnaire.

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Appendix 10.0 Discrete choice experiment



Online DCE choice questions

Choice 1 of 16


	PRACTICE IN your local neighbourhood	PRACTICE OUTSIDE your local neighbourhood
Open on Saturday and Sunday morning (8am-12pm)	Not open on Saturday or Sunday morning	Open on Saturday and Sunday morning
Open at lunchtime (12-2pm)	Open at lunchtime	Open at lunchtime
Extended opening hours (either 7-8am or 6-8pm)	No extended opening hours	Extended opening hours
How quickly can usually be seen by a GP	Same day appointment	Same day appointment
Meets your specific health needs	Meets your specific needs	Meets your specific needs
Experiences of other health care services in your local neighbourhood	Has previous experience with your local health services	Has previous experience with your local health services
Which of these two practices would you choose to register with?	<input type="radio"/>	<input type="radio"/>




Choice 2 of 16

	PRACTICE IN your local neighbourhood	PRACTICE OUTSIDE your local neighbourhood
Open on Saturday and Sunday morning (8am-12pm)	Not open on Saturday or Sunday morning	Not open on Saturday or Sunday morning
Open at lunchtime (12-2pm)	Open at lunchtime	Not open at lunchtime
Extended opening hours (either 7-8am or 6-8pm)	Extended opening hours	No extended opening hours
How quickly can usually be seen by a GP	Next day appointment	Same day appointment
Meets your specific health needs	Does not meet your specific needs	Meets your specific needs
Experiences of other health care services in your local neighbourhood	Has previous experience with your local health services	Does not have previous experience with your local health services
Which of these two practices would you choose to register with?	<input type="radio"/>	<input type="radio"/>







Online DCE choice questions *continued*

YouGov What the world thinks 

Choice 3 of 16


	PRACTICE IN your local neighbourhood	PRACTICE OUTSIDE your local neighbourhood
Open on Saturday and Sunday morning (8am-12pm)	Not open on Saturday or Sunday morning	Open on Saturday and Sunday morning
Open at lunchtime (12-2pm)	Open at lunchtime	Not open at lunchtime
Extended opening hours (either 7-8am or 6-8pm)	No extended opening hours	No extended opening hours
How quickly can usually be seen by a GP	Appointment in a few days	Appointment in a few days
Meets your specific health needs	Meets your specific needs	Does not meet your specific needs
Experiences of other health care services in your local neighbourhood	Has previous experience with your local health services	Does not have previous experience with your local health services
Which of these two practices would you choose to register with?	<input type="radio"/>	<input type="radio"/>



YouGov What the world thinks 



Choice 4 of 16

	PRACTICE IN your local neighbourhood	PRACTICE OUTSIDE your local neighbourhood
Open on Saturday and Sunday morning (8am-12pm)	Open on Saturday and Sunday morning	Open on Saturday and Sunday morning
Open at lunchtime (12-2pm)	Open at lunchtime	Not open at lunchtime
Extended opening hours (either 7-8am or 6-8pm)	Extended opening hours	No extended opening hours
How quickly can usually be seen by a GP	Same day appointment	Appointment in a week or more
Meets your specific health needs	Does not meet your specific needs	Does not meet your specific needs
Experiences of other health care services in your local neighbourhood	Has previous experience with your local health services	Has previous experience with your local health services
Which of these two practices would you choose to register with?	<input type="radio"/>	<input type="radio"/>








Online DCE choice questions *continued*

Choice 5 of 16


	PRACTICE IN your local neighbourhood	PRACTICE OUTSIDE your local neighbourhood
Open on Saturday and Sunday morning (8am-12pm)	Open on Saturday and Sunday morning	Not open on Saturday or Sunday morning
Open at lunchtime (12-2pm)	Open at lunchtime	Not open at lunchtime
Extended opening hours (either 7-8am or 6-8pm)	Extended opening hours	No extended opening hours
How quickly can usually be seen by a GP	Appointment in a week or more	Appointment in a few days
Meets your specific health needs	Meets your specific needs	Does not meet your specific needs
Experiences of other health care services in your local neighbourhood	Has previous experience with your local health services	Does not have previous experience with your local health services
Which of these two practices would you choose to register with?	<input type="radio"/>	<input type="radio"/>




Choice 6 of 16

	PRACTICE IN your local neighbourhood	PRACTICE OUTSIDE your local neighbourhood
Open on Saturday and Sunday morning (8am-12pm)	Not open on Saturday or Sunday morning	Not open on Saturday or Sunday morning
Open at lunchtime (12-2pm)	Open at lunchtime	Not open at lunchtime
Extended opening hours (either 7-8am or 6-8pm)	Extended opening hours	Extended opening hours
How quickly can usually be seen by a GP	Appointment in a week or more	Appointment in a week or more
Meets your specific health needs	Meets your specific needs	Meets your specific needs
Experiences of other health care services in your local neighbourhood	Has previous experience with your local health services	Has previous experience with your local health services
Which of these two practices would you choose to register with?	<input type="radio"/>	<input type="radio"/>







Online DCE choice questions *continued*

YouGov What the world thinks 

Choice 7 of 16


	PRACTICE IN your local neighbourhood	PRACTICE OUTSIDE your local neighbourhood
Open on Saturday and Sunday morning (8am-12pm)	Not open on Saturday or Sunday morning	Not open on Saturday or Sunday morning
Open at lunchtime (12-2pm)	Open at lunchtime	Open at lunchtime
Extended opening hours (either 7-8am or 6-8pm)	No extended opening hours	Extended opening hours
How quickly can usually be seen by a GP	Appointment in a few days	Next day appointment
Meets your specific health needs	Does not meet your specific needs	Does not meet your specific needs
Experiences of other health care services in your local neighbourhood	Has previous experience with your local health services	Has previous experience with your local health services
Which of these two practices would you choose to register with?	<input type="radio"/>	<input type="radio"/>



YouGov What the world thinks 


Choice 8 of 16

	PRACTICE IN your local neighbourhood	PRACTICE OUTSIDE your local neighbourhood
Open on Saturday and Sunday morning (8am-12pm)	Not open on Saturday or Sunday morning	Open on Saturday and Sunday morning
Open at lunchtime (12-2pm)	Open at lunchtime	Open at lunchtime
Extended opening hours (either 7-8am or 6-8pm)	Extended opening hours	No extended opening hours
How quickly can usually be seen by a GP	Next day appointment	Next day appointment
Meets your specific health needs	Meets your specific needs	Does not meet your specific needs
Experiences of other health care services in your local neighbourhood	Has previous experience with your local health services	Has previous experience with your local health services
Which of these two practices would you choose to register with?	<input type="radio"/>	<input type="radio"/>







Online DCE choice questions *continued*

YouGov What the world thinks 

Choice 9 of 16


	PRACTICE IN your local neighbourhood	PRACTICE OUTSIDE your local neighbourhood
Open on Saturday and Sunday morning (8am-12pm)	Open on Saturday and Sunday morning	Not open on Saturday or Sunday morning
Open at lunchtime (12-2pm)	Open at lunchtime	Open at lunchtime
Extended opening hours (either 7-8am or 6-8pm)	No extended opening hours	Extended opening hours
How quickly can usually be seen by a GP	Next day appointment	Appointment in a week or more
Meets your specific health needs	Meets your specific needs	Does not meet your specific needs
Experiences of other health care services in your local neighbourhood	Has previous experience with your local health services	Does not have previous experience with your local health services
Which of these two practices would you choose to register with?	<input type="radio"/>	<input type="radio"/>



YouGov What the world thinks 


Choice 10 of 16

	PRACTICE IN your local neighbourhood	PRACTICE OUTSIDE your local neighbourhood
Open on Saturday and Sunday morning (8am-12pm)	Open on Saturday and Sunday morning	Open on Saturday and Sunday morning
Open at lunchtime (12-2pm)	Open at lunchtime	Not open at lunchtime
Extended opening hours (either 7-8am or 6-8pm)	No extended opening hours	Extended opening hours
How quickly can usually be seen by a GP	Next day appointment	Appointment in a few days
Meets your specific health needs	Does not meet your specific needs	Meets your specific needs
Experiences of other health care services in your local neighbourhood	Has previous experience with your local health services	Has previous experience with your local health services
Which of these two practices would you choose to register with?	<input type="radio"/>	<input type="radio"/>







