PIRU POLICY INNOVATION RESEARCH UNIT

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

Final report

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Executive summary

Background

The choice of general practice pilot began in April 2012 for 12 months and allowed patients to choose to seek care from any volunteer general practice in four volunteer Primary Care Trust (PCT) areas of the country (Westminster, Salford, Manchester and Nottingham City) without being restricted by practice boundaries. Patients could either register with a pilot practice as an out of area (OoA) patient, or be seen as a 'day patient', while remaining registered with their original practice. The aim of the evaluation was to describe the uptake of the pilot scheme, and give an early indication of its potential costs and benefits for participating practices and patients over a 12-month period, recognising that it would not be possible to quantify costs and benefits definitively over such a short time.

Methods

The evaluation comprised a mix of semi-structured interviews; surveys of pilot patients, General Practice Patient Survey (GPPS) patients, and pilot practice and PCT staff; and a discrete choice experiment (DCE) with a web survey of the general public.

Results

Forty-three practices participated in the pilot, with approximately half of the practices (46.5%) in Westminster. Eleven practices recruited no OoA registered or day patients. A total of 1108 patients registered as OoA registered patients and 250 patients attended as day patients.

Pilot and non-pilot practices in the four PCTs were very similar in terms of the experiences and views of their patients according to the GPPS, a survey administered by NHS England twice each year, giving patients the opportunity to provide feedback on their experience and a range of issues related to their local GP practice. Compared with the first wave of year 7 GPPS data (July-September 2012), OoA registered (n=1108) and day patients (n=250) were much younger, more likely to be in work and have better self-reported health than other patients in the pilot practices or in the rest of the practices in the pilot PCTs. Despite these characteristics, they were at least as likely as GPPS patients to describe their most recent experience or visit to a pilot practice as 'very good'.

There were four distinct types of OoA registered patients:

1. Patients who had moved house, but did not want to change their practice (26.2%)
2. Patients who had chosen their practice for convenience (32.6%)
3. Patients who were new to the area and had registered with a pilot practice, but lived outside the practice's catchment area (23.6%)
4. Patients who were dissatisfied with their previous practice or chose their new practice for specific services or to see a particular GP (13.9%).

Most OoA registered patients were positive about the scheme. Convenience and continuity of care after moving house appeared to be the main benefits perceived. The scheme also suited patients with long commutes.

There were three distinct types of day patients:

1. Patients motivated by convenience related to their lifestyle or place of work (68.8%)
2. Patients who could have been registered as Temporary Residents (18.8%)
3. Patients who wanted to see a particular GP or obtain care that their registered practice did not provide, or who were not satisfied with the quality of care at their registered practice (7.8%).

Most day patients expressed positive views of the scheme for its convenience to their work or lifestyle and ease of making an appointment. The scheme suited patients wishing to remain registered with a practice near their homes; many (38.7%) were aware they could change their registration, but just one in five (14.5%) did during the pilot.

The scheme was not costed in detail, but the additional costs of setting up the scheme were perceived as modest by PCTs and practices. Although there were a number of practical problems to be resolved in implementing the pilot in the four PCT areas, none were seen as insuperable.

PCT managers had some concerns related to the risk that with out-of-area registration, practice populations could become more socio-economically segregated. Another concern for the future, if more patients found themselves living outside the area where their general practice was located, relates to making and managing referrals and their costs. Practice staff were broadly (though not uniformly) positive about extending the out of area registration aspect of the scheme.

The DCE showed that a minority of the population would be willing to register with a practice outside their neighbourhood provided that there was such a practice available that was more convenient for them. However, there was considerable heterogeneity in preferences. Some sub-groups, either because they are less mobile (e.g. older people and those with caring responsibilities), or because they are satisfied with their local services, were far less interested in registering at a practice outside their neighbourhood. In choosing a practice, people feel most strongly about obtaining an appointment with a GP as quickly as possible. Most people did not regard weekend opening (Saturday and Sunday) as important in determining their choice of practice. Some people, in particular those who worked and older people, felt strongly about having responsive services that had extended opening hours, whether it meant that they had to register with a practice locally or not. These findings are consistent with the results from the surveys of patients using the pilot.

Conclusions

The findings of the pilot evaluation suggest that patients participating were positive about the scheme and their experience was superior to that of similar patients in the GPPS. There was little sign of major increased cost, though demand was not high. Patients and the majority of pilot practices were very positive about extending the scheme. PCT managers were more cautious.

After the evaluation was completed, NHS Employers, on behalf of NHS England, reached agreement with the General Practitioners Committee (GPC) of the British Medical Association (BMA), as part of its annual contract negotiations, for all GP practices to be able to register patients from outside their traditional practice boundary areas without any obligation to provide home visits for such patients. Practice participation will remain voluntary. NHS England will be responsible for arranging in-hours urgent medical care when needed at or near home for patients who register with a practice away from home. This will become available in October 2014. The day patient option will not be provided. However, as the number of pilot patients in the first 12 months was relatively small and patients had participated in the pilot for less than 12 months in only four areas, it is not possible to reach definitive conclusions about the level of demand, benefits and service costs of the pilot as it is extended nationally and over the long term.

Summary report

Background

National Health Service (NHS) patients are generally expected to access their general practitioner (GP) services at the practice with which they are registered. There have been concerns that this system may not be sufficiently convenient for some patients, leading to a series of initiatives in the English NHS to improve access to first contact care and/or urgent care by developing new forms of provision, such as NHS Walk-in Centres.

By contrast, the choice of general practice pilot began in April 2012 for 12 months as a variation to the NHS General Medical Services (GMS) contract and allowed patients to choose to seek care from any volunteer existing general practice in four volunteer Primary Care Trust (PCT) areas of the country (Westminster, Salford, Manchester and Nottingham City) without being restricted by practice boundaries. Patients could either register with a pilot practice as an out of area (OoA) patient, or be seen as a 'day patient', while remaining registered with their original practice. For day patients, the pilot practice had to pass details of each consultation to the patient's registered practice and the pilot practice received a fee for each day patient consultation from a special fund provided to the PCT where it was located.

Aim and objectives

The aim of the evaluation was to describe the uptake of the pilot scheme, and give an early indication of its potential costs and benefits for participating practices and patients over a 12-month period, recognising that it would not be possible to quantify costs and benefits definitively over such a short time.

The objectives of the study were to:

- Describe the uptake of the pilot and how the scheme was used by pilot patients
- Understand why pilot patients chose to receive general practice care at practices within the pilot, their experiences of care at the pilot practice, and the perceived benefits and drawbacks they reported
- 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, and the benefits and disadvantages to practices
- Identify from participants an indication of the potential additional costs to the NHS, if any, of offering two forms of additional patient choice of general practice that could be set against the perceived benefits to patients.

Methods

- Collation of basic quantitative administrative and clinical data on patients using the pilot scheme
- Semi-structured interviews with:
  - OoA registered patients (n=18) and day patients (n=6) choosing one of the pilot practices
  - GPs and practice managers in pilot practices (n=15)
  - Staff in the 4 pilot PCTs (n=13)
- A web-based survey of clinical and managerial staff in all practices participating in the pilot (23/45, 51% response rate)
- Postal surveys of all OoA registered patients (315/886, 36%) and day patients (64/188, 34%)

- A comparison of postal survey results with those from the General Practice Patient Survey (GPPS) for patients not in the scheme but at the same practice, within the same PCT and across the whole of England
- A Discrete Choice Experiment (DCE) to explore the determinants of choice of GP practice registration in a general population YouGov web survey (n=2431).

Results

A total of 43 practices participated in the pilot, with approximately half of the practices (46.5%) in Westminster. However, 11 practices recruited no OoA registered or day patients during the 12 months. The pilot and non-pilot practices in the four PCTs and nationally were very similar in terms of patient experiences and views according to the GPPS, a survey administered by NHS England twice each year, giving patients the opportunity to provide feedback on their experience and a range of issues related to their local GP practice. This means that pilot patient reports can generally be attributed to their experience of the pilot, as opposed to simply attending a 'better' practice.

A total of 1108 patients registered with pilot practices as OoA registered patients and 250 patients attended pilot practices as day patients.

Compared with the first wave of year 7 GPPS data (July to September 2012), OoA registered and day patients were much younger and more likely to be in work than either the other patients in the pilot practices or patients in the rest of the practices in the pilot PCTs. Those in work were about twice as likely to have a more than 30-minute journey to work than other patients in the pilot practices. They had better self-reported health than other patients in the pilot practices.

There were four distinct types of OoA registered patients, based on their circumstances and main reason for registering 'out of area' with a pilot practice:

1. Patients who had moved house but did not want to change their GP (26.2%)
2. Patients who had chosen their practice for reasons of convenience (for example, because it was close to their workplace) (32.6%)
3. Patients who had just moved to the neighbourhood and registered with a practice near their new home, but their home was outside the relevant practice's catchment area (23.6%)
4. Patients who were dissatisfied with their previous practice or, alternatively, gave a positive reason for choosing their current practice as an out of area patient (for example, because of the services offered) (13.9%).

Two in three OoA registered patients said that they had not changed practice, including people new to the NHS and those who had moved house but stayed with the same practice.

Most OoA registered patients were positive about the scheme and were eager for the scheme to continue. Convenience and continuity of care despite moving house appeared to be the main benefits that these patients perceived. The scheme also suited those commuters, including patients with long commutes (who leave home early and return home late), who had struggled to attend a practice even during the extended hours of their local GP practice.

Compared with the other patients at the same pilot practices, OoA registered patients give more positive overall views of the practice. They were also at least as likely as GPPS patients in general to describe their most recent experience or visit

to a pilot practice as 'very good'. Although the differences were not large, this is important in view of the much younger age profile of OoA registered patients and the fact that younger patients tend to be more critical of their GP practice in the GPPS (Kontopantelis, Roland and Reeves 2010). Among those OoA registered patients who had changed practice, three in five said that their new practice was much (46.5%) or somewhat (14.5%) better than their previous one and one in four (23.8%) that it was about the same.

There were three distinct types of day patients, based on their preferences and main reason for attending a pilot practice as a day patient:

1. Patients motivated by convenience to their lifestyle or place of work (68.8%)
2. Patients who could have been registered as Temporary Residents (for example, because they fell ill while visiting family or staying at a hotel while on holiday) (18.8%)
3. Patients who prefer a specific practice because they want to see a GP at that practice (for example, if they were once registered at this practice but since moved out of the area and changed their registration), they receive specialist care that their registered practice does not provide, or they were not satisfied with the quality of care at their registered practice (7.8%).

Day patients generally attended practices for acute infections (51.6%), most commonly upper respiratory infections (20.4%). Other acute conditions accounted for a further one in five (21.2%) day patient visits, followed by medication issues (7.6%) and chronic conditions (5.2%). This contrasts with the overall pattern in general practice where over half of consultations are for on-going or chronic conditions (Wilson, Buck and Ham 2005). Two-thirds (66.0%) of day patients received a prescription during their visit. Referrals were less common, with only one in ten (10.1%) day patients referred by the GP for tests or other services. Similar clinical data were not available for OoA registered patients.

Most day patients expressed positive views of the scheme for its convenience to their work or lifestyle and ease of making an appointment. The scheme suited patients wishing to remain registered with a practice near their home; among day patients, many (38.7%) were aware they could change their registration but just one in five (14.5%) did. Two in five day patients considered the practice they visited as a day patient to be as good as (40.0%) their registered practice, while one in three (34.6%) felt it was much or somewhat better. Only 9.1% thought it was worse than their registered practice. The scheme may have diverted some patients from other urgent or primary care services, since, if the scheme was not available, many day patients (42.4%) stated that they would have attended an A&E department, walk-in centre or urgent care centre.

The additional costs of setting up and running the scheme were perceived as modest by PCT and pilot practice staff, though these were not directly measured. Although there were a number of practical problems to be resolved in implementing the pilot in the four PCT areas, none were seen as presenting insuperable difficulties. Most patients and practices (in the case of the OoA registration option, in particular) were broadly positive about the scheme and about extending it in future.

PCT managers, perhaps unsurprisingly, were more cautious about a large-scale rollout of the scheme since they took a wider, more systemic perspective. Particular concerns related to the risk with OoA registration that greater patient choice of practice could lead to more mobile, younger, healthier patients being recruited

disproportionately to some practices, leaving less mobile, older, sicker patients with other practices such that, over time, practice populations became much more socio-economically segregated. There were related concerns about choice leading to some practices expanding while others ceased to be viable due to falling patient numbers. Another major concern, as more patients had found themselves living outside the area where their general practice was located, related to making and managing referrals and their costs.

While OoA registered patients represented competition between practices which could have adverse consequences for some practices, day patients represented a more fragmented approach to primary care which some managers felt could harm continuity and thus quality of care.

The DCE showed that there is some appetite for OoA registration in the general population, at least hypothetically, in that a minority of the population would be willing to register with a practice outside their neighbourhood provided that there was such a practice available that was more convenient for them. However, there is considerable heterogeneity in preferences in the population. In particular, some sub-groups, either because they are less mobile (e.g. older people and those with caring responsibilities), or because they are satisfied with their local services, are far less interested in the idea of registering at a practice outside their neighbourhood. In choosing a practice, people feel most strongly about obtaining an appointment with a GP as quickly as possible. This is more important than any other aspect of GP services to them (e.g. more important than extended opening hours or a practice responsive to their needs). Most people did not regard weekend opening (Saturday and Sunday) as an important characteristic in determining their choice of practice. Some people, in particular those who worked and older people, felt strongly about having responsive services that had extended opening hours, whether it meant that they had to register with a practice locally or not. These findings are consistent with the results from the surveys of patients using the pilot.

Conclusions and policy implications

After the evaluation was completed, NHS Employers, on behalf of NHS England, reached agreement with the General Practitioners Committee (GPC) of the British Medical Association (BMA), as part of its annual contract negotiations, for all GP practices to be able to register patients from outside their traditional practice boundary areas without any obligation to provide home visits for such patients. Practice participation will remain voluntary. NHS England will be responsible for arranging in-hours urgent medical care when needed at or near home for patients who register with a practice away from home. GPC and NHS Employers is working with NHS England to resolve any practical issues prior to implementation (see below for the issues identified during the evaluation). This OoA option will become available in October 2014. The day patient option in the pilot will not be provided. To what extent do the findings from the current study support this decision? Overall, the findings of the 12-month GP Practice Choice pilot suggest that the scheme was welcomed by participating patients and practices. Pilot patients tended to have at least as good an experience of care as other patients. The pilot appeared to have been delivered with little sign of major increased cost, though demand was not high in the 12 month period. Patients and the majority of pilot practices were very positive about extending the scheme. PCT managers were more cautious about a large-scale rollout.

As the number of pilot patients in the first 12 months was relatively small, and patients had participated in the pilot for less than 12 months in only four areas, it is not possible to reach definitive conclusions about the level of demand, benefits and service costs of the pilot were it extended throughout the NHS over the long term. For example, it was not possible to study the impact of the removal of practice boundaries on the patient mix of practices and on timely access to general practice by different population sub-groups. However, it seems that the scheme is likely to appeal to only a minority of patients in particular parts of the country, especially people who move house but want to keep the same practice or GP and those who want convenient access to primary care near their workplace.

There is a strong case for putting in place an evaluation now that the OoA registration option is to continue at a larger scale, since the question remains as to whether the same or similar improvements in access and convenience could be obtained at the same or lower cost in different ways, such as by requiring practices to extend their opening hours still further, or by retaining, but widening practice boundaries (via the Outer Boundaries policy, 2012), or by offering more patients the option to consult a GP or practice nurse by phone, video link or email.

The extension of the OoA registration option raises a number of practical implementation issues:

1. How to improve the current arrangements in relation to OoA registered patients for:
   i. referrals to community health services near home, given that, over time and as the scheme grows, increasing numbers of primary care practices and community health services are likely to need to find ways of working together, sometimes over considerable distances
   ii. out of hours care and home visiting, despite likely very low levels of demand for the latter
2. How to ensure reliable, prompt and secure transfer of clinical information between practices and other service providers in relation to OoA registered patients seen by the out-of-hours service in the area where they live
3. How to monitor the total cost to the NHS of providing out of area registration and related care compared with previous arrangements (e.g. to calculate the extra costs involved in contracting for out of hours and home visiting services for OoA registered patients)
4. How to allocate the costs to commissioners of prescribing and referred services generated by patients who are not resident in a CCG's area
5. Whether, and if so, how to regulate the number of patients that participating practices can register (e.g. to protect the interests of locally resident patients or prevent a situation in which local residents cannot register with a practice because it has many OoA registered patients)
6. How to provide general practice capacity in parts of England where there may be strong demand for out of area registration (i.e. 'importing' areas), but very little capacity and how to manage and fund the demand for 'immediate and necessary' treatment from OoA registered patients in areas with large concentrations of such patients (i.e. 'exporting areas')
7. How to monitor the cumulative effect of patient choice of practice and practice choice of patient on the choices available to different types of patients and the needs profile of different practices to ensure that particular patient sub-groups and practices are not being discriminated against systematically.

1. Introduction

Perceived problems in first contact and immediate care in the English NHS

Over the last 15-20 years, there has been a growing complaint that National Health Service (NHS) general practitioner (GP) services, which are based on patient registration with a single general practice, are not sufficiently convenient for patients. For example, in 2007, the Confederation of British Industry (CBI) published a report arguing that NHS GP services were not only of variable quality, but also difficult to access in a timely manner for about a third of patients, particularly in deprived areas and inner cities (CBI 2007). It was claimed that patients frequently complained that practices were not open at weekends, early in the morning or in the evening when it would be more convenient for many patients to visit. The CBI recommended, among other things, development of alternatives to existing GP services to increase patient choice and stimulate competition between providers of first contact and immediate care. Specifically, the report advocated that patients should be able to register with more than one GP practice, wherever they liked, rather than be confined to a single practice with a limited catchment area. This was a response to the fact that, while NHS patients can theoretically choose which general practice to register with, generally they find they can only register if they live within the boundary set by the practice and agreed with the former Primary Care Trust (PCT).

The CBI's proposal is very similar to the choice of GP practice pilot scheme announced by the Government in April 2012, although the pilot did not allow dual registration. The pilot is the subject of this evaluation report. Despite the CBI's criticisms, the GP choice pilot scheme is, in fact, one in a long line of initiatives intended to improve the availability and responsiveness of first contact and immediate care, including GP services, undertaken in the previous decade. There have been further initiatives since the GP practice pilot. Alongside changes to enable practices to register patients from outside their traditional boundaries from October 2014, the Prime Minister has announced pilots of 8am-8pm 7-day GP practice availability and a challenge fund to test further innovative ways to improve access to general practice (NHS England 2013). All these developments need to be seen in the context of longstanding NHS arrangements for patients to be seen 'out-of-area' by a GP practice other than the one they are registered with as either temporary residents or patients requiring 'immediate and necessary' care.

Developments in first contact and immediate care provision since 1997

There are four main ways to improve access to NHS GP services, all of which have been adopted in the recent past:

- Increase the number of general practices, especially in less well served areas
- Encourage and/or require existing general practices to provide longer and/or more convenient opening hours and appointment systems
- Allow patients who live outside practices' catchments to register with, or use, services on an ad hoc basis by encouraging or requiring practices to be 'open' to new patients
- Establish alternative sources of first contact and immediate non-hospital care either to increase capacity or to increase patient choice and competition between providers of services.

The series of initiatives over the last 15 years in the English NHS designed to improve access to, and enhance appropriateness and choice of, provider for first contact care and/or urgent care are summarised in Figures 1.1 and 1.2 and Table 1.1.

The main focus up to 2009 was on setting up new forms of provision alongside the conventional NHS general practice. Thus from 1997, NHS Direct and the initial programme of NHS Walk-in Centres sought to improve appropriate access to out of hours and urgent care while the Advanced Access scheme intended to improve timely, planned access to GP appointments. While these initiatives improved access to some degree, they had limited impact on diverting patients away from A&E departments for non-urgent care (see Appendix 1 for a detailed review of the evidence of the impact of these initiatives) (Salisbury, Chalder et al 2002; Knowles, O'Cathain and Nicholl 2012; Munro, Clancy et al 2003).

From 2005, policy reforms focussed on increasing choice through a new generation of NHS Walk-in Centres in A&E departments and near commuter train stations to improve convenience. There was high patient satisfaction with these new primary and urgent care services, however many of the Walk-in Centres were underutilised and had high per visit costs. It was difficult for evaluators to assess value for money, especially as the range of options in primary and urgent care expanded continuously and it was often unclear what the appropriate comparator service should be, especially as patients could use more than one source of care (Salisbury, Hollinghurst et al 2007; O'Cathain, Coster et al 2009).

Improving access to non-urgent primary care and enhancing patient choice of where and how to access primary care was further signalled in the NHS White Paper of 2006, with commitments to having open practice lists, and supporting providers that wished to expand or practise in underserved areas. The possibility of 'dual registration', which would have allowed patients to register with more than one practice at the same time, as proposed by the CBI in 2007, had been considered, but discounted because it would undermine the principle of registration, continuity of care and be difficult and costly to implement (Department of Health 2006).

Subsequent policy initiatives aiming to enhance choice and competition in primary care included the development of the NHS Choices website, extended opening hours of GP practices, new provision through Equitable Access to Primary Medical Care (EAPMC), polyclinics and urgent care centres (see Table 1.1 for details of each initiative). Aside from polyclinics, this set of initiatives was not independently evaluated.

Despite high levels of patient satisfaction with new services, these efforts to improve first contact and immediate care provision faced a number of implementation challenges including:

- Rapid pace of implementation resulting in poor siting, inadequate local needs assessment and limited publicity, leading, in turn, to low levels of use (e.g. in the case of the first and third waves of NHS Walk-in Centres)
- Some duplication between programmes but little ability to monitor and understand these patterns of patient use
- Complicated referral pathways, especially where there was no parallel integration of information systems between old and new providers (Peckham et al 2012).

As a result, from 2005, patients faced an increasingly complex system for primary and urgent care with many overlapping initiatives.

The evidence on the demand for, and substitution between, services, equity of access, patient satisfaction, referrals and costs of the initiatives between 1997 and 2010 suggests that:

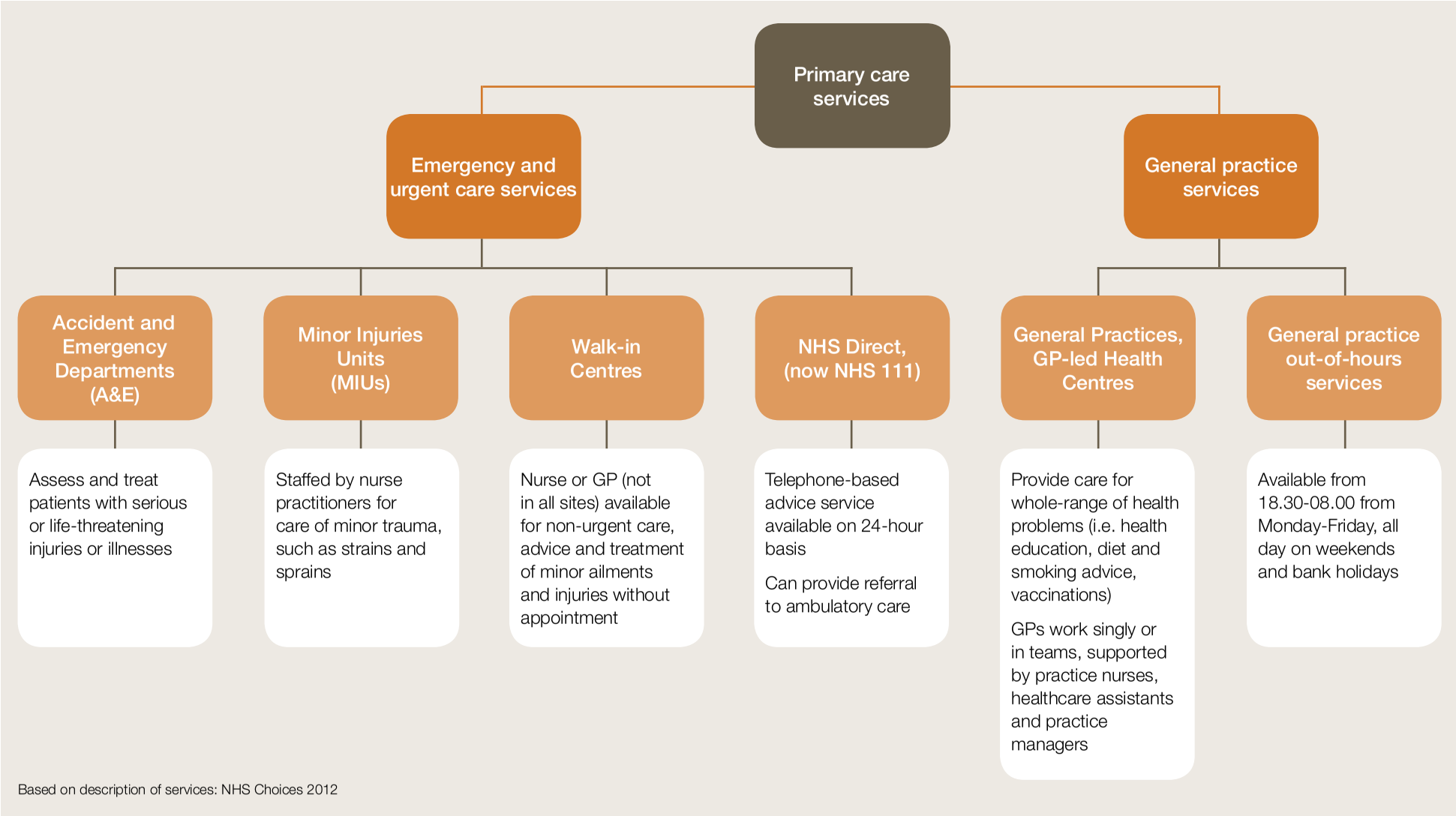
- Patterns of demand for urgent and/or first contact care from hospital A&E departments were resistant to change or substitution
- Patients experienced greater convenience and ease of access
- New face to face services tended to be more costly than conventional GP services
- There is no proper evidence on the cost-effectiveness of these initiatives versus the status quo ante, or against each other.

The Coalition Government's 2010 White Paper, Equity and Excellence: liberating the NHS, built upon New Labour's reforms and committed to giving patients a right to choose to register with any GP practice without being restricted by where they lived or by the practice boundaries agreed with Primary Care Trusts (PCTs), and also to be able to stay with their practice if they wished when they moved to a new house outside the practice boundary (Department of Health 2010a).

This commitment was followed by a public consultation on increasing choice of GP practice. The consultation drew on a November 2009 Ipsos-Mori GP Choice online survey that appeared to show that a sub-group of individuals would take up an offer of greater choice of general practice. The survey found that 18% of respondents were likely to register with a different practice within their local area (i.e. outside their current practice's catchment) if the option to do so was available. Twenty per cent of respondents would consider changing practice without moving house, and 16% of respondents aged 55 years or above had considered changing practice without moving house. Six per cent of respondents wished to register with a GP practice near their place of work. The survey also found that of those who had sought to change their practice, 11% eventually registered with the only other available practice in their catchment area (Department of Health 2010b).

Consistent with the survey findings and its commitment in the 2010 White Paper, the Department of Health formally approved a new Outer Boundaries policy in 2012, whereby patients who move to a new house a short distance away from their old one are able to continue to be registered with the same practice even if they now live outside the practice catchment (Department of Health 2012a). This was a direct precursor to the choice of general practice pilot which is the subject of this report.

Figure 1.1 Current pattern of urgent and primary care services in the English NHS



Based on description of services: NHS Choices 2012

Figure 1.2 Initiatives to improve access and choice in urgent and primary care in the English NHS

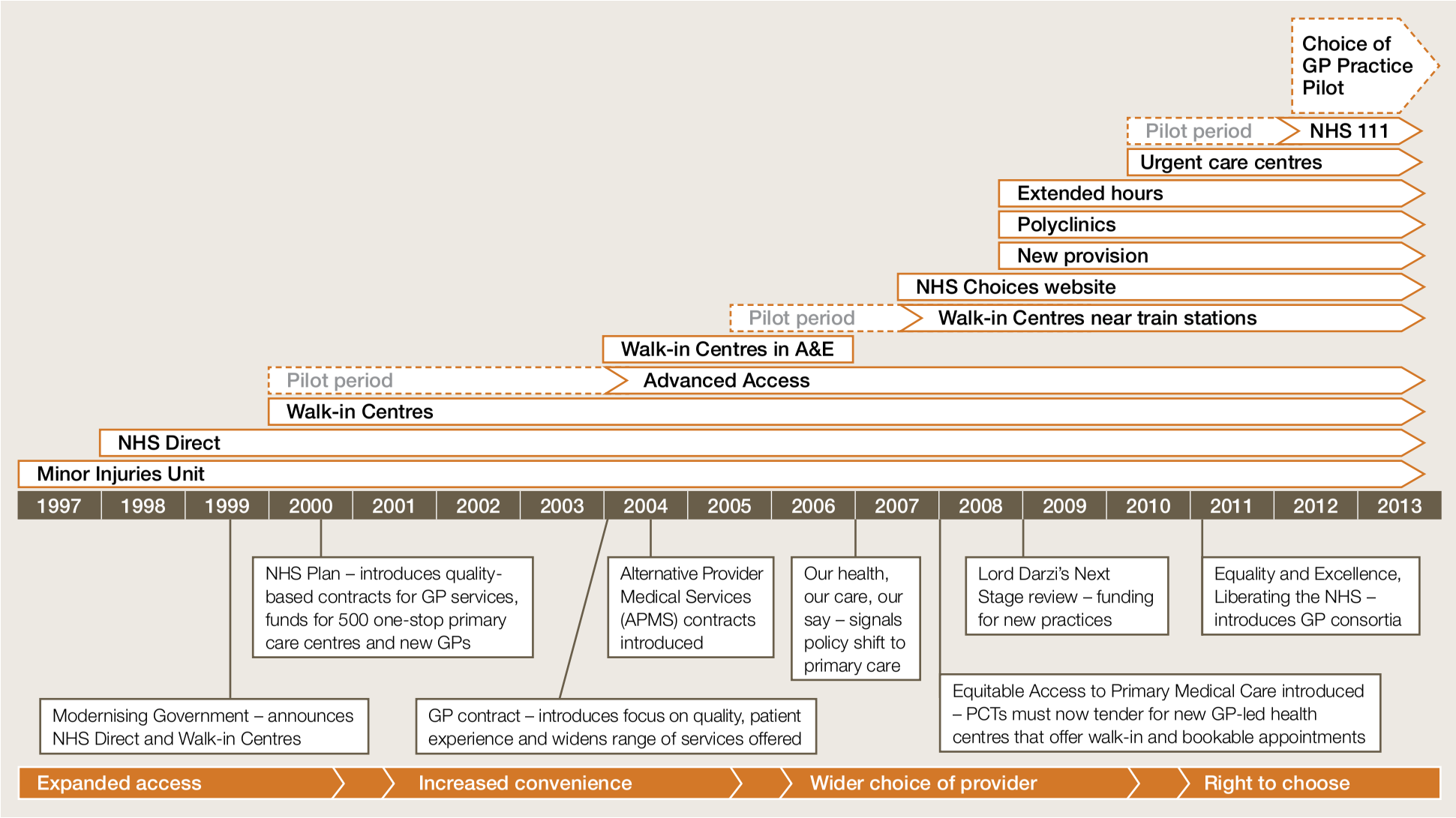


Table 1.1 Description and policy aims of initiatives and programmes to increase access and choice in urgent and primary care in the English NHS 1997-2012

Initiative	Description	Stated outcomes
NHS Direct	• 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.	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."[1]
Advanced Access	• 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.	To guarantee "access to a primary care professional within 24 hours and to a primary care doctor within 48 hours by 2004." 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."[2]
Walk-in Centres	• Provide rapid access, without an appointment, for first contact care. • Operate as an alternative to the A&E department.	"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."[3]
Walk-in Centres in A&E	• Provide urgent and primary health services at patient's preferred point of access. • Triage patients jointly with A&E attenders.	*n/a*
Walk-in Centres near train stations	• 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.	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."[4]
Alternative Provider Medical Services (APMS)	• 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.	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."[5]

Table continued over page >

Table 1.1 *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
NHS Choices	• 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.	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]
Equitable Access to Primary Medical Care (EAPMC)	• 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.	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]
Urgent care centres	• 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.	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." 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]
Polyclinics	• 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.	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" 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]

Table continued over page >

Table 1.1 *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	• 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.	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]
NHS 111	• 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.	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]
Choice of GP	• 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.	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." To "shift the NHS to put patients' interests and desires at the heart of services."[13]

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Recent developments in GP practice choice in Finland, Norway and Sweden

In many countries, patient choice of health provider is becoming an important facet of health services. However, choice in primary care has received less attention than for secondary care in most countries. Evidence on how patients choose their primary care provider is scant. Most studies focus on patient preferences for individual GPs or continuity of care with a specific care provider and suggest that patients most often exercise choice in order to see a GP whom they already know. Where a minority of patients might choose to change primary care provider without changing address, they would typically do so because of convenience, with distance being identified as a more common reason to change than dissatisfaction with the current GP practice (Billingshurst and Whitfield 1993). This may be because patients lack information, or because in many situations there is limited convenient provision and thus little capacity for patients to exercise choice (Coulter and Jenkinson 2005).