Online DCE choice questions *continued*

YouGov What the world thinks 

Choice 11 of 16


	PRACTICE IN your local neighbourhood	PRACTICE OUTSIDE your local neighbourhood
Open on Saturday and Sunday morning (8am-12pm)	Open on Saturday and Sunday morning	Not open on Saturday or Sunday morning
Open at lunchtime (12-2pm)	Open at lunchtime	Open at lunchtime
Extended opening hours (either 7-8am or 6-8pm)	Extended opening hours	No extended opening hours
How quickly can usually be seen by a GP	Appointment in a few days	Same day appointment
Meets your specific health needs	Meets your specific needs	Does not meet your specific needs
Experiences of other health care services in your local neighbourhood	Has previous experience with your local health services	Has previous experience with your local health services
Which of these two practices would you choose to register with?	<input type="radio"/>	<input type="radio"/>



YouGov What the world thinks 


Choice 12 of 16

	PRACTICE IN your local neighbourhood	PRACTICE OUTSIDE your local neighbourhood
Open on Saturday and Sunday morning (8am-12pm)	Not open on Saturday or Sunday morning	Open on Saturday and Sunday morning
Open at lunchtime (12-2pm)	Open at lunchtime	Not open at lunchtime
Extended opening hours (either 7-8am or 6-8pm)	No extended opening hours	Extended opening hours
How quickly can usually be seen by a GP	Appointment in a week or more	Same day appointment
Meets your specific health needs	Does not meet your specific needs	Does not meet your specific needs
Experiences of other health care services in your local neighbourhood	Has previous experience with your local health services	Does not have previous experience with your local health services
Which of these two practices would you choose to register with?	<input type="radio"/>	<input type="radio"/>







Online DCE choice questions *continued*

YouGov What the world thinks 

Choice 13 of 16


	PRACTICE IN your local neighbourhood	PRACTICE OUTSIDE your local neighbourhood
Open on Saturday and Sunday morning (8am-12pm)	Not open on Saturday or Sunday morning	Not open on Saturday or Sunday morning
Open at lunchtime (12-2pm)	Open at lunchtime	Open at lunchtime
Extended opening hours (either 7-8am or 6-8pm)	Extended opening hours	Extended opening hours
How quickly can usually be seen by a GP	Same day appointment	Appointment in a few days
Meets your specific health needs	Does not meet your specific needs	Meets your specific needs
Experiences of other health care services in your local neighbourhood	Has previous experience with your local health services	Does not have previous experience with your local health services
Which of these two practices would you choose to register with?	<input type="radio"/>	<input type="radio"/>



YouGov What the world thinks 


Choice 14 of 16

	PRACTICE IN your local neighbourhood	PRACTICE OUTSIDE your local neighbourhood
Open on Saturday and Sunday morning (8am-12pm)	Open on Saturday and Sunday morning	Not open on Saturday or Sunday morning
Open at lunchtime (12-2pm)	Open at lunchtime	Not open at lunchtime
Extended opening hours (either 7-8am or 6-8pm)	No extended opening hours	No extended opening hours
How quickly can usually be seen by a GP	Same day appointment	Next day appointment
Meets your specific health needs	Meets your specific needs	Meets your specific needs
Experiences of other health care services in your local neighbourhood	Has previous experience with your local health services	Has previous experience with your local health services
Which of these two practices would you choose to register with?	<input type="radio"/>	<input type="radio"/>







Online DCE choice questions *continued*

YouGov What the world thinks 

Choice 15 of 16


	PRACTICE IN your local neighbourhood	PRACTICE OUTSIDE your local neighbourhood
Open on Saturday and Sunday morning (8am-12pm)	Open on Saturday and Sunday morning	Not open on Saturday or Sunday morning
Open at lunchtime (12-2pm)	Open at lunchtime	Open at lunchtime
Extended opening hours (either 7-8am or 6-8pm)	Extended opening hours	No extended opening hours
How quickly can usually be seen by a GP	Appointment in a few days	Same day appointment
Meets your specific health needs	Meets your specific needs	Does not meet your specific needs
Experiences of other health care services in your local neighbourhood	Has previous experience with your local health services	Has previous experience with your local health services
Which of these two practices would you choose to register with?	<input type="radio"/>	<input type="radio"/>



YouGov What the world thinks 

Choice 16 of 16

	PRACTICE IN your local neighbourhood	PRACTICE OUTSIDE your local neighbourhood
Open on Saturday and Sunday morning (8am-12pm)	Open on Saturday and Sunday morning	Open on Saturday and Sunday morning
Open at lunchtime (12-2pm)	Open at lunchtime	Not open at lunchtime
Extended opening hours (either 7-8am or 6-8pm)	Extended opening hours	Extended opening hours
How quickly can usually be seen by a GP	Appointment in a few days	Next day appointment
Meets your specific health needs	Does not meet your specific needs	Meets your specific needs
Experiences of other health care services in your local neighbourhood	Has previous experience with your local health services	Does not have previous experience with your local health services
Which of these two practices would you choose to register with?	<input type="radio"/>	<input type="radio"/>





Appendix 10.1 Descriptive statistics of the original study population for the DCE study

Variable	Obs	Mean
Socio-demographic characteristic		
Age	2431	49.424
17-24 years	2431	7.7%
25-49 years	2431	40.0%
50-64 years	2431	29.3%
65+ years	2431	23.0%
White	2420	91.3%
Female	2431	51.9%
A-levels or more	2431	48.4%
Working*	2431	55.3%
Workers with lower education	2431	27.7%
Workers with higher education (A-levels or more)	2431	27.6%
Looking after home or family	2431	13.0%
Retired	2431	25.6%
Has dependent (children or others)	2431	31.3%
Household income (per £1,000/year)**	1775	34.846
Did not answer income question	2426	20.9%
Residence		
North East	2430	4.9%
North West	2430	13.7%
Yorkshire and the Humber	2430	10.2%
East Midlands	2430	8.4%
West Midlands	2430	9.3%
East of England	2430	11.5%
London	2430	14.5%
South East	2430	16.7%
South West	2430	10.6%
Lives in rural areas	2431	10.7%
Lives in urban areas	2431	78.4%
Lives in town/fringe areas	2431	8.9%
Lives in Manchester, Birmingham or London	2431	17.5%
Health and use of health services		
Longstanding health condition	2431	46.4%
Health self-assessed as bad/very bad	2431	35.7%
Did see GP in the past 12 months	2431	79.6%
Registered with GP for less than 1 year	2431	6.3%
Registered with GP for 5 years or more	2431	74.7%
No use of GP services***	2431	16.8%
Current GP practice opening times not convenient	2431	23.7%
Current GP practice doesn't meet specific health needs****	2431	17.2%
Fairly/very poor experience with current GP practice	2431	8.7%
Any dissatisfaction with current GP practice	2431	8.0%

Notes: * Part-time or full-time, training scheme, unpaid work, about to start ** Calculated on mid-point of income bracket
 *** Didn't see GP in 12 months and didn't use any of services mentioned **** Doesn't meet needs very well or not at all



Appendix 10.2 Descriptive statistics of the general population sample for the DCE

Variable	Obs	Mean
Socio-demographic characteristic		
Age	1706	46.7
18-24 years	1706	11.0%
25-49 years	1706	45.3%
50-64 years	1706	23.0%
65+ years	1706	20.8%
White	1700	90.8%
Female	1706	53.2%
A-levels or more	1706	48.2%
Working*	1706	56.4%
Workers with education up to GCSE	1706	28.4%
Workers with higher education (A-levels or more)	1706	28.1%
Looking after home or family	1706	12.3%
Retired	1706	23.3%
Has dependent (children or others)	1706	30.7%
Household income (per £1,000/year)**	1243	33.9
Did not answer income question	1704	20.0%
Residence		
North East	1706	5.2%
North West	1706	13.5%
Yorkshire and the Humber	1706	10.7%
East Midlands	1706	8.4%
West Midlands	1706	8.5%
East of England	1706	11.0%
London	1706	15.9%
South East	1706	16.6%
South West	1706	10.1%
Lives in rural areas	1706	10.3%
Lives in urban areas	1706	79.0%
Lives in town/fringe areas	1706	8.5%
Lives in Manchester, Birmingham or London	1706	18.8%
Health and use of health services		
Longstanding health condition	1706	43.3%
Health self-assessed as bad/very bad	1706	33.8%
Seen GP in the past 12 months	1706	78.2%
Registered with GP for less than 1 year	1706	7.2%
Registered with GP for 5 years or more	1706	72.1%
No use of GP services***	1706	18.1%
Current GP practice opening times not convenient	1706	17.9%
Current GP practice does not meet specific needs****	1706	9.1%
Fairly/very poor experience with current GP practice	1706	8.1%
Any dissatisfaction with current GP practice	1706	24.8%