Finland, Norway and Sweden are countries with tax-funded systems, and commitments to universal and equitable access to health care similar to England's. As a result they offer potentially helpful experience and policy lessons on the implementation and impact of widening choice of primary care provider (Miani, Pitchforth and Nolte, see Appendix 2). They differ from England in that administrative and political responsibility for health services is partly or fully devolved to local or regional authorities. In England, health policy is set nationally while the commissioning and provision of care is largely devolved to local health care organisations.

There has been a range of recent policy developments in the three countries aiming to enhance access to and quality of care by allowing patients to access non-urgent care outside hospital or modifying or relaxing requirements that patients register with a GP or practice (see Table 1.2 for details of policy reform in these countries and Appendix 2 for a full account of developments in these countries).

In all three countries, urban residents are more likely to exercise primary care provider choice than those in rural areas because of the far greater number of practices within easy reach, though generally there was relatively little shopping around for care. Interviews with policy informants in the three countries also showed that there was a relative lack of publicly available information to enable patients to make informed choices between primary care providers even where choices were available. This challenged implementation of choice reforms. The Nordic countries have developed web sites where patients can share their experiences to promote choice, but this has not been accompanied by systematic provision of information on the quality or nature of care, aside from basic information such as on opening hours. 'Trip Advisor' type websites are beginning to emerge to fill information gaps.

These findings resonate with what is known about patient behaviour in the UK where patients appear to value continuity of care most highly, particularly those with long term conditions, and in discrete choice experiments, patients will often prioritise continuity of care over reduced waiting times or more convenient appointments (Cheraghi-Sohi, Hole et al 2008). The limited UK evidence on voluntary disenrollment from general practices suggests that the small minority of patients who opt to leave their current GP practice without moving house are leaving practices with relatively low levels of patient satisfaction, especially in terms of the quality of doctor-patient communication (Nagraj, Abel et al, 2013).

The experience of recent policy reforms (including allowing for registration beyond administrative boundaries) to enhance choice of primary care provider in the three countries suggests that policy implementation is likely to be more straightforward where:

- The number of registration transfers is limited in number
- It is easy to let money follow the patient (i.e. the payment system can cope with patients who live in one area using services, including referrals from primary care, in another)
- IT systems allow for easy transfer of medical records and information on consultations between different providers of primary care.

Table 1.2 Main features of the public primary health care system and choice of primary care provider in Finland, Norway and Sweden (adapted from Miani, Pitchforth and Nolte 2013)

	Finland[a]	Norway[b]	Sweden[c]
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.[d]	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.

a Vuorenkoski, Mladovsky et al. 2008; Ministry of Social Affairs and Health 2010.
b Ministry of Health and Care Services 1999; Ministry of Health and Care Services 2000; Johnsen 2006.
c Anell, Glenngård et al. 2012.
d HELFO 2012 and key informants.

Patient choice of general practice and the choice of GP practice pilot

In April 2012, the Coalition Government built on the commitments in the 2010 NHS White Paper to give patients a right to choose to register with any GP practice without being restricted by the practice boundaries agreed with PCTs, and also to be able to stay with their practice if they wished when they moved to a new house by extending the 'outer boundaries' policy to establish the choice of GP practice pilot. The pilot was negotiated with the British Medical Association's General Practitioner Committee (GPC) as a 12-month variation to the NHS General Medical Services (GMS) contract. The pilot allowed patients to access participating practices in four selected areas, regardless of where the patients lived. It was expected that the pilot would benefit patients by giving them more freedom, choice and control over where they accessed care.

The scheme allowed patients who lived out of the pilot practice catchment area to either fully register with the pilot practice as an OoA registered patient, or be seen by a GP or nurse as a 'day patient' at a pilot practice. Participating practices were required to provide both the out of area registration and day patient options to patients.

From April 2012-March 2013, residents in England could register at any general practice that had volunteered to join the pilot scheme in the four PCTs, regardless of their permanent address. OoA registered patients were able to register with a GP practice participating in the pilot and to have access to all primary medical services provided by the practice, except home visiting and the provision of urgent care, which had to be arranged by the PCT where they lived. When a patient registered with a pilot practice the global sum funding for that patient was transferred to the pilot practice for the following year or the next payment period. The pilot ended in March 2013, but practices can keep their OoA registered patients (Department of Health 2013).

The pilot also included a second arrangement that enabled pilot practices to see patients, for non-urgent or routine care, if they were in the practice's area for less than 24 hours, as a 'day-patient.' Patients were able to attend a pilot practice as a day patient up to five times during the 12 months of the pilot. In this case, they remained registered with the practice near their home, which remained responsible for all their other general practice care. The pilot practice had to pass details of each consultation to the registered practice and pilot practices received a fee of £12.93 for each day patient consultation from a special fund provided to the PCT where the pilot practice was located. The new category of day patient did not alter the pre-existing arrangements for providing GP care to Temporary Residents or those requiring 'immediate and necessary' care (Department of Health 2012b). The day patient option was only available until March 2013. Additional funds were made available to participating PCTs in order to cover day patient visits, and any additional prescribing and referral costs.

The British Medical Association (BMA) had advocated for the inclusion of the day patient option because it provided access to non-urgent and routine care for patients without disrupting out of hours care and without adding complexity to referrals to community health services.

When introducing the scheme, the Department of Health had expected that most pilot patients would be away from their area of residence during the day (for example, people who commuted to work), but the pilot was available to anyone who wished to attend a GP practice participating in the pilot for whatever reason and at any time the practice was open (Department of Health 2012b).

Implementation of the pilot was planned to take place in Manchester Teaching PCT, Salford PCT, Nottingham City PCT, Westminster PCT, City and Hackney Teaching PCT and Tower Hamlets PCT which had volunteered for the pilot. However, the two PCTs in East London were eventually unable to participate (see Chapter 3 for more on this). In each of the PCT areas, GP practices were invited to participate in the pilot on a voluntary basis from April 2012 (Department of Health 2012b).

Evaluation of the pilot was one of the BMA's conditions when it agreed to a time-limited pilot scheme as part of the changes to the GP contract for 2012-13. Specifically, the agreement stated that the GP choice pilot '….would be subjected to an independent evaluation organized by the Department, with the results published and considered before further implementation.'

An independent evaluation was commissioned by the Department of Health to describe the uptake of the Choice of GP Practice pilot, and, as far as possible in the short time available, estimate its potential costs and benefits over the 12-month period, April 2012 – March 2013.

Aim, objectives and research questions of the evaluation

Aims

To describe the uptake of the pilot scheme, and give an early indication of its potential costs and benefits for participating practices and patients over a 12-month period, recognising that it would not be possible to quantify costs and benefits definitively over such a short time.

Objectives

The objectives of the evaluation were to:

- Assess the scale of patient demand to take part in the pilot and how the scheme was used by pilot patients
- Understand why patients chose to receive general practice care at practices within the pilot, their experiences of care at the pilot, and the perceived benefits and drawbacks to patients
- 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 and the benefits and disadvantages to practices
- Identify from participants an indication of the potential additional costs to the NHS, if any, of offering two forms of additional patient choice of general practice that could be set against the perceived benefits to patients.
- Review programmes and initiatives to improve choice and access to primary and urgent care in the English NHS from 1997-2010 to put the pilot in the context of past policy developments
- Put the pilot in wider context by reviewing similar developments in patient choice in Finland, Norway and Sweden, countries with general practice systems based on patient enrolment.

Research questions

The scale of demand for GP practice choice

1. How many practices and patients, and which types of patients (e.g. from other PCTs or from within other parts of the pilot PCTs), took part in the general practice choice pilot?
2. How many pilot patients took up the option to register out of area or to be seen as day patients at each pilot practice and what was their pattern of, and reasons for, service use (including use in their home area)?

3. Why and how did patients come to take up one or other of the options available at pilot practices (e.g. on what basis did they choose a specific pilot practice, what were they looking for in taking up the pilot option)?

The impact on patients

1. What were their experiences of care in the pilot practice and, as far as possible, in their original practice, during and before becoming involved in the pilot?
2. What benefits (e.g. greater convenience and choice, less time away from work, avoiding going to A&E) and drawbacks (e.g. communication delays or failures between practices, difficulties getting timely appointments with pilot practices, discontinuity between 'home' and pilot practice style of care, difficulties with pilot practice GPs' unfamiliarity with services in patients' home areas) did pilot patients perceive compared with their previous general practice care?
3. How well did patients in the pilot understand how the scheme worked in relation to urgent care, home visits, care when they were off work, etc. (i.e. when they may need general practice care near where they live)?

The impact on commissioners and practices

1. Why did pilot practices volunteer, or not, to take part in the scheme and what benefits (drawbacks) did they envisage and realise?
2. How much extra work did taking part in the pilot generate for practices, managerial, administrative and clinical staff? How was this managed and did it pose any difficulties (e.g. did pilot practices have to close lists, or increase waiting times for appointments)? Did pilot practices increase their opening hours and/or staffing?
3. Where, if any, were any additional costs to PCTs and practices being generated in setting up, promoting and running the pilot in the four PCTs (e.g. the costs of setting up an in-hours emergency service for residents registered with out of area pilot practices)?
4. Were any problems encountered by pilot practices in ensuring quality, continuity and safety of care (e.g. did pilot practices experience longer waiting times as a result of taking on more out of area patients)?
5. What were the additional costs to PCTs and practices of setting up, promoting and running the pilot in the three areas, and more widely, including any extra costs associated with patients who were able to receive care via more than one NHS general practice (e.g. the costs of setting up an in-hours emergency service for residents registered with out of area pilot practices) to set against the perceived benefits to patients?
6. How good was the communication between 'sending', and 'receiving' pilot practices and PCTs in relation to registration changes, (non-registered, out of area) service use, urgent/out of hours care, data transfer, etc.?

Options for improvements to the pilot

1. What suggestions for improvements to the scheme did participating patients and practices have relevant to extending the scheme more widely?
2. What can be learned from similar schemes for patient choice of general practice in other countries relevant to the design of any general practice choice scheme and its evaluation?
3. What are the preferences of members of the public for greater convenience over other attributes of general practice?

2. Methods

Overview

The evaluation covered the 12 months of the initial pilot period (April 2012 – March 2013). Data collection continued for a further four months after the end of the pilot period (April 2013 – July 2013). The evaluation comprised the following:

- Collation of basic quantitative administrative and clinical data on patients in the pilot (age, gender and postcode area for OoA registered patients, and additionally home practice, prescriptions and referrals for day patients)
- Semi-structured interviews with:
  - Patients choosing one of the pilot practices as a OoA registered patient or as a day patient
  - GPs and practice managers in pilot practices
  - Staff in pilot PCTs
  - A representative from the Local Medical Committee (LMC) in each area, where possible
- A web-based survey of clinical and managerial staff sent to all practices participating in the pilot
- A postal survey sent to all OoA registered and day pilot patients over 18 years of age
- A discrete choice experiment (DCE) to explore the determinants of choice of practice registration in different groups of the general population.

No attempt was made, given the very limited time available, to include a detailed quantitative costing of the pilot, though participants in practices and PCTs were asked about the work involved, where costs were generated and whether these were signficant. The evaluation also included, and was informed by, two literature reviews. The first was a review of the evidence of the impact of programmes and initiatives to improve choice of, and access to, primary and urgent care introduced to the English NHS from 1997 to 2010. The second was an international review of experience with choice of general practice and set of interviews with policy makers involved in similar schemes in other countries, to identify possible implementation issues of the English NHS pilot. These are in Appendices 1 and 2.

Ethical approval

Ethical approval to undertake the study was granted by the Northern and Yorkshire Research Ethics Committee (REC reference 12/NE/0245) and the research ethics committee of the London School of Hygiene and Tropical Medicine. We obtained local research governance permission from each PCT we worked with.

Quantitative administrative and clinical data analysis

Out of area registration

The National Health Applications and Infrastructure Services (NHAIS, now Health and Social Care Information Centre as at the end of March 2013) provided the evaluation team with anonymised administrative data for OoA registered patients in the pilot scheme. The NHAIS system identified participating patients using twelve text strings uploaded to GP Links by GP practices. From September 2012 to May 2013, NHAIS sent the evaluation team an Excel spreadsheet with the following information at the end of each month: PCT, new GP practice code, patient age, gender, and the first three or four characters of their home post code. This information is discussed in Chapter 3 and presented in Table 5.1 in Chapter 5. In the time available for a 12-month study, it was not possible to access any clinical information about OoA registered patients since this would have required negotiations to take the data directly from pilot practice computer systems.

During the evaluation, discrepancies between the number of patients reported by NHAIS and one of the pilot PCTs were noted. To rectify this, the PCT lead shared the NHS numbers of its recorded participating patients directly with the NHAIS contact for cross-checking, so the evaluation team did not access individual patient identifiable data. NHAIS corrected the discrepancy by manually amending the relevant patient records on a one-off basis. Our contact at NHAIS reported that the discrepancies resulted from variations in phrases used or typographical errors in the GP Links text string.[1] It was not feasible to manually amend individual patient records for the other three participating PCTs, so some OoA registered patients may have been missed in the data NHAIS provided. This problem had been anticipated during initial meetings with the GP Choice Network Group's IT committee in summer 2012. It was not possible to introduce the GP Practice Choice pilot as an option in the GP Links drop down menu for a pilot practice. It is thus possible that patient participation rates could have been higher than reported.

Day patients

PCTs (and from April 2013, NHS England Local Area Teams) received day patient forms from GP practices as part of the reimbursement process for day patient visits. They were responsible for removing identifiable information and passing this information to the evaluation team. These were collected in person, by post or through a secure web portal hosted by LSHTM at regular intervals during the evaluation. The day patient forms provided age, gender, registered GP practice (where applicable), reason for presentation, date of visit(s) and whether a prescription and/or referral was given. This information is presented in Table 5.9 to supplement the qualitative interviews in Chapter 5.

Day patient information-sharing presented particular difficulties for the evaluation because it was paper-based and contained identifiable patient data and clinical information. The pilot guidance included a template (see Appendix 3) for day patient data sharing which had to be adapted so that part of it could be provided to the evaluation team without identifiable patient information. However some practices did not use it or omitted clinical and identifiable information when submitting forms to the PCT for reimbursement. There were delays in obtaining day patient forms because of the time needed for PCT staff to collate and anonymise forms so that they could go to the evaluation team. In Salford, there was an under-count between PCT and practice-reported DP numbers. We were unable to resolve this after the PCT was dissolved on 31 March 2013. It is possible that there is an undercount of day patients in other PCTs if day patient forms were lost or not submitted to all PCTs before they were dissolved.

Interviews

Practice interviews

A condition of participating in the pilot was that a practice must also agree to be part of the evaluation. The research team conducted face-to-face interviews at 10 out of 43 practices with 15 practice staff and/or GPs. In some cases, the PCT nominated practices that were willing to speak with the evaluation team. In others, the PCT arranged interviews with practice managers and GPs selected by the team. Semi-structured interviews were conducted with a practice manager, and occasionally a GP, from at least two practices in each PCT. A second round of interviews of practice staff was undertaken with some practices in Salford and Nottingham. Consent forms and information sheets for practice interviews are available in Appendix 4.