Notes: * Part-time or full-time, training scheme, unpaid work, about to start ** Calculated on mid-point of income bracket
 *** Didn't see GP in 12 months and didn't use any of services mentioned **** Doesn't meet needs very well or not at all



Appendix 10.3 Comparison of main socio-demographic characteristics of the sub-sample used in analysis and the English population

	Sub-sample	English population ¹
Age groups		
18-29	20.7	20.7
30-39	16.9	16.9
40-49	18.6	18.6
50-64	23.0	23.0
65+	20.8	20.8
% Male	46.8	48.6
18-29	8.6	10.4
30-39	8.4	8.5
40-49	9.2	9.2
50-64	11.4	11.3
65+	9.2	9.2
% Female	53.2	51.4
18-29	12.1	10.3
30-39	8.5	8.5
40-49	9.4	9.4
50-64	11.6	11.6
65+	11.6	11.6
% Employed	56.5	60.0
18-29	13.5	13.8
30-39	13.5	13.6
40-49	13.4	15.3
50-64	13.0	15.3
65+	3.1	2.1
Residence		
North East	5.2	5.0
North West	13.5	13.3
Yorkshire and the Humber	10.7	10.0
East Midlands	8.4	8.6
West Midlands	8.5	10.5
East of England	11.0	11.0
London	15.9	15.3
South East	16.6	16.3

1. Based on Census 2011 data



Appendix 10.4 Technical appendix on the econometric analysis of DCE analysis

Analysis of preferences

The econometric methods used to analyse the data from choice experiments employ the random utility framework developed by McFadden (McFadden 1974). According to this framework, the utility derived by individual i from the consumption of an alternative k in a choice set C can be decomposed into two parts: a deterministic component (V) which is a function of the attributes of the alternative (X_{ik}) and a random component (ε_{ik}), which represents unmeasured variation in preferences that stems from unobserved attributes, individual heterogeneity in tastes, or measurement errors affecting choices:

$$U_{ik} = V_{ik} + \varepsilon_{ik} = \beta_i X_{ik} + \varepsilon_{ik}$$

As a result, it is assumed that utility-maximising rational individuals choose alternative k if and only if it maximises their utility amongst the set of J alternatives proposed. From the equation above, one derives that alternative k is chosen over alternative m if and only if:

$$U_{ik} > U_{im} \Leftrightarrow V_{ik} + \varepsilon_{ik} > V_{im} + \varepsilon_{im} \Leftrightarrow V_{ik} - V_{im} > \varepsilon_{im} - \varepsilon_{ik}$$

Inequality (2) shows that the distribution of individual error terms determines the distribution of the difference between utilities. The various econometric models developed to analyse individual choices mainly differ in the assumptions they make about the distribution of the error terms.

In the DCE analysis presented in the report, the same model specification is used for the different population groups (general population and sub-group analyses). In practice, the model estimates the two utility functions associated with the two types of practice:

$$U_{Local} = \beta_{L1} EHOURS_L + \beta_{L2} WEEKND_L + \beta_{L3} APP2_L + \beta_{L4} APP3_L \\ + \beta_{L5} APP4_L + \beta_{L6} NEED_L + \varepsilon_{Li}$$

$$U_{Out} = ASC_O + \beta_{O1} EHOURS_O + \beta_{O2} WEEKND_{Out} + \beta_{O3} APP2_O + \beta_{O4} APP3_O \\ + \beta_{O5} APP4_O + \beta_{O6} NEED_O + \beta_{O7} LUNCH_O + \beta_{O8} KNOW_O + \varepsilon_{Oi}$$

Note that, in keeping with usual practice in labelled DCEs, alternative-specific coefficients¹ are estimated, even for attributes that are defined similarly across local and OoA alternatives (e.g. extended hours). We systematically tested whether GP practice characteristics were indeed valued similarly across the two alternatives, and for most attributes we found that valuations were different. Interestingly, we found that, in general people, valued the fact that practice had extended opening hours equally.

We proceed to exploring preference heterogeneity in different ways:

- To test whether preferences for practice outside the neighbourhood are different for different sub-groups in general, we introduce interaction terms between the alternative-specific constant and different socio-demographic characteristics that are likely to be associated with a particular a priori position in favour or against out of area registration. For example, we test whether people who work, or those who have caring responsibilities are more likely to value out of area registration. In

¹ In a labelled design attributes are expected to be valued differently in the different alternatives. In effect alternative-specific coefficients capture the interaction between the attributes and the label.



practice this means that we are estimating the utility derived by the OoA alternative, including how these preferences are associated with a range of socio-demographic characteristics (X_i):

$$U_{out} = ASC_o + \beta_{01}EHOURS_o + \beta_{02}WEEKND_{out} + \beta_{03}APP2_o + \beta_{04}APP3_o + \beta_{05}APP4_o + \beta_{06}NEED_o + \beta_{07}LUNCH_o + \beta_{08}KNOW_o + \beta_{09}Xi + \varepsilon_{oi}$$

- To control for correlation arising from the 16 choices, we include the alternative-specific constant as a normally distributed random parameter (Hole, 2008).

With the development of computing power, new estimation techniques (simulated maximum likelihood estimation) have been developed, and with them the introduction of a model evaluated through numerical simulations, the Random Parameter Logit (RPL) model (Hensher and Greene 2003). The RPL proposes a general modelling framework that addresses the main limitations encountered in the Multinomial logit model. First, it solves the IIA assumption issues and allows alternatives to be uncorrelated, without constraining groups of alternatives to be similar. Second, it proposes a way to model the serial correlation across choices. Finally, it can be used to test for unobserved preference heterogeneity through the use of random parameters. However, here we do not want to explore unobserved heterogeneity, and instead by specifying the alternative specific constant ASC_o as a normally distributed random parameter, we introduce a random effect which, in essence controls for the potential correlation across the 16 choice sets completed by each respondent.

Latent Class Models (LCM) provide an alternative approach to the RPL model to accommodate response heterogeneity. In LCM, it is assumed that the population of respondents can be divided into a set number (Q) of classes, or groups of individuals, who will differ in their preferences. In other words, whilst the groups are different from each other (i.e. they are defined by different parameter vectors), all members of the same group share the same parameters. As the analyst ignores which observation is in which class, the model assumes that individuals belong to a certain group up to a probability. As a result, the logit choice probability function for an individual belonging to a specific class q from J alternatives can be written as:

$$Pr(y_{it} = 1 | class q) = P_{it|q} = \frac{e^{x_{itj}\beta q}}{\sum_{j=1}^J e^{x_{itj}\beta q}}$$

The probability that an individual i belongs to class q (out of a total of Q classes) is given by:

$$H_{iq} = \frac{e^{\theta_q}}{\sum_{q=1}^Q e^{\theta_q}}$$

Reference:

Hole A R (2008) "Modelling heterogeneity in patients' preferences for the attributes of a general practitioner appointment." *Journal of Health Economics* 27(4): 1078-1094.



Appendix 10.5 Trading patterns in the DCE survey

N	% of respondents who chose practice inside the neighbourhood N times
0	0.5%
1	0.2%
2	0.1%
3	0.1%
4	0.2%
5	0.3%
6	1.4%
7	3.6%
8	9.3%
9	12.9%
10	13.5%
11	14.3%
12	9.5%
13	7.4%
14	6.6%
15	6.0%
16	14.2%

Note: Practice inside the neighbourhood coded '1', outside practice coded '0'.



Appendix 10.6 Policy scenarios for the three sub-groups in the general population

	Uptake of practice outside the neighbourhood		
	Group 1 ("Moderates")	Group 2 ("Convenience shoppers")	Group 3 ("Demanding local loyalists")
Choice of two 'average' practices	41.8%	64.5%	9.6%
Busy local practice	52.3%	99.5%	32.1%
Very busy local practice	59.8%	99.9%	45.9%
Practice inside the neighbourhood doesn't meet needs	83.6%	40.6%	9.3%
Practice outside the neighbourhood with extended hours and weekend openings	56.8%	87.7%	23.7%
Practice outside the neighbourhood with extended hours	68.4%	87.5%	19.9%
Practice outside the neighbourhood with weekend openings	54.2%	64.0%	7.8%
Practice inside the neighbourhood with extended hours and weekend openings	27.5%	9.4%	2.7%
Practice inside the neighbourhood with extended hours	29.3%	17.0%	2.8%
Practice inside the neighbourhood with weekend openings	39.8%	48.1%	9.6%



Appendix 10.7 Results of RPL models for sub-groups

Preferences for GP practice of older individuals (65 years and older)

	Parameter estimates	95% confidence intervals
Characteristics of practice		
Practice in neighbourhood		
The practice has extended hours	0.592 ***	(0.386 , 0.797)
Practice is open on Sat/Sun morning	0.130	(-0.059 , 0.318)
Usually get appointment next day [same day]	-1.421 ***	(-1.816 , -1.026)
Usually get appointment in a few days [same day]	-2.423 ***	(-2.840 , -2.006)
Usually get appointment in > a week [same day]	-3.214 ***	(-3.695 , -2.734)
Practice meets your specific needs	0.936 ***	(0.681 , 1.191)
Practice outside neighbourhood		
Alternative-specific constant (mean)	-3.032 ***	(-3.618 , -2.447)
Alternative-specific constant (standard deviation)	0.013	(-0.783 , 0.808)
Practice is open at lunchtime	1.523 ***	(1.310 , 1.736)
Practice has extended hours	0.369 ***	(0.139 , 0.599)
Practice is open on Sat/Sun morning	0.275 ***	(0.102 , 0.448)
Usually get appointment next day [same day]	-0.547 ***	(-0.726 , -0.368)
Usually get appointment in a few days [same day]	-1.156 ***	(-1.331 , -0.981)
Usually get appointment in > a week [same day]	-3.744 ***	(-4.131 , -3.356)
Practice meets your specific health needs	1.614 ***	(1.289 , 1.939)
Practice knows your local services	-0.162	(-0.422 , 0.099)
Individual characteristics associated with preference for practice outside neighbourhood		
Lives in London, Birmingham or Manchester	0.243 ***	(0.088 , 0.397)
Full-time worker	0.088 0	(-0.126 , 0.302)
Self-reported long standing health condition	0.156 ***	(0.038 , 0.273)
Has caring responsibilities	-0.174 *	(-0.357 , 0.008)
Has used GP services in past 12m	-0.216 ***	(-0.304 , -0.127)
Has been with GP for 5+ years	-0.210 **	(-0.392 , -0.028)
Dissatisfied with GP practice	0.639 ***	(0.468 , 0.810)

Note: Number of respondents=559; Number of observations: N=8,944; % predictions correct: .78.1% ; AIC/N= 0.891; *** p<0.01, ** p< 0.05 , * p<0.1.



Results of RPL models for sub-groups *continued*

Preferences for GP practice of individuals living in Birmingham, London and Manchester

	Parameter estimates	95% confidence intervals
Characteristics of practice		
Practice in neighbourhood		
The practice has extended hours	0.473 ***	(0.326 , 0.620)
Practice is open on Sat/Sun morning	0.110	(-0.027 , 0.248)
Usually get appointment next day [same day]	-0.624 ***	(-0.865 , -0.384)
Usually get appointment in a few days [same day]	-1.218 ***	(-1.477 , -0.958)
Usually get appointment in > a week [same day]	-1.707 ***	(-1.985 , -1.429)
Practice meets your specific needs	0.897 ***	(0.731 , 1.063)
Practice outside neighbourhood		
Alternative-specific constant (mean)	-1.907 ***	(-2.297 , -1.516)
Alternative-specific constant (standard deviation)	0.023	(-0.812 , 0.859)
Practice is open at lunchtime	1.039 ***	(0.890 , 1.187)
Practice has extended hours	0.558 ***	(0.413 , 0.703)
Practice is open on Sat/Sun morning	0.533 ***	(0.398 , 0.668)
Usually get appointment next day [same day]	-0.448 ***	(-0.618 , -0.279)
Usually get appointment in a few days [same day]	-0.864 ***	(-1.016 , -0.711)
Usually get appointment in > a week [same day]	-2.198 ***	(-2.435 , -1.962)
Practice meets your specific health needs	0.647 ***	(0.454 , 0.840)
Practice knows your local services	-0.129	(-0.286 , 0.027)
Individual characteristics associated with preference for practice outside neighbourhood		
65 years and over	0.032	(-0.136 , 0.201)
Full-time worker	-0.073	(-0.197 , 0.051)
Higher education	0.013	(-0.099 , 0.126)
Self-reported long standing health condition	0.097	(-0.019 , 0.213)
Has caring responsibilities	-0.034	(-0.209 , 0.142)
Has low commuting time	-0.038	(-0.173 , 0.097)
Has used GP services in past 12m	-0.035	(-0.119 , 0.048)
Has been with GP for 5+ years	-0.002	(-0.122 , 0.119)
Dissatisfied with GP practice	0.509 ***	(0.392 , 0.627)

Note: Number of respondents=559; Number of observations: N=8,944; % predictions correct: 78.1%; AIC/N= 0.891; *** p<0.01, ** p< 0.05, * p<0.1



Results of RPL models for sub-groups *continued*

Preferences for GP practice choice amongst full-time workers

	Parameter estimates	95% confidence intervals
Characteristics of practice		
Practice in neighbourhood		
The practice has extended hours	0.737 ***	(0.613 , 0.861)
Practice is open on Sat/Sun morning	0.295 ***	(0.191 , 0.399)
Usually get appointment next day [same day]	-0.990 ***	(-1.228 , -0.752)
Usually get appointment in a few days [same day]	-1.775 ***	(-2.023 , -1.527)
Usually get appointment in > a week [same day]	-2.178 ***	(-2.450 , -1.907)
Practice meets your specific needs	0.574 ***	(0.427 , 0.720)
Practice outside neighbourhood		
Alternative-specific constant (mean)	-2.455 ***	(-2.809 , -2.100)
Alternative-specific constant (standard deviation)	0.002	(-0.412 , 0.417)
Practice is open at lunchtime	1.224 ***	(1.093 , 1.355)
Practice has extended hours	0.684 ***	(0.572 , 0.797)
Practice is open on Sat/Sun morning	0.476 ***	(0.369 , 0.584)
Usually get appointment next day [same day]	-0.454 ***	(-0.583 , -0.325)
Usually get appointment in a few days [same day]	-0.871 ***	(-0.981 , -0.760)
Usually get appointment in > a week [same day]	-2.520 ***	(-2.729 , -2.310)
Practice meets your specific health needs	0.920 ***	(0.731 , 1.110)
Practice knows your local services	-0.266 ***	(-0.392 , -0.140)
Individual characteristics associated with preference for practice outside neighbourhood		
65 years and over	-0.004	(-0.169 , 0.223)
Lives in London, Birmingham or Manchester	-0.011	(-0.245 , 0.065)
Higher education	0.078 *	(-0.120 , 0.221)
Self-reported long standing health condition	0.093 **	(-0.376 , 0.038)
Has caring responsibilities	-0.481 ***	(0.036 , 0.291)
Has low commuting time	0.156 ***	(-0.112 , 0.071)
Has used GP services in past 12m	-0.039	(-0.234 , 0.028)
Has been with GP for 5+ years	-0.052	(0.407 , 0.661)
Dissatisfied with GP practice	0.330 ***	(0.246 , 0.415)