1 The twelve string text phrases used by NHAIS to identify new OoA registered patients: choice pilot, choice scheme, OoA reg scheme, out of area pilot, out of area reg, out of area registration, out of area scheme, patient choice pilot, patient choice scheme, pc-ooa, pcs-ooar and pilot scheme.

The topic guide for these semi-structured interviews aimed to understand practices' reasons for taking part in the pilot; the potential benefits they foresaw; and their experience of the implementation process including their perception of the costs incurred by taking part. The second round or follow up interviews with pilot practice staff covered similar issues but included whether their expectations of the scheme were realised, any further support they would have liked and their plans for the future (e.g. if the scheme were rolled-out nationwide). Topic guides are available in Appendix 5. Interviews were transcribed and data were analysed using NVivo 10. Interview data were analysed thematically. First level coding was based on themes from the research questions and interview topic guides. Second level themes emerged inductively from the interview transcripts. The research team discussed initial themes before agreeing main themes and sub-themes for further analysis. Findings from these interviews appear in Chapters 4 and 7.

PCT staff and LMC representatives' interviews

The research team conducted 13 face to face interviews with staff at all four PCTs in the pilot. Some staff were interviewed twice (at the beginning and end of the pilot period). Interviews were semi-structured and focussed on the implementation process, communication with practices, and their perception of the actual and potential benefits and costs of the pilot scheme.

LMC Chairs from all of the pilot areas were invited to an interview and one interview was conducted. LMCs represent the interests of GPs in their localities to the NHS, and we felt their views should be included in the evaluation.

Interviews were transcribed and data were analysed using NVivo 10. Interview data was analysed through thematic analysis. First level coding was based on themes from the research questions and interview topic guides. The research team discussed initial themes before agreeing main themes and sub-themes for further analysis. Findings from these interviews appear in Chapters 4 and 7.

Patient interviews

The research team was unable to directly approach patients for interview due to ethical constraints and had to rely on PCTs and practices to communicate with patients. The research team produced a packet of information to accompany the invitation to be interviewed, which was provided to PCTs/practices to post to pilot patients. This included an introductory letter, details of the study and consent form. The letter provided reassurances about confidentiality, explained that participation was entirely voluntary and that their care would not be affected by their participation. If willing to be interviewed, patients signed a consent form and mailed it to the research team who then contacted the patient to explain the study in more detail and arrange an appointment for a telephone interview. The packet also included details of how the person could opt out of any further contact with the research team. This information packet is included in Appendix 6. Patients did not receive a follow-up request for interview because the research team was not permitted under the study's research ethics approval to initiate direct contact with patients to encourage their participation in the evaluation.

The evaluation team first approached PCTs on how best to engage patients. One PCT offered to contact patients directly. Thirty-five patients at three separate practices received an invitation packet to participate in an interview. No patients responded to this.

The second attempt to recruit patients involved asking PCTs to liaise with participating practices to approach their patients to speak to the evaluation team. In one participating PCT, all practices with any patients were instructed to contact their patients using the information packet supplied by the evaluation team (see Table 2.1 for details on recruitment process). Three participating practices confirmed they did so. In others, the contact information of willing practices was shared with the evaluation team. The evaluation team then approached these practices. Of these, four agreed to recruit patients. In total, eight practices helped the evaluation; 310 day and out of area patients received a single invitation explaining the evaluation's aims, an information sheet about the pilot, a consent form and stamped addressed return envelope. 26 patients responded to our invitation for interview; 22 ultimately conducted interviews by telephone while four others did not respond to phone or email requests to set up an appointment. The day patient postal survey asked respondents to provide their contact information if they were willing to speak to, or be contacted by, a researcher. Eight respondents provided their contact information; each of the 8 respondents who provided contact information were sent two invitations for interview, and two of them agreed to be (and were) interviewed. In total, 24 patients were interviewed following recruitment through practices and via the day patient survey. See Table 2.2 for further details on patients interviewed.

Table 2.1 Recruitment rate for patient telephone interviews by PCT

	Westminster	Nottingham	Manchester	Salford	Totals
All participating practices	22	7	8	8	**45**
Number of practices inviting patients	2	3	2	3	**10**
Number of patients invited	126	135	72	20	**353**
Number of patient interviews	8	9	7	0	**24**
Response rate	*6.3%*	*6.7%*	*9.7%*	*0.0%*	***6.8%***

Table 2.2 Patients interviewed

	Gender (N)		Age (N)			Economic status (N)		Health status (N)	
	Male	Female	18-34	35-54	55+	In work	Retired	Chronic condition	No chronic conditions
OARP	13	5	6	8	4	15	3	9	9
DP	3	3	3	2	1	5	1	1	5
Total	16	8	9	10	5	20	4	10	14

The interviews were semi-structured. Topic guides were informed by PCT and practice interviews and the concurrent literature reviews (available in Appendices 1, 2 and 5). The interviews sought to understand why patients had joined the pilot, how they had learned about it, their use of health services and their perceptions of the benefits and drawbacks of the scheme. Interview data were transcribed and analysed using NVivo 10.

Interview data were analysed thematically. First level coding was based on themes from the research questions and topic guide. Second level themes emerged inductively from the interview transcripts. The research team discussed initial themes before focussing the analysis on six main themes with five to eight sub themes. Findings from these interviews appear in Chapters 5 and 7.

Web-based practice survey

We developed a web-survey for practice managers or the primary contact person at every practice that participated in the pilot scheme. The survey was informed by the face to face practice interviews. The survey was administered using Survey Monkey; a copy can be viewed in Appendix 7. The questionnaire was comprised of multiple choice, short answer and open ended questions. Respondents could answer as many or as few questions as they liked. A total of 46 practice managers or GPs at 45 practices[2] were emailed. A total of 20 out of 45 invited practices completed the survey in full. A further three completed most of the survey; these results were included because of the short-form answer structure. In total, 23 of 45 practices (51.1%) responded to the survey. The web-survey was also able to capture the views of eight of the 11 practices with no participating patients. In total, one practice with no out of area registered patients, six practices with no day patients and two practices with no out of area or day patients answered the web survey; this included one practice that exited the scheme due to a fall in GP capacity. The survey results were exported into an Excel spreadsheet and coded using NVivo 10. The results of this survey are presented alongside the practice interviews in Chapters 4 and 7. Given the very limited time available for the study and the known difficulty of getting practices, especially GPs, to take part in research, it was not possible to interview or survey any of the practices in the four PCTs that had chosen not to take part in the pilot. It was judged that a lot of time and effort would be spent for little reward attempting to include these practices.

Postal surveys of pilot patients

The postal surveys of pilot patients were modelled on the current GP Patient Survey (GPPS), a survey administered by NHS England twice each year, giving patients the opportunity to provide feedback on their experience and a range of issues related to their local GP practice, to enable comparison with GPPS survey results for non-pilot patients in the same period (survey year 7, first wave, July to September 2012). Some GPPS questions were removed on grounds of relevance and some new questions were added relating to the pilot. Ipsos-MORI administers GPPS and also undertook the survey of pilot patients. Anonymised results were collated into an SPSS file and transferred to the research team. The results of the surveys were analysed in SPSS 20. Data from the pilot patient surveys were compared with data from GPPS patients not in the scheme but at the same practice, within the same PCT and across the whole of England. These results are discussed together with the qualitative patient interview data in Chapters 5 and 7.

Out of area registered patients

A survey of OoA registered patients over the age of 18 was undertaken toward the end of the pilot period (April-May 2013). The questionnaire was informed by early patient interviews. The Department of Health issued an honorary contract to Ipsos-MORI so patient information could be shared via N3 connection for the survey sample. The survey was piloted with five patients in three PCTs that answered the initial requests for qualitative interview. The survey sample included all patients over the age of 18, enrolled in the scheme for any duration from April 2012 to 13 March 2013 when the sample was drawn from the NHAIS database. Due to reported discrepancies in flagging

2 On the advice of our PCT contact, we included two additional practices that were keen to participate, but ultimately did not, in the sample.

OoA registered patients there was potential for under-coverage in the sample frame (see pages 22-23). Patients received an initial invitation to complete the survey. Two reminders were sent at approximately two week intervals from the initial invitation. All patients received a £5 note as a token of appreciation for taking the time to complete the survey. The survey and accompanying letters can be viewed in Appendix 8. Completed questionnaires were received from 315 of the 886 patients included in the sample, giving a response rate of 36% (which is higher than the response to the GPPS in these four PCTs). The data were corrected for non-response and weighted to match the age distribution of all OoA registered patients aged 18+ in the pilot.

Day patients

A survey of day patients was undertaken in June-July 2013. This survey was informed by early patient interviews with day patients in one PCT. The survey sample excluded all patients under 18 years of age (n=38) and those who did not provide home address details (n=24). We were conscious that in some cases, almost a year had elapsed since the patient's last or only visit as a day patient. The name of the practice they attended was included on the invitation letter. The initial invitation letter included a £5 note as a token of appreciation for the time spent filling out the survey. Patients received two reminders to complete the survey at two week intervals. The survey and accompanying letters can be viewed in Appendix 9. Completed questionnaires were received from 64 of the 188 patients included in the sample, giving a response rate of 34%. The achieved sample included a slightly higher percentage of women than did the issued sample (64.5% vs. 57.4%). However, due to the small achieved sample size, it was decided not to weight the data for gender, or any other variables.

In order to conduct the survey, the evaluation team required access to identifiable patient data on the day patient forms. To obtain access to this, NHS England elected to issue an honorary contract to LSHTM, so that LSHTM could conduct the survey for NHS England on a no-fee basis. There were delays in obtaining a data processing agreement because the Department of Health and NHS England were in flux.[3] There were multiple discussions with NHS England and Local Area Teams over who ought to grant access to the day patient forms. As a result, the survey fieldwork could not start until July 2013.

Discrete choice experiment (DCE)

Overall design

The design of the Discrete Choice Experiment (DCE) followed the currently recommended steps designed to ensure quality and internal validity of the experiment (Ryan, Gerard et al 2008).

The first important decision in DCE design is whether to use a labelled or unlabelled design (Hensher, Rose et al 2005). Given the focus of the pilot that allowed people to register with an out of area practice rather than the conventional option of a practice close to their home, we decided to use "practice in your neighbourhood" and "practice outside your neighbourhood" as labels in the DCE. This allowed us to define alternative-specific attributes and to test whether people would value these differently. Although we specifically tried to understand the potential appeal of allowing people to register outside their local practice boundaries, we realised that defining a geographical area with respect to practice boundaries was not very meaningful to most people (who are often unaware of the exact limits of their practice boundaries, which can change over time). Therefore, to convey the idea of "local" choice versus the possibility of choosing a practice not located locally, we defined the two practices as located inside the respondent's neighbourhood, and outside the respondent's neighbourhood.

3 This refers to the April 2013 reorganisation of the English NHS that saw the abolition of strategic health authorities (SHAs) and primary care trusts (PCTs), and the shift of responsibility for commissioning health care to CCGs. In this case, all data owned by the PCT was now held by the Local Area Teams and, by extension, NHS England.

The second step involves the selection of attributes and the definition of levels to include (Lancsar, Louviere 2008). In general, DCEs include five to eight attributes. Findings from the rest of the GP choice pilot evaluation (see Chapters 3, 5 and 7) and the review of policy interventions to improve access to primary care services (see Appendix 1) helped to narrow down the list to six attributes (see Table 2.3), which were thought to account for the majority of variation in choice that could be influenced by policy changes to improve access to GP services. After lengthy debates about the pros and cons of introducing a quantitative attribute (including the possibility this would allow of calculating trade-offs) to reflect the time that patients would have to wait before they could obtain an appointment with their GP, we decided to include a categorical attribute that would better reflect the different range of options, and in particular, would offer the possibility of having an open-ended limit. The categories also reflected the ones proposed in the NHS patient survey, which we could ultimately refer to in our simulation exercise.

For each attribute, levels were selected to reflect the current situation and possible improvements. We organised a small pilot with ten respondents (also members of the online panel used for the final survey). After they had completed the questionnaire, each panel member was debriefed by a trained qualitative interviewer over the phone. All interviews were recorded. During the debriefing interview, respondents were asked to discuss what mattered to them in the choice of GP practice, how they had understood each attribute proposed, the length of the questionnaire, their understanding of a practice being in or outside their neighbourhood, whether some descriptions were confusing, and whether they felt that some important aspects were missing.

Table 2.3 Design of the Discrete Choice Experiment

	Levels	
Attributes	**Practice in your neighborhood**	**Practice outside your neighborhood**
1. Whether the practice is open on Saturday and Sunday morning (8am-12pm)	• Yes • No	• Yes • No
2. Whether the practice is open at lunchtime (12-2pm)	• Yes	• Never open at lunchtime • Sometimes open at lunchtime
3. Whether the practice has extended opening hours – either 7-8am or 6-8pm	• Yes • No	• Yes • No
4. How quickly you can normally be seen by a GP in this practice	• Same day • Next day • A few days later • A week or more	• Same day • Next day • A few days later • A week or more
5. Whether the practice meets your specific health needs	• Yes • No	• Yes • No
6. How well the practice knows the health care services (e.g. hospital, community nurses, etc.) in your neighbourhood	• The practice has previous experience with most of the health care providers in your neighborhood	• The practice has previous experience with most of the health care providers in your neighborhood • The practice does not have previous experience with most of the health care providers in your neighborhood

A few modifications were made to the descriptions of the attributes and levels as a result of the pilot, but no major change was made to the list of attributes chosen. The attributes and levels are presented in Table 2.3.

In the third step of DCE development, we presented respondents with a forced choice (i.e. forcing them to choose between the two hypothetical practices in Table 2.3), and not offering the chance to opt-out by selecting another option (such as their current practice). This was motivated by our objective to understand the relative importance of different attributes in influencing registration choice.

The fourth step consists of combining the attributes into the various choice sets presented to respondents. We organised another small pilot, where 68 members of the online panel completed the DCE questionnaire (built upon an orthogonal design with zero priors). Using the Ngene software programme (Choicemetrics 2011), we developed a Bayesian D-efficient DCE design tailored for the priors obtained from the analysis of the (second) pilot data (Rose, Bliemer 2009). The complete set of forced choice scenarios is given in Appendix 10.0.

The questionnaire also included additional questions capturing socio-demographic characteristics of respondents, their description of the services offered by, and their satisfaction with, their current GP practice, their use of primary care services in the last 12 months, and their self-reported health.

Study population and survey implementation

We contracted the survey company YouGov, a specialist online market research agency operating a UK panel with over 400,000 members.[4] Because they rely on volunteers, web panels are not necessarily 'representative' of the general population and should not normally be used for studies which aim to provide accurate population estimates; however, they are often successfully used by market researchers for exploring consumer attitudes and behaviours, and they can also be useful for examining associations between variables and how these may vary between different sub-groups (AAPOR 2010). The survey was developed as an online tool and members of the panel were contacted by email and invited to respond to the survey. Separate ethical approval was obtained from the London School of Hygiene and Tropical Medicine Research Ethics Committee for this component of the evaluation.

The survey was completed by a sample of 2,431 individuals aged 18+. To be included in the survey, individuals had to be registered with a GP practice. Quotas were set on age within gender. In addition, we over-sampled three sub-groups in the population on the grounds that they might be more or less likely to take up the opportunity of registration at an out-of-area practice – people aged 65 or more; workers with a "higher level" of education (A-levels or more); and workers with a "lower level" of education (less than A-levels). We were particularly interested in exploring whether workers were more likely to be interested in changing their practice registration for convenience reasons, and whether this attitude differed between workers with higher and lower levels of education. By contrast, we also wanted to test whether older people would be more likely to value their local services and less interested in a practice further away from their neighbourhood. Appendix 10.1 presents the main socio-demographic characteristics of this sample.

Due to the over-sampling of certain categories of individuals, the socio-demographic composition of the achieved sample is clearly different from that of the population of England. Since the models used to analyse DCE data cannot use weighting, in order

4 As a means of thanking panel members for their assistance with research studies, YouGov volunteers receive points for completing web surveys; the accumulated points can be exchanged for a variety of vouchers, gift cards and/or merchandise. The number of points received per survey depends on the topic, length and complexity of the questionnaire.

to analyse the data on a sample that more closely resembles the general population in terms of age and sex, we randomly selected a sub-sample of 1706 individuals (from the 2431 in the full sample) to match Census distributions for age and gender.[5] The reconstructed 'general population sample' is used to perform the analysis of the preferences of the English population and includes 1706 individuals, whose socio-demographic characteristics are described in Appendix 10.2. Appendix 10.3 compares distributions on a number of socio-demographic characteristics for this general population sample with those from the 2011 Census for England.

Econometric analysis

To analyse data from this choice experiment, we used two types of models: a Random Parameter Logit (RPL) model and a Latent Class Model (LCM). The RPL model was used for both the analysis of the preferences of the general population sample and for the three sub-group analysis, while the LCM was used to investigate heterogeneity of preferences with regard to practice characteristics within the general population (i.e. it identifies different patterns of preferences in the population and identifies individual characteristics associated with these different preferences). Technical details of each model can be found in Appendix 10.4.

Each specification estimated with an RPL model included two types of variables:

- Characteristics of the two GP practice choices offered (estimated separately) as well as a separate alternative-specific constant,[6] associated with the alternative outside the neighbourhood (in order to estimate the general preference in the population for that option against the local one)
- Individual socio-demographic characteristics of respondents included as interaction terms with the alternative outside the neighbourhood, in order to investigate whether preference for this practice in general varies according to specific observed individual characteristics, likely to explain differences in preferences.

The second set of variables was included to test the extent to which some groups of the population might have different attitudes towards the option of registering at a practice outside their neighbourhood. In particular we wanted to test the following hypotheses:

- That individuals living in large cities (London, Birmingham, Manchester), might be more in favour of registering outside their immediate neighbourhood than people living in smaller urban areas
- That workers might be more likely than non-workers to register with a practice outside their neighbourhood, on the grounds of convenience
- That older people (aged 65 years or more), who are likely to be less mobile, would value GP services in their neighbourhood more
- That people less satisfied with their current (local) practice would be more likely to be interested in registering with a practice outside their neighbourhood.

Details of the model specifications are available in Appendix 10.4.

Coefficient estimates derived from the econometric models were then used to predict, under various circumstances, what proportion of respondents would choose a practice outside their neighbourhood versus a practice inside their neighbourhood. In essence, the model assumes that each respondent chooses the practice for which he or she has the highest overall utility, calculated as an additive function of the terms in the utility function (characteristics of the two practices defined in the scenarios associated with how much they are valued by individuals, as shown by the coefficient estimates).

5 We used the following five age categories: 18-29y, 30-39y, 40-49y, 50-64y and over 65 years. We actually replicated the age-sex breakdown of the English population for all age groups except the first one, where this would have been impossible to replicate without losing nearly 1,000 observations from the original sample.

6 Note that in the RPL models, this constant is estimated as a random parameter, in order to test for random heterogeneity. In all specifications the standard deviation associated with the mean coefficient estimate of that random parameter is not significant, and therefore we did not report it.

To evaluate the relative impact of making access to practices inside and outside the neighbourhood more convenient, we defined a number of scenarios differing in the types of practices available to respondents. These simulations included a baseline "average" scenario reflecting typical characteristics of GP practices available both inside and outside the neighbourhood: we assumed that individuals could choose between two practices that are able to offer same day appointments, are both open at lunchtimes, and both meet patients' needs, but neither one offers extended opening hours (either at weekends or in the evening), and finally the practice inside the neighbourhood has a good knowledge of local services while the practice outside the neighbourhood does not. Departing from this scenario, we estimate four scenarios:

1. Where the practice inside the neighbourhood is worse than in the base scenario: it is either quite busy (offering appointments only the next day or 2-3 days after) or not meeting the patients' needs
2. Where the practice inside the neighbourhood offers more convenient services than in the base scenario (and relative to the practice outside the neighbourhood)
3. Where a practice outside the neighbourhood offers more convenient services than in the base scenario (and relative to the practice inside the neighbourhood)
4. Where both types of practice offer more convenient opening times (extended hours and sometimes weekend opening as well).

It is important to note two things, with regards to these simulations. First, each one assumes that all respondents face exactly the same choice of GP practices, which is obviously not the case in the real world. Second, preferences are shaped by the choice sets that participants are presented with during the choice task, which also differ from the actual supply of GP practices available throughout the country. Considering these caveats, the simulations should not be interpreted literally as the impact that the introduction of a particular policy would have, but instead as a way of understanding the relative importance that respondents place on particular aspects of GP practice choice.

The findings are presented in Chapter 6.

3. Profile of the pilot practices

Characteristics of the pilot practices

In total, 43 practices participated in the pilot – between 8% and 38% of eligible practices in each of the PCT areas. In Westminster and Nottingham, practices in the pilot were similar to those that were not in the pilot. In Salford and Manchester, pilot practices tended to have larger average list sizes. In Manchester and Salford, pilot practices tended to have fewer patients over 65 years and more patients aged 20-64 years than practices not in the pilot. In Nottingham, pilot practices had a similar age structure to non-pilot practices, while in Westminster, pilot practices were a bit more likely to have patients over 65 years. Table 3.1 provides summary information on pilot and non-pilot practices.

Table 3.1 Pilot and non-pilot practices by PCT, October 2012

	Westminster		Nottingham		Manchester		Salford	
	Pilot practice	Not in pilot	Pilot practice	Not in pilot	Pilot practice	Not in pilot	Pilot practice	Not in pilot
Number of practices	20	33	7	56	8	94	8	43
List size: average[1]	4667	5141	5707	5446	6533	5580	6032	4650
Average % on list aged: <20	16.2	18.9	22.6	24.8	23.0	24.9	20.9	24.5
20-64	72.5	71.7	65.7	63.3	69.3	64.5	68.3	59.7
65+	11.3	9.4	11.7	11.9	7.7	10.6	10.8	15.8
Average QOF score[2]	944.35	926.36	979.56	958.38	975.57	945.85	976.25	943.21

1. The average list size excludes atypical practices with less than 300 registered patients: 5 in Westminster and 2 in Manchester.
2. Each PCT's average QOF scores are: Westminster, 933.85; Nottingham, 960.73; Manchester, 948.18; and Salford, 948.82.

Approximately 60% of the practices participating in the pilot offered additional services beyond core General Medical Services (GMS), including: substance misuse services; support services for ethnic minorities; refugees and asylum seekers; acupuncture; and sexual health clinics. The pilot practices included a range of organisational forms including single-handed practices (6 of 43) and practices with six or more affiliated GPs (9 of 43). Most of the pilot practices offered extended hours (defined as any clinic hours outside 8:00am to 6:30pm, for example, opening from 7:30am to 8:00am, or staying open until 8:00pm on weekdays), with seven practices offering extended hours three or more times a week, and ten of the pilot practices open during weekends. Some of the practices that had extended hours three or more times a week had high numbers of OoA registered patients. A few practices featured pre-existing Walk-in Centre facilities while functioning as ordinary practices. See Appendix 11 for further details of each of the practices participating in the pilot.

In all PCTs, QOF scores for pilot practices were higher than for non-pilot practices (Table 3.1). On average, practices in Nottingham had the highest overall QOF score (960.73), those in Westminster had the lowest (933.85), with Manchester and Salford in the middle and very close to each other (948.18 and 948.82 respectively). Overall, Salford's pilot practices appear to be higher performing practices, with just one scoring below the PCT average. Santos et al (2013) find that QOF scores predicted practice choice better than other routinely available measures of practice quality such as patient satisfaction or ambulatory care-sensitive admissions.

Patient uptake among participating practices

Participation rates varied between practices in all PCTs. Six practices enrolled the vast majority (71%) of all OoA registered patients in the scheme while most of the remaining practices (16/28 practices with OoA registered patients) each enrolled fewer than 24 patients during the pilot. Many (35%) of the participating practices did not register any OoA registered patients while two-thirds (65%) did not have any day patients. One practice accounted for almost half (46%) of all day patients. A quarter of all participating practices (n=11, 25.6%) did not have any OoA registered patients or day patients (see Table 3.2). Practice participation varied widely in all PCTs (see Table 3.3).

Table 3.2 Distribution of pilot practice patient numbers by PCT

	Out of area registered patients (OARPs)						Day patients (DPs)				OARPs & DPs	OARPs only	DPs only	No OARPS or DPs
PCT	100+	75-99	50-74	25-49	1-24	None	50+	25-49	1-24	None				
Westminster	4	–	1	3	8	4	1	1	6	12	6	10	2	2
Nottingham	1	–	–	–	2	4	–	–	5	2	3	–	2	2
Manchester	1	–	–	–	2	5	–	–	–	8	–	3	–	5
Salford	–	–	–	2	4	2	–	–	2	6	2	4	–	2
Total	**6**	**–**	**1**	**5**	**16**	**15**	**1**	**1**	**13**	**28**	**11**	**17**	**4**	**11**

Table 3.3 Pilot patient numbers by individual practice

PCT	Practice	OARPs	DPs	Practice QOF score
Westminster	Lees Place Medical Centre	52	12	997.02
Westminster	The Belgravia Surgery	153	0	993.93
Westminster	Crawford Street Surgery	0	0	992.74
Westminster	Dr Victoria Muir's Practice, Belgrave MC	3	0	986.67
Westminster	The Connaught Practice	22	116	984.70
Westminster	Marylebone Health Centre	142	21	984.04
Westminster	Cavendish Health Centre	5	3	981.30
Westminster	Dr Maher Shakarchi's Practice, Belgrave MC	0	0	980.18
Westminster	Harrow Road Health Centre	4	0	979.65
Westminster	Soho Square Surgery	161	0	979.17
Westminster	The New Elgin Practice	1	5	975.98
Westminster	Westminster Medical Centre	7	0	954.54
Westminster	West Two Health	12	0	941.67
Westminster	Half Penny Steps Health Centre	35	0	929.25
Westminster	The Marven Medical Practice	35	0	920.02
Westminster	The Medical Centre, Shirland Road	36	0	916.66
Westminster	Milne House Medical Centre	6	5	887.72
Westminster	The Garway Medical Practice	115	0	885.80
Westminster	Covent Garden Medical Centre	0	25	834.21
Westminster	The Mayfair Medical Centre	0	9	781.82

Table continued over page >

Table 3.3 *continued* Pilot patient numbers by individual practice

PCT	Practice	OARPs	DPs	Practice QOF score
Nottingham	Wollaton Vale HC	0	14	999.29
Nottingham	Bakersfield MC	0	1	992.57
Nottingham	Bilborough MC	1	18	989.21
Nottingham	Beechdale Surgery	0	0	988.35
Nottingham	Family Medical Centre	0	0	985.94
Nottingham	Windmill Practice, Sneinton Health Centre	1	13	957.1
Nottingham	NEMS Platform One Practice	119	6	944.45
Manchester	Tregenna Group Practice	0	0	996.77
Manchester	Borchardt Medical Centre	0	0	996.02
Manchester	Wellfield Medical Centre	12	0	990.64
Manchester	Oswald Medical Practice	0	0	987.05
Manchester	Arch Medical Practice	1	0	967.95
Manchester	The Docs Surgery	101	0	961.26
Manchester	Fernclough Surgery	0	0	958.71
Manchester	Charlestown Medical Practice	0	0	946.20
Salford	Mosslands Medical Practice	1	1	994.14
Salford	Clarendon Medical Practice	0	0	990.19
Salford	Sorrel Bank Medical Practice	2	0	984.63
Salford	Salford Care Centres – Irlam Clinic and Cornerstone Medical Practice	0	0	980.932[1]
Salford	Langworthy Medical Practice	29	0	980.92
Salford	Salford Medical Practice – Dr A Salim	23	1	978.34
Salford	Chapel Medical Centre	2	0	974.84
Salford	Blackfriars Medical Practice	27	0	921.33
Totals		**1108**	**250**	**–**

1. This practice has two sites. The QOF score above is the average of both sites.

As Tables 3.1 and 3.3 show, although average QOF scores for pilot practices were higher than for non-pilot practices, there was considerable variation at practice level. In Nottingham and Manchester, the practices that recruited the most pilot patients were below the average for the PCT. In Westminster, a practice with a QOF score below the PCT average recruited a comparable number of patients to those with the highest scores in the PCT. Although many above average practices joined the pilot scheme, over one in four pilot practices were below the QOF average for their PCT (although just one in eight were below average in Manchester and Salford).

Patients' characteristics and quality of patient experience from the GPPS

An important question relevant to the evaluation of the pilot was whether practices participating in the GP choice pilot scheme were more or less highly thought of by their patients than practices within the same PCTs who decided not to participate. In other words, if any differences in patient experience were identified could these be attributed simply to the fact that pilot practices were 'better' practices rather than the fact that patients derived greater benefit because they had been able to choose the practice. It was also important to know if, and if so, how pilot patients differed from non-pilot patients, again, in order to interpret their experiences of pilot practices.

In order to examine these questions, data from the GP Patient Survey (GPPS) were used. The GPPS is a large-scale survey funded by the Department of Health and undertaken twice a year (July to September and January to March). Each year, around 2.8 million patients (aged 18 or over) are sent a postal questionnaire asking for their views on making appointments at their practice, waiting times, satisfaction with opening hours, the quality of care provided by GPs and practice nurses, out-of-hours care, and their own current health circumstances. Our analysis used data from the first wave of year 7 GPPS collected between July and September 2012, and included completed questionnaires on nearly one million patients in England. We compared results from the 4721 GPPS patients in the 43 pilot practices with those from the 22,391 GPPS patients in the 224 non-pilot practices in the four pilot areas, as well as with all 982,999 GPPS patients.[7]

As can be seen from Table 3.4, patients in pilot and non-pilot practices were generally similar, with only small differences in age composition and employment status. Compared with patients in non-pilot practices in pilot PCTs:

- Patients in pilot practices were somewhat less likely to be aged 18-24 (7.7% v 13.7%) and more likely to be aged 25-44 (48.1% v 41.5%). This was found in 3 of the 4 PCTs (Westminster being the exception, where patients in pilot practices were more likely to be aged 45+)
- Patients in pilot practices were more likely to be in full-time work (46.9% v 39.7%). This was found in 3 of the 4 PCTs (Salford being the exception).

However, reflecting differences between the four pilot PCTs and PCTs in the rest of England, there were quite a few demographic differences between patients in pilot practices and all GPPS patients. Patients in pilot practices were:

- More likely to be male (52.4% v 48.9%)
- Much more likely to be aged 25-44 (48.1% v 35.0%) and less likely to be aged 65+ (14.4% v 21.8%)
- Much less likely to be White (76.1% v 87.2%)
- More likely to be unemployed (9.7% v 5.7%) or sick/disabled (6.7% v 4.7%) and less likely to be retired (13.3% v 21.1%)
- A bit less likely to be a parent (23.6% v 26.5%) or a carer (15.1% v 18.5%).

7 The GPPS analysis was weighted for unequal probabilities of selection and differential non-response, using 'wt_new' included with the dataset.

Table 3.4 Patient demographics: comparing GPPS patients[1] in pilot practices with non-pilot practices and all England

	Four pilot PCTs only		All England
	GPPS patients in pilot practices	GPPS patients in non-pilot practices	All GPPS patients
	%	%	%
Gender			
Men	52.4	51.3	48.9
Women	47.6	48.7	51.1
Age			
18-24	7.7	13.7	9.6
25-34	25.6	22.1	17.0
35-44	22.5	19.4	18.0
45-54	18.3	17.1	18.5
55-64	11.5	12.0	15.1
65+	14.4	15.7	21.8
Ethnicity			
White	76.1	73.4	87.2
Mixed	2.8	2.1	0.9
Asian	9.2	11.6	6.5
Black	5.6	6.4	2.7
Other	6.3	6.5	2.6
Economic status			
Full-time work	46.9	39.7	43.4
Part-time work	10.8	12.2	13.7
Full-time education	5.1	8.6	3.4
Unemployed	9.7	10.0	5.7
Sick/disabled	6.7	6.9	4.7
Retired	13.3	15.0	21.1
Looking after home	4.5	5.0	5.5
Other	3.0	2.7	2.4
Journey time to work (for those in work)			
Up to 30 minutes	57.9	58.7	59.4
31 minutes to 1 hour	28.8	28.8	24.8
More than 1 hour	5.8	7.6	10.1
Live on site	7.5	5.0	5.7
Parent			
Yes	23.6	26.6	26.5
No	76.4	73.4	73.5
Carer			
Yes	15.1	16.9	18.5
No	84.9	83.1	81.5

1. GPPS year 7, wave 1 (July to September 2012).

Within the pilot PCTs, there were no notable differences between patients in pilot practices and those in non-pilot practices in terms of their health (Table 3.5). They were also very similar in terms of health compared with all GPPS patients, which is perhaps surprising given the younger age profile of patients in pilot practices – for example, in reporting a longstanding health condition or having any of the listed medical conditions. This appears to be largely due to patients in the 45-64 age group in the four pilot PCTs being more likely than all GPPS patients in that age group to report a longstanding health condition, medical condition, etc. For example, in the four pilot PCTs, 56.0% of patients aged 45-64 had a longstanding health condition compared with 49.0% of all GPPS patients. This is likely to reflect the type of area (e.g. urban and relatively deprived) of the pilot PCTs.