Note: Number of respondents=559; Number of observations: N=8,944; % predictions correct: 78.1%; AIC/N= 0.891; *** p<0.01, ** p< 0.05 (* p<0.1)



Appendix 10.8 Preferences for GP practice choice, estimated on the sample of those 90% who responded the slowest

	Coefficients	95% confidence intervals
GP practice characteristics		
Practice in neighbourhood		
The practice has extended hours	0.793 ***	(0.686 , 0.899)
Practice is open on Sat/Sun morning	0.143 ***	(0.055 , 0.230)
Normally can get appointment next day	-1.207 ***	(-1.411 , -1.002)
Normally can get appointment in a few days	-2.024 ***	(-2.240 , -1.809)
Normally can get appointment in > a week	-2.670 ***	(-2.907 , -2.434)
Practice meets your specific needs	0.701 ***	(0.574 , 0.828)
Practice outside neighbourhood		
Alternative-specific constant (mean)	-2.381 ***	(-2.681 , -2.082)
Alternative-specific constant (standard deviation)	0.008	(-0.353 , 0.369)
Practice is open at lunchtime	1.379 ***	(1.268 , 1.491)
Practice has extended hours	0.662 ***	(0.566 , 0.758)
Practice is open on Sat/Sun morning	0.306 ***	(0.217 , 0.396)
Normally can get appointment next day	-0.505 ***	(-0.606 , -0.404)
Normally can get appointment in a few days	-1.091 ***	(-1.181 , -1.001)
Normally can get appointment in > a week	-3.122 ***	(-3.305 , -2.939)
Practice meets your specific needs	1.236 ***	(1.068 , 1.404)
Practice knows your local services	-0.327 ***	(-0.436 , -0.218)
Heterogeneity in preference for practice out-of-area		
65 years and over	-0.231 ***	(-0.226 , -0.061)
Lives in London, Birmingham or Manchester	-0.040	(-0.054 , 0.089)
Full-time worker	0.042	(-0.061 , 0.075)
Self-reported long standing health condition	0.069 **	(0.034 , 0.162)
Has caring responsibilities	-0.143 ***	(-0.256 , -0.063)
Has used GP services in past 12m	-0.079 ***	(-0.093 , 0.005)
Has been with GP for 5+ years	-0.103 ***	(-0.154 , -0.019)
Dissatisfied with GP practice	0.376 ***	(0.338 , 0.476)
Number of respondents	1,535	
Number of observations	24,560	
% predictions correct	77.1%	
AIC/N	0.949	

Note: *** p<0.01, ** p< 0.05 , * p<0.1.



Appendix 11 GP practices participating in the pilot

Practice	GPs (n)	Nurses (n)	Weekend surgery hours?	Weekday surgery hours (outside 0800-1830)	Practice list size	Information about pilot participation on website?	Available information sources	Additional and/or specialty services
Manchester								
Arch Medical Practice	8 (4 partners, 1 salaried partner, 3 other)	4	No	No	9,617	No	Website, NHS Choices	Not applicable
Fernclough Surgery	2 (both GPWS)	1	No	Tues, 1830-1930	2,033	No	Website (under construction) NHS Choices	Drug misuse. Both are GPs with a special interest: the first is a family planning practitioner, formerly registrar in general and orthopaedic surgery; the second is a specialist in obstetrics and gynaecology.
Borchardt Medical Centre	10 (7 partners, 1 salaried GP, 2 registrars)	2	No	Mon, 1830-2000 Tues, 1830-1930	11,342	No	Website, NHS Choices	Drug misuse.
Oswald Medical Practice	3	2	Sat, 0800-2230	Mon, 1830-1930 Weds, 0730-0800	4,620	No	NHS Choices	Not applicable
Charlestown Medical Practice	2	1	Sat, 0900-1300	Mon & Thurs, 1830-2000	2,898	No	Website, NHS Choices	Not applicable
Wellfield Medical Centre	4	3	No	No	9,022	No	Website, NHS Choices	Training practice. Online booking for appointments and requests for repeat prescriptions.
Tregenna Group Practice	4	No info	No	No	6,601	No	NHS Choices	Not applicable
The Docs Surgery	3 (all partners)	4	No	Weds, 1830-2000	6,134	Yes, very detailed information on homepage!	Website, NHS Choices	Sexual health centre with same day HIV testing and results service every Wednesday. Community services also available through practices: podiatry, midwives. On-site mental health assessment and counselling. Provides referrals to mental health services for the Chinese community.

Table continued over page >



GP practices participating in the pilot continued

Practice	GPs (n)	Nurses (n)	Weekend surgery hours?	Weekday surgery hours (outside 0800-1830)	Practice list size	Information about pilot participation on website?	Available information sources	Additional and/or speciality services
Nottingham								
The Windmill Practice, Sneinton Health Centre	7	4	Sat, 0830-1230	No	7,619	No ²	Website, NHS Choices	Weekly outreach clinic for the homeless. Specialises in social support for those disadvantaged by physical, mental and social problems, with expertise in issues relating to homelessness, drug and alcohol abuse, asylum seekers and refugees. Emphasises that 3 GPs have been at the practice for over 20 years, all other 4 have joined in last 10-15 years.
Wollaton Vale Health Centre	1	1	No	Fri, 1830-1945	2,573	No	Website, NHS Choices	ECG (routine, non-urgent), obesity clinic, teenage sexual health, learning disability health check clinics. Minor surgery clinic also offers joint injections (small and large joints, weight bearing joints).
Beechdale Surgery	3 (1 is dermatology trainee)	1	No	No	4,171	No	Website, NHS Choices	Training practice.
Bilborough Medical Centre	9	No info	Sat, 0800-1130 Sun, 0830-1100	No	8,540	No	Website, NHS Choices	Allergy testing (in-house, same day results), chiropody clinic, physiotherapy, drug misuse.
Bakersfield Medical Centre	4	No info	No	No	5,247	No	Website, NHS Choices	Not applicable
NEMS Platform One Practice	4	1	No	Tues, 1830-1900 Weds, 1830-1900 Fri, 0730-0800	3,867	No	Website, NHS Choices	ECGs (routine, non-urgent), substance misuse clinics, support to nursing homes, support for refugee and asylum seekers.
Family Medical Centre	10 (4 part-time)	3	Sat, 0830-1215	No	7,930	No	Website ³	Mental health, rheumatology monitoring, substance misuse, YMCA exercise referral, teaching practice.

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GP practices participating in the pilot continued

Practice	GPs (n)	Nurses (n)	Weekend surgery hours?	Weekday surgery hours (outside 0800-1830)	Practice list size	Information about pilot participation on website?	Available information sources	Additional and/or specialty services
Salford								
Langworthy Medical Practice	7	5	No	Thurs, 1830-2000	14,589	No	Website, NHS Choices	Affiliated with the University of Salford since 1983, operates branch surgery on campus. Training practice for the University of Manchester. Can book appointments online, offers complementary clinics including homeopathy and acupuncture, psychotherapy, community alcohol team help (once per week).
Ciarendon Medical Practice	7 (3 partners, 3 associates, 1 registrar)	2	Sat, 0930-1200	No	8,850	No	Website, NHS Choices	Teaching practice
Sorrel Bank Medical Practice	5 (2 partners, 2 attached GPs, 1 other)	3	No	Mon, Tues, Weds, Fri, 0700-0800 Thurs, 0730-0800	8,537	No	Website, NHS Choices	Joint injections, pharmacy onsite, phlebotomy (cholesterol screening).
Salford Medical Practice	2	1	No	Tues, 0730-0800 Weds, 1830-1940	3,100	No	Website, NHS Choices	Not applicable
Mosslands Medical Practice, Irlam Medical Centre	6 (5, with 1 additional locum GP)	1	Sat, 0800-1130	No	8,736	Yes, in registration details ⁴	Website, NHS Choices	Not applicable
Chapel Medical Centre	1	1	No	Weds, 0700-0800	1,642	No	NHS Choices	Not applicable
Blackfriars Medical Practice	3	2	No	Mon & Tues, 1830-1930	3,504	No	Website, NHS Choices	Chronic kidney disease monitoring, palliative care, cryotherapy.
Salford Care Centres –Irlam Clinic/Cornerstone Medical Practice	2	1	No	No	5,333	No	NHS Choices	Not applicable