Table 3.5 Health questions: comparing GPPS patients[1] in pilot practices with non-pilot practices and all England

	Four pilot PCTs only		All England
	GPPS patients in pilot practices	GPPS patients in non-pilot practices	All GPPS patients
	%	%	%
Smoking status			
Never smoked	52.4	54.5	54.3
Ex-smoker	24.8	22.2	27.1
Occasional smoker	10.0	9.6	7.6
Regular smoker	12.8	13.7	11.1
Longstanding health condition			
Yes	42.6	43.5	43.5
No	51.3	50.9	52.5
Don't know	6.1	5.6	4.0
Activities limited today			
Limited a lot	5.9	5.9	4.4
Limited a little	15.1	15.8	13.8
No	79.0	78.3	81.8
Any medical conditions			
None of the conditions asked about	44.2	43.5	43.2
Confident in managing own health			
Very confident	40.2	42.7	43.4
Fairly confident	49.4	47.3	49.4
Not very confident	8.8	8.3	6.0
Not at all confident	1.6	1.7	1.3

1. GPPS year 7, wave 1 (July to September 2012).

There were differences in patients' views of their practices (Table 3.6). One difference was that patients in pilot practices were less likely than all GPPS patients to report being seen on the same day as contacting their GP (27.4% v 36.2%) and more likely to report waits of a week or longer (19.0% v 13.8%). But in most other respects views were similar between patients in pilot practices, non-pilot practices in pilot PCTs and all GPPS patients. Within the four pilot PCTs, it therefore appears that pilot and non-

pilot practices are similar in terms of patient experiences and views. It also appears that they are quite typical of the average patient experience throughout England. This is important to know when interpreting data on patient experience from pilot patients themselves compared with non-pilot patients since it suggests that any differences observed are unlikely to be simply a practice effect (see Chapter 5).

Table 3.6 Patient views of their GP practice: comparing GPPS patients[1] in pilot practices with non-pilot practices and all England

	Four pilot PCTs only		All England
	GPPS patients in pilot practices	GPPS patients in non-pilot practices	All GPPS patients
	%	%	%
How long after contact before appointment			
Same day	27.4	31.9	36.2
Next working day	14.2	13.8	13.7
Few days later	35.7	36.2	33.1
Week or more later	19.0	14.8	13.8
Can't recall	3.8	3.3	3.3
How convenient was appointment			
Very convenient	46.6	46.7	47.6
Fairly convenient	45.3	44.6	45.3
Not very convenient	7.2	7.3	6.2
Not at all convenient	0.9	1.3	0.9
Overall experience making an appointment			
Very good	37.4	35.6	36.7
Fairly good	39.4	40.0	41.1
Neither	13.6	13.5	12.8
Fairly poor	6.5	6.7	6.2
Very poor	3.1	4.2	3.2
How long wait in waiting room after appointment			
Don't usually make appointments	4.3	4.1	3.4
Less than 5 minutes	9.8	9.5	9.9
5 to 15 minutes	54.6	53.1	57.7
More than 15 minutes	27.0	28.6	25.0
Can't recall	4.4	4.6	4.1
Satisfied with opening hours			
Very satisfied	42.6	40.4	40.1
Fairly satisfied	38.1	39.9	40.3
Neither	8.8	8.5	8.6
Fairly dissatisfied	4.8	5.1	5.2
Very dissatisfied	1.6	2.4	2.1
Don't know	4.1	3.8	3.6

Table continued over page >

Table 3.6 *continued* **Patient views of their GP practice: comparing GPPS patients[1] in pilot practices with non-pilot practices and all England**

	Four pilot PCTs only		All England
	GPPS patients in pilot practices	GPPS patients in non-pilot practices	All GPPS patients
	%	%	%
Are opening hours convenient			
Yes	77.4	76.9	77.5
No	15.0	15.6	16.0
Don't know	7.6	7.5	6.5
GP gives you enough time			
Very good	53.1	52.9	53.8
GP listens to you			
Very good	54.9	55.6	56.2
GP involves you in decisions			
Very good	45.2	43.9	44.3
GP treats you with care			
Very good	51.6	50.1	51.4
Confidence and trust in GP			
Definitely	64.7	65.8	67.8
Overall experience of surgery			
Very good	44.2	43.7	45.7
Fairly good	42.1	42.1	41.8
Neither	8.8	9.4	8.5
Fairly poor	3.9	3.6	3.0
Very poor	1.0	1.2	1.0
Recommend surgery			
Definitely	51.2	48.9	50.5
Probably	29.5	29.4	30.5
Not sure	9.7	11.5	10.3
Probably not	4.3	5.0	4.6
Definitely not	3.0	2.8	2.4
Don't know	2.3	2.5	1.7

1. GPPS year 7, wave 1 (July to September 2012).

4. How the GP Choice pilot was implemented by PCTs and practices

The findings in this Chapter are derived primarily from face to face interviews with PCT and pilot practice managers together with the web survey of practice managers or lead GPs in pilot practices.

Relationship between the GP Practice Choice pilot and other options for out of area GP care

Prior to the pilot, PCTs and practices were using a variety of mechanisms to provide general practice care to patients that lived out of the area, including:

- Temporary Resident scheme
- 'Immediate and Necessary' care scheme
- Practices with inner and outer boundaries
- 'Fringe list' arrangements
- At Practice Discretion and
- Private patients.

Table 4.1 provides a description of the eligibility criteria and services provided under each of these mechanisms plus the two options available under the GP Practice Choice pilot. The table makes it clear that the NHS already has a range of ways of responding to the needs of patients who require care outside their locally registered practice. It also shows the potential overlap between the conditions under which patients can use the different schemes.

Practices do not receive additional activity-based funding for patients that are seen as Temporary Residents and those requiring 'Immediate and Necessary' treatment, as they are obliged to provide services for these patients in their contracts. Practices manage the services they provide under these mechanisms very closely (for example, by only providing acute medical services to Temporary Residents, and not providing care beyond the required three-month period).

Practices are also able to register patients that live beyond the 'normal' practice catchment boundary as an outer boundary or 'fringe' list patient, or occasionally practices may allow a patient to register entirely at the practice's discretion. Practices are usually required to provide home visits to all patients on their registered list when clinically necessary. However, under the arrangements of the GP Choice pilot, home visits for OoA registered patients are provided by the home PCT.

Some practices were located on, or adjacent to, university campuses with a large number of students who lived out of the area. Students often remained registered with their family practice when they moved away to study, and when they needed treatment during term time would generally be seen as Temporary Residents. Where students were living outside the catchment area of the practice (for example, on the other side of the city), they could only be seen by the university practice if their needs were deemed to be 'Immediate and Necessary'.

Table 4.1 Range of mechanisms for providing primary care to out of area patients

	Eligibility criteria	Service provided	Example	Funding	Comments
Temporary Resident	A person who is living within the practice boundary for less than three months.[1]	Acute medical services only.	A person visiting a friend or relative for a few weeks, who requires treatment for a urinary infection. Can also include tertiary students who tend to retain their registration with their family practice.	The practice is not paid an additional fee for Temporary Resident consultations.	Practices would generally not provide e.g. an asthma review for a Temporary Resident, unless they were having an episode, and would not see the patient outside of the three month period.
Immediate and Necessary	Any person who requires immediate care.	Immediate or urgent care only.	Ear infection, emergency medication, injury, sexual health check.	The practice is not paid an additional fee for Immediate and Necessary consultations.	Practices note that demand for Immediate and Necessary consultations are likely to be lower in areas with Walk-in Centres.
Outer Boundary	A patient that used to live in the practice catchment area but has subsequently moved a short distance away. Practices may allow the patient to stay registered with the practice at their discretion.	Patients receive care in the same way as any registered patient, including home visits.	All primary care is available to outer boundary patients.	A registered patient on the practice list.	Some practices may also accept new patients from the outer boundary. Practices are not obliged to accept patients from their outer boundary.
Fringe List	An outer boundary that extends into an adjacent PCT area.	Patients receive care in the same way as any registered patient, including home visits.	All primary care is available to fringe list patients.	A registered patient on the practice list.	The PCT must grant the practice access to their patients. They will give the practice a code for the patients and place the practice on the Fringe List.
Practice Discretion	The practice chooses to allow the patient to register with the practice even though they live beyond the practice boundary, generally for very specific, and perhaps time limited, reasons.	Patients receive care in the same way as any registered patient. Practices are obliged to provide home visits.	A patient that used to live in within the practice boundary but has moved and there is a clinical need to keep the patient with the practice for a period of time, for example a mental health issue.	A registered patient on the practice list.	Practices are very careful to limit the number of patients they keep at their discretion as they are still required to provide home visits if necessary.

Table continued over page >

Table 4.1 *continued* Range of mechanisms for providing primary care to out of area patients

	Eligibility criteria	Service provided	Example	Funding	Comments
Private	Practices may accept patients that live outside the practice boundary on a private basis.	Patients may access a specific service and are seen outside of NHS hours.	Yellow fever services.	Privately funded by patient.	There was very little mention of private patients in the practice interviews.
Out of Area Day Patients under the GP Choice Scheme	Any person who lives outside of the practice boundary and visits the practice as an out of area day patient.	Patient may visit the practice up to 5 times in one year as a day patient, for any purpose. Some practices will not refer a day patient to other services.	Flu jabs, screening, diabetes checks, contraceptives, infections.	An activity based payment of £12.93 per consultation. Practices are reimbursed for no more than 5 consultations in one year.	The patient will remain registered with their home practice. A wider range of services are available to Day Patients than Temporary Residents and Immediate and Necessary.
Out of Area registered patients under the GP Choice Scheme	Patients who live out of the practice catchment area but want to register with the practice, for example commuters. May also include patients that have moved their home beyond the practice boundary and wish to remain registered with the practice.	Patients receive care in the same way as any registered patient. Patients may choose to be referred to services near their practice or near their home. Home visits are provided by their home PCT.	All primary care is available to out of area registered patients.	A registered patient on the practice list.	Similar to Outer Boundary, Fringe List and At Discretion patients, except that the practice is not obliged to provide home visits.

1. Practices also refer to a two week version of the Temporary Resident status.

The pilot areas

While six PCTs were involved in the very early stages of the pilot, it was implemented in only four volunteer areas: Westminster, Nottingham City, Manchester and Salford PCTs. The pilot was not implemented in the two East London PCTs – City & Hackney and Tower Hamlets (see Box 4.1 for details). The four pilot PCT areas are large city centres with high numbers of commuters. In addition, Salford and Manchester are adjacent PCTs that worked together very closely. Before the pilot, the PCTs provided a range of services for patients who lived out of the area, including Walk-in Centres and APMS (Alternative Provider Medical Services) practices that provided services on a walk-in basis.

In the three to four years before the pilot, Salford had been actively reducing the options available for urgent care services, closing two Walk-in Centres and the equitable access GP-led health centre to improve the quality of GP gate-keeping and reduce demand for urgent care services. The PCT considered the reduction of urgent care services to be a very successful policy initiative, and was concerned that the GP Practice Choice pilot was inconsistent with its previous approach. This PCT participated because they wanted to understand the local impact of the scheme if it were to be unrolled nationwide.

PCTs noted that any confusion generated by the pilot had "been exacerbated by the organisational upheaval[8] that we're obviously currently going through as well" (PCT manager).

Box 4.1 East London: the experience of the City and Hackney, and Tower Hamlets PCTs

While both City and Hackney, and Tower Hamlets PCTs were involved in the early stages of the development of the GP Practice Choice pilot, it was never implemented in East London.

The City of London is a centre of finance and employment with a small resident population of approximately 9,000 people. Hackney has a larger resident population than the City with approximately 230,000 people. The City receives up to 360,000 people who commute into the area to work each day.

The City and Hackney PCT had been concerned that commuters into the area had unmet need for primary care services (recently commissioning and co-funding research in this area (Public Health Action Support Team 2012)) and was interested in participating in the GP Practice Choice pilot. Past efforts to meet the needs of commuters included the Liverpool Street Walk-in Centre which was funded centrally by the Department of Health for five years.[9]

Although the resident population of the City is sufficient to sustain one or two GP practices, there was limited capacity at any existing City practice to absorb new users. Thus participation in the pilot was contingent on the establishment of a centrally- or PCT- funded 'pop-up' practice for the duration of the pilot. The PCT did not consider this barrier to be insurmountable.

In Tower Hamlets, the commuter population is significant but smaller than in City and Hackney, with 125,000 people commuting to Canary Wharf daily, and a

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8 This refers to the April 2013 reorganisation of the English NHS that saw the abolition of strategic health authorities (SHAs) and primary care trusts (PCTs) and shift of responsibility for commissioning health care to Clinical Commissioning Groups (CCGs).

9 The PCT decided against assuming financial responsibility for the Walk-in Centre following the five year period because there was no mechanism in place to re-charge commuters' home PCTs for treatment.

resident population of approximately 240,000 people. In addition, there was some provision of primary care services for commuters, with a Walk-in Centre at Canary Wharf. Unlike City and Hackney, there were two practices with capacity near Canary Wharf, which expressed interest in joining the pilot.

The primary barrier to participation in both PCTs was meeting the costs of services for patients with an out of area registration. Under the pilot, the PCT would be required to cover the costs of prescriptions and referrals for all OoA registered patients. The average commissioning costs for a patient in City and Hackney was then £2,000 per patient. Even if only one per cent of the commuter population were to register as an out of area patient, and their average commissioning costs were half those of the average resident in the area, the commissioning costs for OoA registered patients could easily have reached £3m. As the PCT was considered to be an 'over target' area (in terms of its fair share of NHS resources) and growth was low, there was no expectation of an increase in funding for the PCT in the short term. Thus the PCT was likely to be required to cover the costs of the OoA registered patients from within its current allocation.

While in some PCTs there is a possibility of the flow of patients into, and out of, the area balancing out, City and Hackney and Tower Hamlets PCTs considered this to be unlikely in the City and Canary Wharf. Given the magnitude of the commuter populations compared with the resident populations in these two localities, the PCTs were concerned that the potential impact of the costs of OoA registered patients on their budgets could have been significant.

Both PCTs were willing to accept day patients under the pilot because the majority of their primary care costs were recoverable within the pilot, and the PCTs were not required to cover the additional costs of day patients (although increased capacity would have been required and practices had expressed concerns about the day patient element of the pilot).

There were multiple efforts to resolve the financial barriers to participation. At the local level, both PCTs discussed with the CCGs (operating in shadow form) the possibility of capping the number of participants (e.g. to accept a predetermined number of patients or to halt participation when costs reach a predetermined sum) and using non-recurrent funds to underwrite pilot costs. However the CCG had alternate plans for these funds. At the national level, both PCTs explored potential solutions that involved provision of additional funding or underwriting of risk with the Department of Health, but these did not eventuate. Ultimately, no consensus was reached and the concerns about the potential costs associated with OoA registered patients resulted in the PCTs being unable to proceed.

In addition to the concerns about costs of the pilot, practices in East London were also concerned about the continuity of care for patients, information transfer, referrals to local community health services and the impact on their existing patients. The fee for the day patient consultation was also considered to be insufficient.

In future, both PCTs anticipate that the CCGs would resist the scheme unless there is a clear mechanism whereby money can follow the patient reasonably quickly or the financial risk is underwritten centrally. In addition, upfront investment may be required to increase capacity and minimise impact on existing patients.

Practices' decisions to participate in the pilot

In deciding whether to participate in the pilot, some practices were already aware of the demand for out of area services, as patients would regularly present at the practice asking for treatment, or existing patients would request to stay with the practice when they moved house out of the practice catchment area. For example, one practice manager described when patients "were leaving a residential area in the city centre and moving out to the suburbs but still working in the city, they would ask could [sic] they still be registered with us, because obviously for work purposes they'd be in town every day, and we would have to say, 'No', unfortunately".

While practices would refuse out of area patients who wanted to register with the practice, they would sometimes take patients as Temporary Residents or Immediate and Necessary. Practices were not always comfortable with that arrangement, for example as one practice manager said: "We've got no records on them at all, we've got no idea. In a way you feel uncomfortable, are you doing them harm or are you doing them good? So it was something we were struggling about, so we were waiting for the pilot and we were asking when the pilot was going to come up".

Some practices had explicit financial reasons for joining the pilot. For example some APMS practices have financial penalties if their list size does not increase[10] and some of the GMS/PMS practices described themselves as wanting to grow their lists, with one practice manager explaining they had "space to extend into for more doctors and more nurses". In addition, one PCT manager found that initially a number of practices were interested in joining the pilot because they "thought it was an opportunity to get income for Temporary Residents. There are lots of challenges around the number of temporary residents compared to what was originally built into the baseline. When it was clear that that wasn't the situation some of them fell by the wayside".

A number of practices described themselves as very active and always embracing change, saying 'Yes' to any new things that come along; and one practice was attracted to the feasibility test aspect of the pilot, wanting to prepare themselves, to "practise and learn how this would work, so that if somebody said, 'From the 1st April 2013 there are no boundaries', we were prepared" (Practice manager).

Practices also referred to the benefits for patients, enabling patients to have an appointment and not take time off work, and enabling a patient to stay with a practice if they moved outside the practice's catchment area.

One PCT manager noted that some practices were seeing out of area patients privately and joining the pilot was "a way to continue that, but with a bit more, sort of, access, because you could obviously do it during NHS hours, instead of saying to them, 'You'll have to come back outside of core hours'".

Initial concerns of pilot practices

While considering whether to participate in the pilot, a number of practices raised concerns about the day patient element. The day patient fee of £12.93 was considered to be very low given the anticipated workload resulting from the administrative requirements for day patients. Some practices had expected that the fee would be an "enhanced service type model, so that they would get a GMS rate and then an incentive payment on top" (PCT manager). In addition, the limit of five visits per day patient during the year was considered to be overly restrictive.[11] In terms of prescribing, there were concerns about patients 'double-dipping', seeking

10 Although in some parts of the country, practices have no difficulties in terms of list size, so increasing list size will not always be a motivation for joining the pilot.

11 While day patient data indicate that only a very small number of patients had visited a pilot practice multiple times, the postal survey of day patients indicates that more patients than reported may have visited a pilot practice multiple times.

prescription medication from more than one source, and that the home GP might be required to continue medication prescribed by the pilot practice, when the home GP might not have prescribed in the same way. GPs were also concerned about the possibility of 'doctor shopping', whereby patients would seek second opinions until they obtained what they wanted even if it was not necessarily in their interests; and that it would be difficult to manage safeguarding issues (for example, where a GP might suspect abuse of a patient as a result of frequent visits for certain types of injuries).

Practices expressed concerns about potential discontinuity of care for day patients, particularly about the potential difficulty of communication with the home practice. One practice manager was concerned about "who would be responsible legally, heaven forbid, if there was a mishap as a result of not good communication… if that fax doesn't make its way to the other practice…".

There was some suggestion that more practices would have been involved in the pilot if it had been limited to out of area registrations.[12] For some practices, the day patient requirements were the "....deal breaker. If it had not been for that, they [the interested practices] would have gone ahead with the pilot" (PCT manager).

With the out of area registration component of the pilot, practices were concerned about the home visiting arrangements and some GPs were uncomfortable with having another practice provide a home visit to a patient that they would be responsible for.

Practices raised concerns about the potential costs of referrals and prescriptions for patients that did not live locally and the potential impact on the budgets of practices and the PCTs. Some practices did not join the pilot because of the concern about the impact of a delay in payments for services delivered and practice budgets. While practice budget allocations are adjusted retrospectively (in some cases quarterly and in others annually), if the patient needs a referral it must be paid for at the time, "so with a small number of patients that might not necessarily be a problem, but if it was going to really take off then it would be" (Practice manager). While it was the PCT that would pay for the referral, practices were very conscious that the cost would be 'tagged' to their practice.

One PCT agreed with the CCG that if a practice was already having problems staying within its budget, the PCT would not allow them to join the pilot.

In addition, there was an implication that the out of area patients were likely to live in more affluent suburbs than the inner city areas of the pilot practices and there was a concern about funding prescriptions and referrals for these patients. Practices were also concerned about the potential demand of pilot patients and the impact on their existing patients (e.g. availability of appointments), and about raising expectations with pilot patients that the pilot would extend beyond the agreed 12 months. Practices were also concerned about the potential for migration of difficult patients towards pilot practices (for example, patients with particularly complex needs or substance misuse issues). Finally, some GPs "feel that they are the family doctor for that community and this type of arrangement cuts across that idea" (PCT manager).

Practices noted that when first considering potential involvement in the pilot they were not able to access clear information about various aspects of implementation (for example whether home visits were required, how community health services would be accessed and paid for, and the role of pregnancy services and midwifery). This meant that practices were unable to determine the full impact of the pilot on their practice and thus potential involvement in the pilot was less attractive.

12 As reported by practices involved in the pilot – the evaluation team did not interview any practices that declined to be involved in the pilot.

Implementation of the pilot

The Department of Health produced guidance (Department of Health 2012a) that outlined the actions required of PCTs and practices to implement the pilot (see Figure 4.1 for a diagram of the main requirements).

Joining the pilot

PCTs sent a letter to all practices in their areas, inviting them to express interest in being involved in the pilot. PCTs were very careful to ensure the letter emphasised the voluntary nature of the pilot. One PCT outlined the requirements of the pilot in the form of a locally enhanced service (LES) under the NHS general practice contract and practices were required to express an interest on that basis. Two PCTs described sending the letter either via the LMC, or with LMC endorsement. The PCTs then ran various meetings and workshops to discuss the pilot. These served several purposes, for example, to:

- Discuss the background, principles and objectives of the pilot with interested practices
- Discuss the pilot with other commissioning and PCT partners e.g. finance, patient data, Patient Advice and Liaison Services (PALS)
- Provide an opportunity for practices to raise concerns
- Distribute materials about the pilot to practices e.g. leaflets and guidance.

Some PCTs preferred to have DH attendance at the meetings and others were very keen for DH to not be present, emphasising the local implementation and local 'ownership' of the pilot initiative.

Some practices criticised PCTs for not always having clear information at these meetings and for overstating the level of publicity that DH and the PCTs would be able to provide to support the pilot (see Implementation – publicity for further details).

Practices were required to formally 'sign up' to the pilot. While there was some local variation, the sign up process was via a letter or a LES that detailed the requirements placed on the pilot practice. For example, Nottingham PCT took all relevant commitments from the guidance (e.g. to take part in the evaluation and provision of documentation for home practices) and put them in a letter. This was to make it clear what the commitment was, and to prevent misunderstandings later.

Some PCTs used assessment criteria during the expressions of interest process. For example, they "looked at them in terms of performance, not just primary care performance, but also how they were performing with their CCG colleagues in terms of spend, activity… were they high users of A&E…" (PCT manager).

Following the formal expressions of interest process, the PCTs provided training and workshops. Generally practices were not keen to begin accepting pilot patients until they had received training, and this caused delays of a few months in some instances.

Practice preparations for the pilot included training of staff, development of maps and lists of postcodes depicting the inner boundary, outer boundary, fringe list and potential pilot patient areas for reception staff, regular staff meetings, development and provision of information for patients, and trialling the administrative requirements of the pilot.

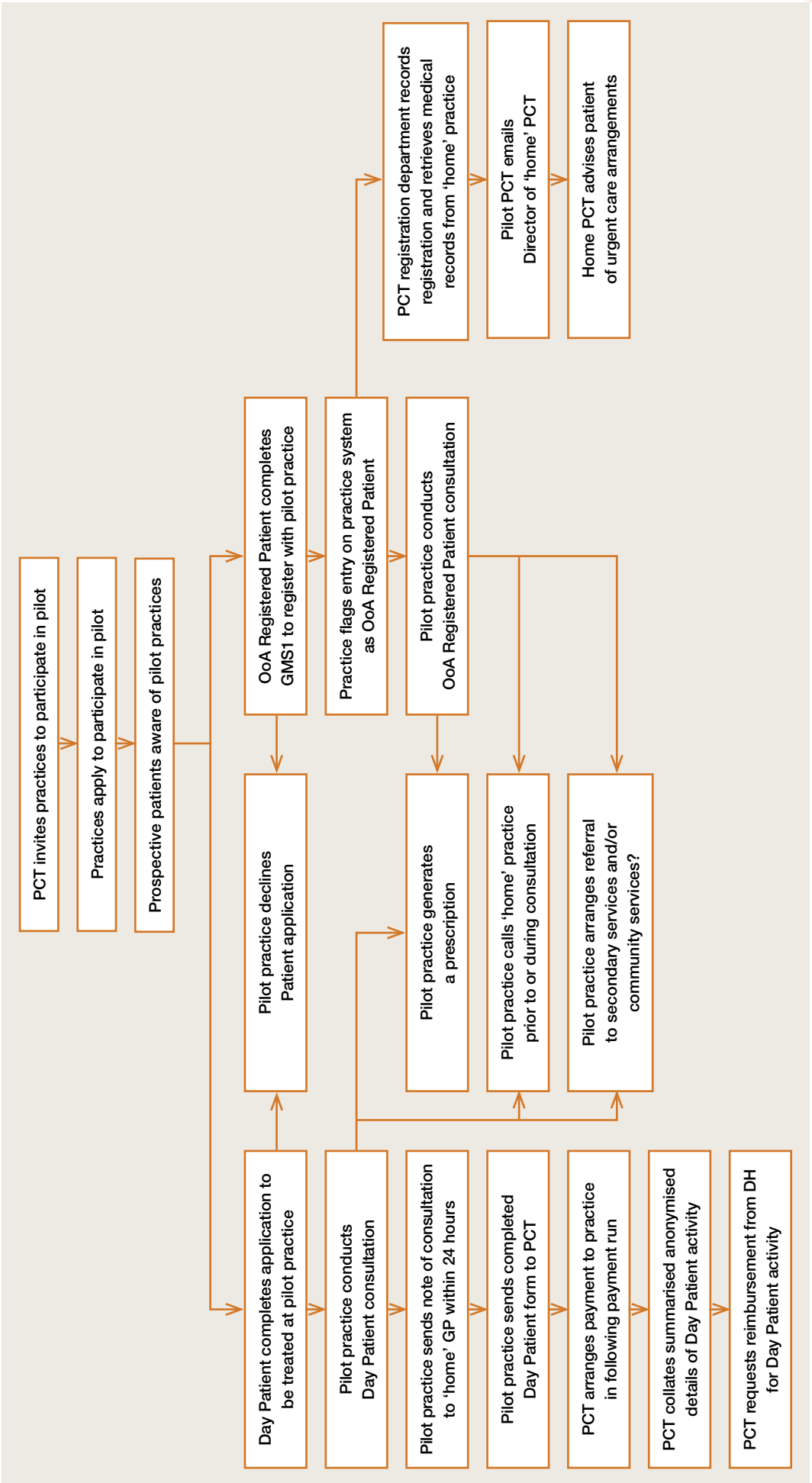


Figure 4.1 Overview of implementation of the pilot
(based on the main requirements specified in the guidance)

Administrative processes for out of area registered patients

While OoA registered patients included working commuters, practices found that existing patients who were moving their home beyond the practice boundary, but wanted to remain registered with the practice, were also able to register as OoA registered patients. Administration of these patients caused difficulties in some areas. Practices were required to de-register then re-register the patient as an OoA registered patient. Generally practices would make an adjustment on their practice system, notify the PCT and retain the patient records. However, one PCT required printed copies of patient records for any patient that was de-registered. In paper-light practices, this was a disincentive to de-register patients that were staying with the practice and they did not always tell the PCT that their patients were now living out of area (these patients would not have been included in the pilot evaluation as they would not be known to the system as an out of area registration).

One PCT did not consider that patients moving out of area but wanting to stay with a practice were eligible to be in the pilot. "So, if someone has moved out of their catchment area, we had said that that wasn't part of the scheme. The scheme was to register patients who didn't live there. So technically I suppose they could've de-registered them and then re-registered them, but I think we had that question about twice and we said 'No', that's not what the pilot's about" (PCT manager).

Practices varied in the way they recorded out of area patients on their practice systems. Generally reception staff would enter free text rather than a read code, which increased the likelihood of errors and made it difficult to search for out of area patients or to track and monitor them. One practice adopted an existing clean code on their EMIS system to tag its out of area patients.

Administrative processes for day patients

For each day patient visit, a Day Patient Form was meant to be completed at the pilot practice (see Appendix 3). The form contained details of the patient and their home practice, and details of the consultation. Under the guidance, the pilot practice was required to send a copy of the completed form to the PCT to trigger the activity-based payment, and within 24 hours to the home practice to provide details of the consultation. In addition, practices would sometimes seek information from the home practice prior to or during the consultation, obtaining, for example, a brief update on medical history and medication. The practices were not always able to contact the home practice within 24 hours. One practice did not send forms to the home practices at all, assuming that the PCT would forward the forms. In this case, the home practices were not aware that their patients had received treatment elsewhere.

Communicating with the home practice was particularly problematic when patients provided insufficient details of the patient's registered practice or doctor (which was not an uncommon occurrence). Occasionally, the pilot practice manager would search for the practice online to complete the form, but not always.

Many pilot practices described the administrative burden of the day patients, the time involved and the costs (see benefits and drawbacks). One practice noted that one of the reasons they preferred patients to register was "because the bureaucracy and the documentation seems difficult" for day patients.

Practice staff were very concerned about the security of the Day Patient Forms:

- Some practices used a protected mail system to send them to the PCT (a locked bag), while others preferred to scan the forms and email them

- Practices would sometimes telephone the home practice to check that someone was standing by the fax to receive the form, and then telephone again to check it had been received
- Some practices were uncomfortable with the clinical information on the forms being shared with PCT administrators to trigger the day patient payment.

As the pilot progressed, it became more difficult to identify the day patients in some practices. One practice manager described how day patients would "slip in with everybody else", particularly when patients could make appointments weeks or months in advance and it was difficult to differentiate the day patients from the OoA registered patients on practice computer systems. "I found that to be the most difficult bit of it. And it probably didn't work very efficiently if I'm honest. Anything major got over there, but probably not everything if I'm honest. It's very difficult to keep track of it" (Practice manager).

Alternative use of the pilot mechanism

The pilot mechanism was used in one area to enable the provision of primary care for residents of a recently established drug and alcohol treatment facility. The PCT said the facility was struggling to find a practice to provide care for its residents as the centre was in a rural area and not within any practice boundary. As the residents were thus effectively out of area for any existing practice, the PCT arranged for the primary care of the facility's residents to be provided by a specified pilot practice. Without the pilot mechanism, the practice could have accepted the patients at their discretion, but would have been required to provide home visits to the residents if necessary.

Referrals

Pilot practices were responsible for arranging referrals for day patients and OoA registered patients. There was some variation in the approach to referrals for day patients (unless the situation was urgent in which case they would always be referred). While some practices would refer a day patient in the same way as they would any OoA registered patient, others contacted the home practice and advised the patient to visit their home practice for further treatment and referral.

Many of the pilot practices provided a referral for one or more OoA registered patients during the period of the pilot. Where patients were referred to services that were local to the pilot practice, practices reported the process to be very straightforward. Under the pilot, patients were able to choose to be referred to a service close to their home, rather than the pilot practice, which presented more practical difficulties. For referrals to secondary care, pilot practices would use the Choose and Book system. Referrals to other services were more problematic. As with secondary care, pilot patients could choose to access community health services near their home (rather than near the pilot practice). Some pilot practices experienced difficulties referring to a range of services where they did not have a commissioning relationship. For example, practices had problems referring to midwifery and mental health services outside their PCT area.