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GP practices participating in the pilot continued

Practice	GPs (n)	Nurses (n)	Weekend surgery hours?	Weekday surgery hours (outside 0800-1830)	Practice list size	Information about pilot participation on website?	Available information sources	Additional and/or speciality services
Westminster								
Lees Place Medical Centre	8 (3 FTE, 5 additional GPs on PT basis)	5	No	Tues & Thurs, 1830-2000	12,306	Yes, in registration details on own site ⁵	Website, NHS Choices	Private services offered: specialist dietary, lifestyle planning, weight management, pain management, sports injuries, physiotherapy, acupuncture, psychological assessment.
The Belgravia Surgery	3	2	No	No	5,926	Yes, detailed description on own site	Website, NHS Choices	Private services (will not register patients who prefer to see a private GP through PHI).
The Garway Medical Practice	4	2	No	Mon & Thurs, 1830-1950	4,649	No	Website, NHS Choices	Substance misuse, community mental health worker, interpreters (with 48 hrs notice).
Westminster Medical Centre	4	2	No	Mon, Tues, Weds & Thurs 1830-2000	8,785	No	Website, NHS Choices	Allergy testing (in-house, same day results), chiropody clinic, physiotherapy, drug misuse.
The Shirland Road Medical Centre	3 (2 partners, 1 salaried GP)	2	No	Mon & Fri, 1830-1930	3,637	Yes, in temporary registration on own site ⁶	Website, NHS Choices	Not applicable
The Marven Medical Practice	3	1	No	Tues, 1830-1930	5,066	No	Website, NHS Choices	Local eHealth Records.
Covent Garden Medical Centre	5	1	No	Mon, Tues, Weds, Thurs & Fri 1830-2000	5,848	Yes, available on the home page	Website, NHS Choices	Psychotherapy services for patients with Health Anxiety causing Medically Unexplained Symptoms. The practice piloted a very popular weekend walk-in service and is currently building a business case for it to be held every week. Interpreters (prearranged).
The Connaught Square Practice	1	1 (also practice manager)	No	Weds 1830-2000	2,518	No	Website, NHS Choices	Counselling.

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GP practices participating in the pilot continued

Practice	GPs (n)	Nurses (n)	Weekend surgery hours?	Weekday surgery hours (outside 0800-1830)	Practice list size	Information about pilot participation on website?	Available information sources	Additional and/or specialty services
Westminster								
Soho Square Surgery	1	1	No	Tues, 1830-1930	2,316	No	NHS Choices	Not applicable
Crawford Street Surgery	2	1	No	No	3,761	No	Website, NHS Choices	Not applicable
Milne House Medical Centre	2	No info	No	Mon, 1830-2000	2,985	No	NHS Choices	Not applicable
Harrow Road Health Centre	4	2	No	No	4,230	Yes, detailed information on own website ⁷	Website, NHS Choices	Drug and alcohol counselling, welfare and benefits advice, bookable telephone appointments, GPs and nurses are available via email (3 working day response rate for non-urgent issues). The practice also provides support for people in temporary accommodation, health trainer services, support services for Arabic-speakers, carer support services, victim support services and family relationship support.
The Mayfair Medical Centre	2	No info	No	No	1,953	No	NHS Choices	Not applicable
West Two Health	1	1	Sat, 1000-1150	No	2,987	No	Website, NHS Choices	Not applicable
The New Elgin Practice	3	1	No	Tues, 0700-0800, 1830-1930	4,744	No	Website, NHS Choices	Not applicable
Marylebone Health Centre	9 (3 Partners, 5 other GPs hold clinical sessions, 1 locum GP)	1 FT, 2 PT	No	Mon, 1830-1930 Tues, 0700-0800 1830-1930 Weds, 0700-0800	7,923	Yes, detailed information on out of area registrations and day visitors on own site ⁸	Website, NHS Choices	Holds annual community health fair (all day), this year will feature talks about the new CCG, complementary therapies and the impact of the health and social care bill on Westminster residents. There are also the following attached staff specialists: osteopath therapist (2), massage therapist (1), acupuncture (1), medical herbalist (1) and therapeutic massage (1). Anti-coagulation services, health trainer service (lifestyle) help linked to weight loss, improving diets) and alcohol assessment services.

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GP practices participating in the pilot *continued*

Practice	GPs (n)	Nurses (n)	Weekend surgery hours?	Weekday surgery hours (outside 0800-1830)	Practice list size	Information about pilot participation on website?	Available information sources	Additional and/or specialty services
Westminster								
Cavendish Health Centre	6 (3 FTE GPs, 2 specialist trainees, 1 foundation GP)	1	No	No	3,761	No	Website, NHS Choices	Not applicable
Dr Victoria Muir's Practice, The Belgrave Medical Centre	3	1	Sat, 0900-1200	Mon, 1830-2000 Tues, Weds & Thurs, 1830-1900	5,681	No	Website, NHS Choices	Launching personal health action plans for asthma, diabetes and mental health, 1 independent osteopath.
Dr Maher Shakarchi's Practice, The Belgrave Medical Centre	2	1	No	Mon & Weds, 0730-0800 1830-1930 Tues, Thurs & Fri, 0730-0800	3,493	Yes, on NHS Choices ⁹	NHS Choices	Replies to user comments left on NHS Choices.
Half Penny Steps Health Centre	2	2	Sat & Sun, 1000-1600	Mon, Tues, Weds, Thurs, Fri 1830-2000	3,145	Yes, detailed information on Facebook profile ¹⁰	NHS Choices, website under construction, actively-used Facebook profile	Facebook page (established in Feb 2011) offers updates for patients. The GP regularly posts facts and practice news, eg., poverty rates within Westminster, comments from patients (using feedback from NHS choices and the biannual General Practice Patient Survey). Recently announced partnership with the Somali Development (Midaye Organisation) that provides supplementary education for mothers and children.

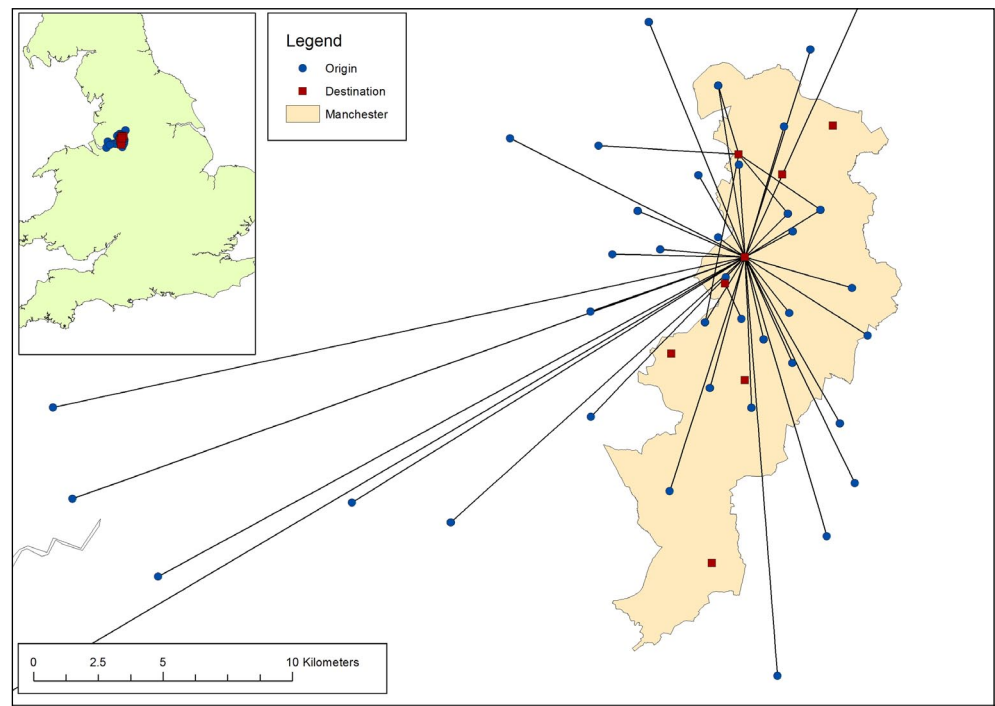
1. There is a link in the sidebar of every page on the practice's personal site. Detailed information about the pilot is available, notably: (1) that the scheme will run until 31 March 2013; (2) "Sometimes, we may decide that it is not in your best interest or practical to provide services to you. For example, if you need to be seen at home, or if urgent treatment is required you may need this from a service nearer your home. The Primary Care Trust for the area in which you live will remain responsible for making sure that any care you need whilst in their area will be available to you." and (3) "If you decide to register as a 'day patient', i.e. you do not fully register with us, we may need to call the practice where you are registered before or whilst seeing you. We will send a clinical note of any consultation back to your own GP practice to be included in your medical records."
 2. This site was unclear. It is possible to register online with practice, but there is no indication whether one is eligible to register if living outside the practice catchment area.
 3. This practice's NHS Choices website provides no information aside from what is automatically generated (address and map).
 4. The site clearly states that as of June 2012, they have been able to register patients on an out-of-area basis. The site also provides details for those who want to see a GP at this practice without changing registration.
 5. The site clearly states that patients that live outside of the catchment area can be registered at this practice through the GP Choice Pilot.

6. Information about the pilot is available through information on temporary registration; refers to it as the "Putting Patients First" pilot scheme and provides a deadline of 31 March 2013 to register.
 7. There is a detailed description of the GP Choice pilot on practice website, which clearly states (1) the changes to out-of-hours and home care for patients who register but live outside the practice area, and (2) the changes to urgent and emergency care for patients outside of the practice's PCT.
 8. There is detailed information on their participation as of July 2012. The site's registration information acts as a screening process for four distinct variants of patient they can register: (1) temporary resident, (2) out-of-area resident, (3) University of Westminster students and (4) those that live in the practice's catchment area.
 9. There is a banner on their NHS Choices site says "OUT OF AREA registration NOW accepted," and provides a link to practice leaflet on NHS choices.
 10. On 21 March 2012, this practice posted the following announcement on Facebook: "Our Walk-in service for non - registered patients will still continue, however it will now be open from 12pm - 8pm Monday to Friday and 10am - 4pm on weekends."

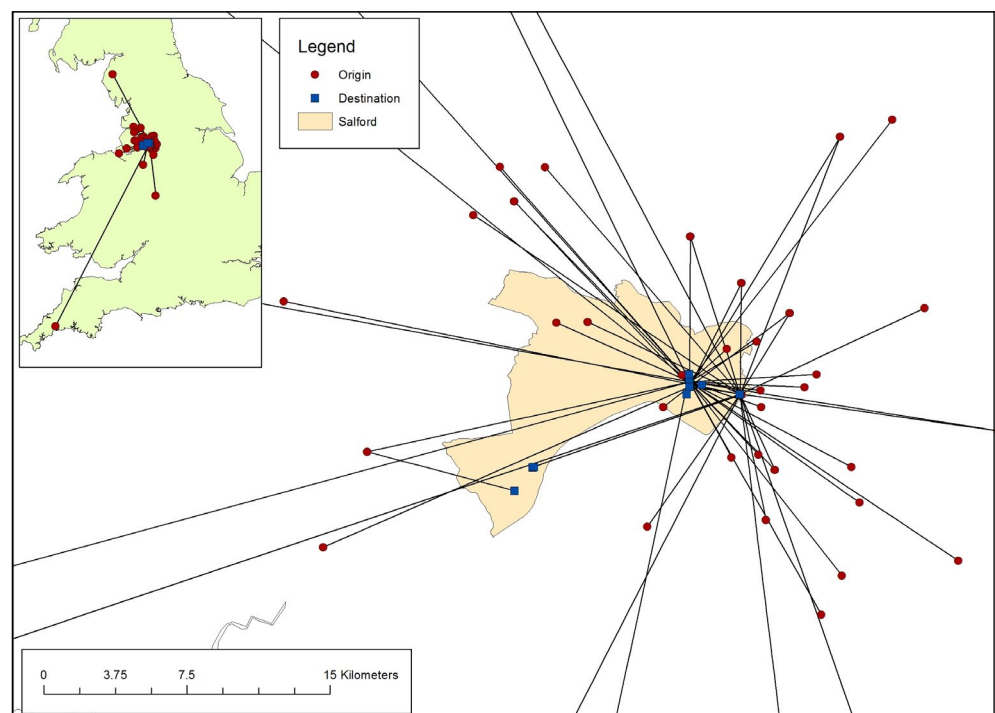


Appendix 12 Out of area registered patient maps for Nottingham, Manchester, Salford and London

Manchester, registered patients

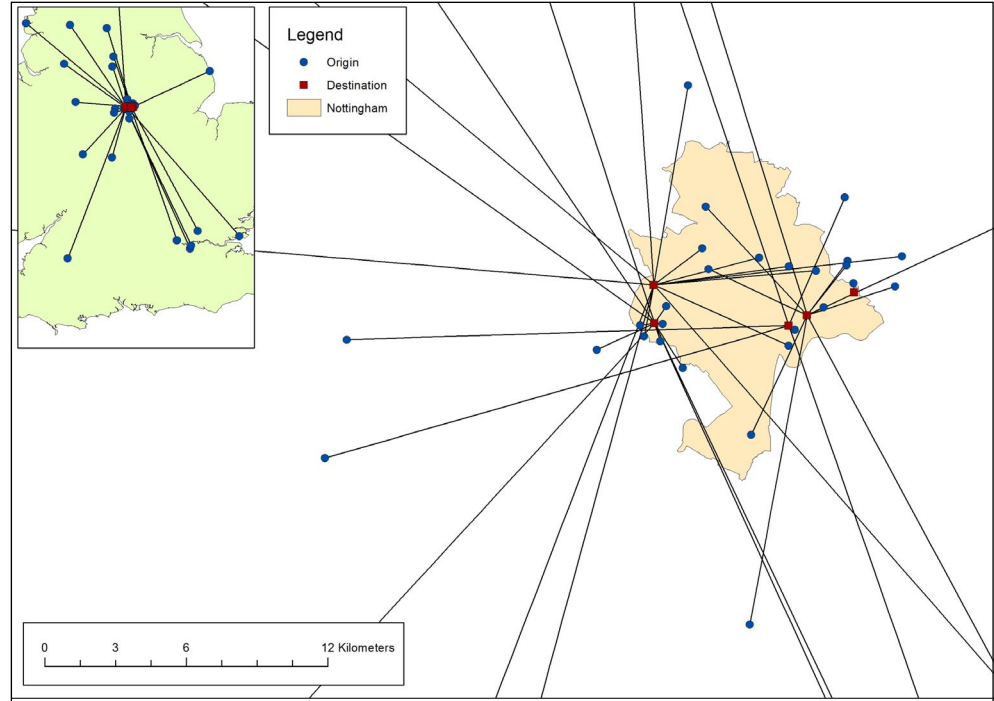


Salford, registered patients

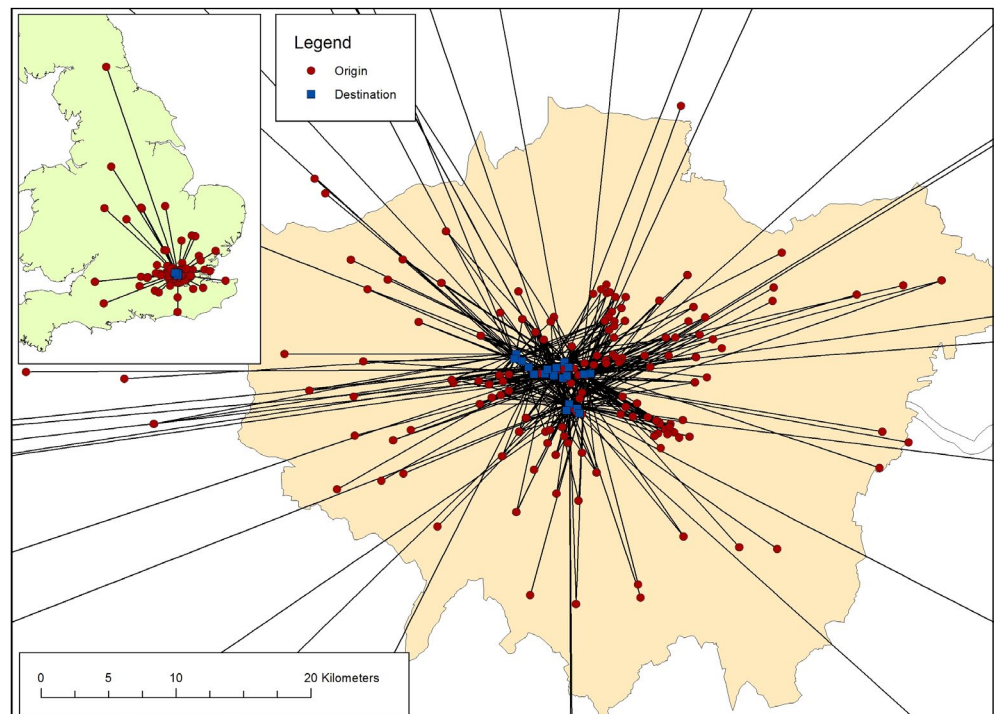




Nottingham, registered patients



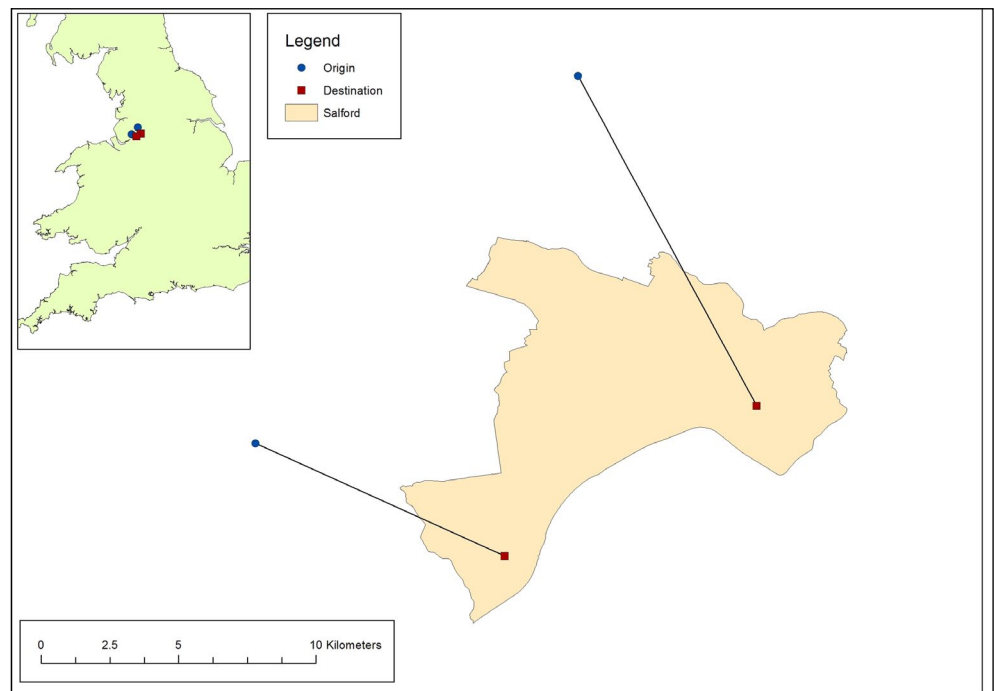
Westminster, registered patients (Greater London)



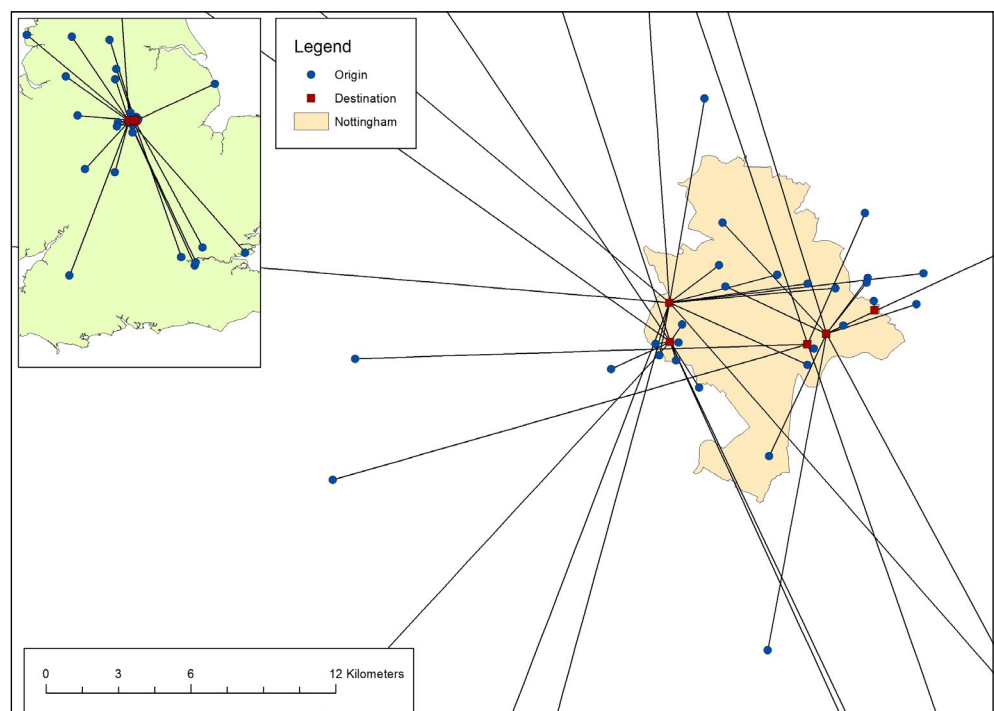


Appendix 13 Day patient maps for Salford, Nottingham and London

Salford, day patients

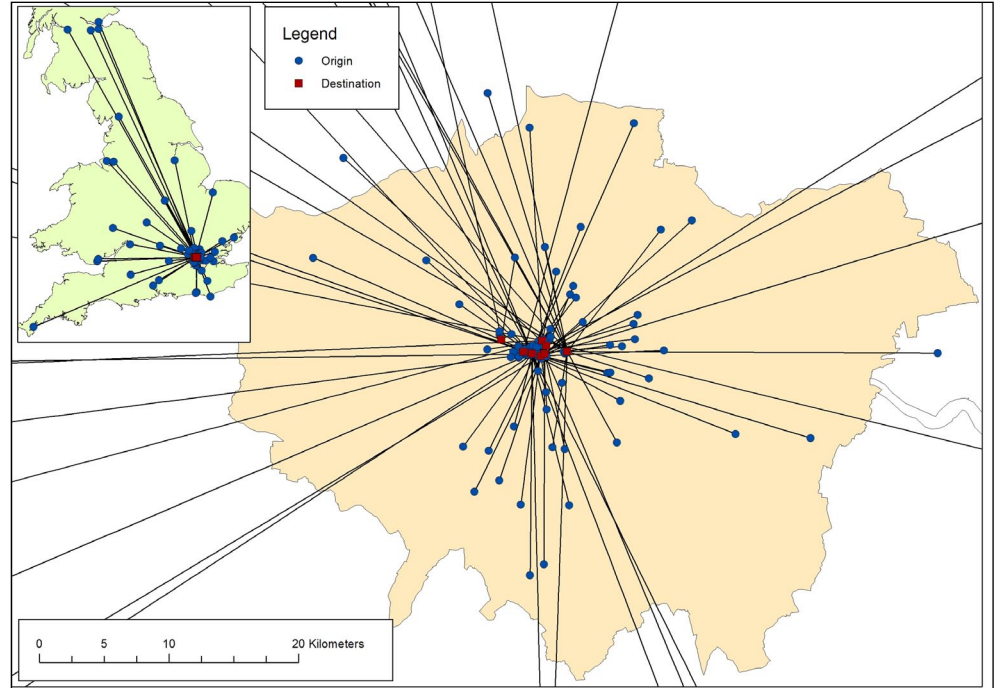


Nottingham, day patients





Westminster, day patients (Greater London)



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