Where the practice did not have a contractual relationship with a service via its local PCT, one practice described how they could use a hospital-based service if necessary. For example, if the patient chose to be referred for physiotherapy near their home (rather than near the practice), they could refer them to the hospital-based physiotherapy service through Choose and Book, "which wouldn't be great – it would be more expensive than the patient actually needed, but it's their choice. So that's the only way around it" (Practice manager). Practices also found that some services (for example, some midwifery and mental health services) would only take referrals from practices in their own areas.

It was the pilot practices' responsibility to arrange referrals, but in some areas it was anticipated that the PCT would provide support. As only a small number of referrals were made for pilot patients within the 12 months of the pilot, any problems were addressed as they arose. Some PCTs expected that referrals would become increasingly problematic were the number of pilot patients and/or the number of areas accepting out of area registrations to increase in future.

Home visits and out of hours care

For OoA registered patients, the home PCT was responsible for providing out of hours care and home visits. When patients registered as out of area, they received information about care at home from the pilot practice and also from their home PCT. As patients registered with practices, pilot PCTs would contact home PCTs to alert them that they needed to put the home visiting arrangements in place.

Practices and PCTs anticipated the requirement for home visits would be low because:

- People who registered as out of area patients were likely to be generally healthy
- "Students wouldn't expect a home visit anyway, it's very very rare" (Practice manager)
- Depending on the severity of illness and alternatives available, patients who were ill at home could dial 111, go to a Walk-in Centre or to A&E
- While practices and PCTs reported that very few home visits had been required in the initial 12 months, they considered the provision for home visits by the home PCT to be an essential part of the scheme and would be unable to accept out of area registrations without arrangements for home visiting in place.

The pilot PCTs were able to report on home visiting arrangements for pilot patients who were resident in the pilot PCT areas, but were registered as out of area registered patients elsewhere. For example, Manchester made arrangements for two practices that provide urgent care to unregistered patients, to provide home-visit primary care services to the whole city. Salford called for expressions of interest for provision of home visiting, and had two practices respond. Some practices indicated they were reluctant to provide the home visit service because their GPs did not want to travel.

Costs of provision of home visiting varied. One PCT paid a £500 retainer to each of four practices in the area for the 12 months, plus an activity fee of approximately £40 per visit. Another PCT paid a £250 per week retainer to one practice to cover the whole city, with no activity fee. While the actual costs are not significant compared with the overall commissioning budget, PCTs were concerned about value for money. The provision for home visiting had to be in place regardless of demand, and as very few practices were interested in providing the service, a PCT manager described having to "pay over the odds". In addition, it was considered to be a double payment, "Let's make no bones about it, we're paying twice. The patient would normally be seen by their own GP and we're actually paying for someone else to do the GP's job for them" (PCT manager). PCTs noted that more guidance on provision of home visiting might have been helpful.

Apart from the cost, other concerns with the home visiting arrangements for OoA registered patients included:

- The flow of clinical information back to the registered practice and potential delays in arranging urgent care
- The administrative burden of providing for home visiting, particularly if the pilot was to be extended or taken up widely across England.

In addition, practices providing home visiting services were concerned about potential demand given the travel distances, with one GP noting "if there had been an enormous amount of visiting required we'd have been really struggling".

One pilot PCT had an OoA registered patient from Wales. As the patient did not live in England, they did not automatically receive information about home visiting arrangements. The PCT contacted the appropriate health services in Wales and asked them to advise the patient as to the local arrangements where they lived.

Where patients have moved their home out of a PCT, but were staying with the current practice as an out of area patient, or where the patient had not previously registered with a practice at home, PCTs had problems arranging out of hours care with the home PCT, as the home PCT had no record of the patient since s/he had never registered with one of its practices.

Publicity

There were unmet expectations around publicity associated with the pilot. Initially some PCTs and practices were expecting DH would undertake some publicity of the pilot, and many practices were expecting PCTs to undertake publicity in their local area.

Some PCTs publicised the pilot to a small degree, for example issuing press releases and developing a brochure for practices to give to patients. One PCT manager was keen to provide clarity and manage expectations through its press release, and "tried to enforce that the GP Choice pilot isn't appropriate for students". Another PCT manager chose not to undertake any publicity, "encouraging practices to do their own". While some PCTs had no budget for publicity, others were concerned about generating high demand, and overwhelming practices with pilot patients. Publicity was also hampered by the fact that not all practices in an area had volunteered to join the pilot so, if successful, non-pilot practices might be approached by large numbers of people seeking access to the pilot.

Practice-led publicity included information on the practice website or in the practice leaflet, and posters in reception. A small number of practices visited large local employers. Many practices relied on word of mouth, or offered the scheme when patients walked into reception. "No one has been coming to us asking to go on GP Choice, they've come into the practice and we've said 'we're doing this scheme would you like to'…" (Practice manager).

Some practices were also concerned about generating high demand and becoming inundated with pilot patients, for example, "We wanted to just take that first small bite, get the processes in place rather than create too much demand and get completely flustered" (Practice manager). Other practices were unsure of what they were allowed to do and what was appropriate, "I did have some leaflets made and we were going to be looking at putting them in things like libraries, but you have to be very careful, you can't just put them through people's doors because it looks like you are trying to grab patients… that are registered at other surgeries…. You don't want to look as though you're desperate and we are really, really, busy" (Practice manager).

Benefits and drawbacks perceived by PCTs and practices

Management costs

The most significant costs of the pilot to the PCTs were attached to the staff time required to initiate and provide ongoing management. This was an opportunity cost rather than the cost of additional staff, as the work was generally squeezed into the day. During the initial phase of the pilot, PCT staff would attend meetings, develop and deliver training for practices, support practices and respond to enquiries. It was not unusual for PCT staff to visit practices, and for many practices to email at least once a week with enquiries in the early stages of the pilot. Estimates of PCT time costs varied, with an average of between 2.5 and 4-5 days a month. One PCT estimated time spent at half a day a week of senior management time, plus one day a week from the person responsible for day to day oversight of the pilot, for the first three or four months. Then as the pilot practices became more established the PCT support reduced to running the pilot in a business as usual phase, requiring 2-3 hours per week.

PCTs also provided finance services to reimburse practices for day patients and patient data services to manage the patient registrations, although the costs of these services for pilot patients were considered to be minimal as the systems were already in place. A PCT finance manager noted "it would take five minutes at most to manage the financial side from a PCT perspective". PCTs also incurred a small amount of direct costs for printing leaflets.

In terms of practice staff time, practices report costs in attending meetings; participating in the expressions of interest process; setting up administration systems; training staff; provision of data to the PCT; and doctors, nurses and administrators contacting the home practice or previous practice of the pilot patients. Generally practice managers required 10 or fewer hours to manage the setting up process, and 5 or fewer hours of GPs time. One practice paid £500 for temporary staff to help the practice prepare for the pilot. Some practices also had direct costs for printing patient leaflets and posters.

When discussing the potential costs of the pilot many practices raised the administrative burden, and associated costs of the day patients. While some practices considered the day patient fee to be about right, the majority of practices considered the day patient fee of £12.93 was too low, given the extra work required in administration, and that day patients often required a longer consultation or double appointment so that the doctor could take the patient history. Of those that considered the fee to be too low, a more appropriate fee was generally considered to be £15-£25.

For OoA registered patients, the practices describe the system as similar to a regular registration "it's the same routine, they've got to fill the form out, we put it on the system, they're registered, we just put in GP Choice patient and it's done. Obviously you take a couple of minutes just to explain you can't be seen out of hours, but they're fine. It's no different" (Practice manager).

Service costs

PCTs were concerned about the cost of provision of home visiting arrangements for patients registered with a GP outside their PCT and about the unknown future costs of prescribing and referrals for pilot patients. Practices were also concerned about the costs to the commissioner and the potential impact on their own prescribing budget. "If you've taken on 300 chronic disease patients over a period of six to nine months [from within the practice boundary], your budget is already bursting at the seams because they've not been taken care of within your set budget, and then you've got

the added pressure of prescribing to people who are not your patients" (Practice manager). Practices were also concerned about the costs of referrals (particularly for patients wanting to be referred to community services near their home), but, of the practices replying to the survey, many practices reported minimal costs of referrals, prescriptions and tests for day patients.

In addition, as day patients are not recognised in the QOF, any work on long term illness (e.g. a full asthma check) would not be recognised, and assuming the patient does not have a repeat asthma check at their home practice, the home practice would not receive the QOF points attached to that patient.

There was the possibility that day patients could generate duplicate costs if they visited their home practice and another practice as a day patient. PCTs did not track these costs anticipating that with small numbers these would have been minimal. One PCT manager noted that "there are bigger pressures on our system than the GP Choice pilot".

Financial and non-financial benefits

Approximately half of the practices that responded to the survey of practice managers and lead GPs considered the pilot to have benefitted their practice. Practices were more likely to identify benefits associated with the out of area registrations than with the day patient arrangements.

Prior to the pilot, patients that moved their home beyond the practice boundary, would generally need to be de-registered. GPs were particularly concerned if the patient had a long term condition and did not register with a new doctor. Under the pilot, these patients were able to remain registered with the practice and GPs "are really happy that they've got the opportunity to manage people, to stabilise them and then just to keep that steadiness in the quality and continuity of care" (Practice manager).

Some practices perceived that they benefited from having greater numbers on their practice lists. Although the OoA registered patients might not usually attract the capitation payment premium that might be attached to, for example, elderly patients, one practice manager noted that the practice received a premium for new registrations.

With one exception, practices and PCTs reported that there had been no negative impact on existing patients with the arrival of pilot patients in the practice. Often the actual number of pilot patients was very low, or where numbers of pilot patients were higher the practices were already growing at such a rate (some practices reported total new registrations at 6 or 7 a day, up to 20 a day, or up to 200 a month) that the relatively small number of pilot patients did not seem to have any additional impact.

The one practice that was the exception had used the pilot as a mechanism for accepting patients from a drug and alcohol residential treatment centre that was outside its catchment boundary. These patients had complex needs and generally required double-length appointments. While the practice was eager to grow their list size, it was concerned about impact on existing patients and had taken on locums and an additional GP (which they were planning to do anyway) to meet this demand.

Some practices reconfigured their clinical services by using a health care assistant to manage low level activity (e.g. blood pressure, registration health checks) so that they were able to manage increased demand, and a small number of practices put locum provision in place in case it was needed. Practices also welcomed the ability

to refuse registrations of out of area patients if on clinical grounds the patient required treatment near home (although the actual use of this provision is likely to have been very limited).

Practices also reported a positive impact on reputation and liked being able to accept patients they would otherwise have had to refuse:

- "It's good for the marketing and it's great for service because you don't have to refuse anybody. No one wants to be sent away, do they?" (Practice manager).
- "I have to say, it is something we have been wishing for years. Because of where we are and because we do get asked day in and day out… for us to be able to say, 'Yes. You can', on a regular basis, is just fantastic" (Practice manager).

One practice estimates they had benefitted financially from the OoA registered patients, "I think we've earned more than we've spent… A lot more, because if you look even at a list growth of thirty, and you look at what you get annually for those, on a PMS. It's more than my time has been so far…. What you've got then to understand, is that on top of that there is a lot more money to be made on patients, because if one comes in for minor surgery, we are then paid additional for that… and obviously the QOF" (Practice manager).

Practice and PCT staff considered that the cost to the NHS of a patient receiving primary care in a GP surgery was likely to be lower than if the primary care was to be provided at an A&E department of a local hospital or at a NHS Walk-in Centre. Although 42.4% of respondents in the postal survey of day patients reported that they would have attended A&E, a Walk-in Centre or an NHS Urgent Care Centre if the day patient option was not available, there is no evidence at this stage that the pilot has so far reduced demand on A&E, Walk-in Centres or other urgent care providers. The PCTs did not anticipate that any savings would result from the pilot during the first 12 months, but were unsure whether there would be any appreciable net increase in costs either.

5. Characteristics and experience of patients in the GP Choice pilot scheme

A total of 1358 patients participated in the pilot, a combination of 250 day patients (DPs in Table 5.1) and 1108 OoA registered patients (OARPs in Table 5.1) that had registered with out of area pilot practices (although not all the new OoA registered patients had necessarily used the services of their new pilot practice). The vast majority of both day patients (78%) and OoA registered patients (71%) used pilot practices in Westminster (which contained almost half of the practices – 20 of 43 participating practices, 46.5%). Basic details of all pilot patients are available from administrative records and are shown in Table 5.1.

Table 5.1 Patients participating in the pilot April 2012 to March 2013: administrative records

	Westminster		Nottingham		Manchester		Salford		Total	
	DPs[1]	OARPs	DPs[1]	OARPs	DPs	OARPs	DPs[2]	OARPs	DPs[1]	OARPs
Total number[3]	196	789	52	121	0	114	2	84	250	1108
	%	%	%	%	%	%	%	%	%	%
Gender										
Men	45.6	44.5	42.3	66.9	–	64.0	[1]	46.4	48.1	49.1
Women	54.4	55.5	57.7	33.1	–	36.0	[1]	53.6	51.9	50.9
Age										
<16	11.2	10.0	27.5	4.1	–	0.9	–	2.4	14.9	7.9
16-24	20.9	21.8	17.6	28.9	–	14.0	–	39.3	23.6	23.1
25-44	44.4	46.9	29.4	56.2	–	72.8	–	51.2	43.5	50.9
45-64	16.4	17.4	21.6	10.7	–	11.4	[2]	7.1	14.3	15.3
65+	7.1	3.9	3.9	–	–	0.9	–	–	3.7	2.9
Estimated distance from home to practice[4]										
< 1 mile	53.5	9.0	14.3	10.7	–	2.6	–	6.0	44.4	8.3
1 to < 2 miles	1.7	22.3	12.2	9.1	–	22.8	–	3.6	4.0	19.5
2 to < 3 miles	2.3	20.7	6.1	3.3	–	26.3	–	9.5	3.1	18.5
3 to < 4 miles	4.7	14.2	14.3	9.1	–	20.2	–	11.9	6.7	14.1
4 to < 5 miles	3.5	9.5	2.0	5.0	–	6.1	–	17.9	3.1	9.3
5 to < 10 miles	9.3	14.7	6.1	3.3	–	14.9	[2]	25.0	9.4	14.3
10 to <25 miles	7.6	5.2	4.1	51.2	–	7.0	–	19.0	6.7	11.5
25 to < 50 miles	5.2	2.8	10.2	5.8	–	–	–	3.6	6.3	2.9
50+ miles	12.2	1.6	30.6	2.5	–	–	–	3.6	16.1	1.7

OARPs, out of area registered patients; DPs, day patients

1. Several day patients have made more than 1 visit (14 in Westminster and 3 in Nottingham).
2. Because of the small number of patients in the base, the numbers are shown in brackets instead of percentages.
3. Cases which are missing information on a particular variable have been excluded from the base when calculating percentages, but are included in the total number row.
4. For OARPs, distance is estimated by looking at the distance between the GP practice's full postcode and the postcode district (i.e. the first part of the postcode up to the space) of the patient's home address. For DPs, the full postcode for the patient's home address has been used. Distance has not been calculated for patients who did not give a complete postcode for their home address or gave one in another country (a total of 24 in Westminster and 3 in Nottingham were excluded on this basis; the 3 in Nottingham were under 18 years of age so automatically excluded from the postal survey).

Overall, about half of the pilot patients were men and half were women, although the proportions varied somewhat by PCT. Day patients were more likely than OoA registered patients to be children aged under 16: 14.9% of day patients compared with 7.9% of OoA registered patients. OoA registered patients were more likely than day patients to be aged 25-44: 50.9% compared with 43.5% of day patients. Only a very small minority – just over 3% – of pilot patients were aged 65 or more.

In Westminster, the age profiles of day patients and OoA registered patients were very similar. This was not the case in Nottingham, where day patients tended to be either much younger (27.5% were children compared with 4.1% of OoA registered

patients) or much older (25.5% were aged 45+ compared with 10.7% of OoA registered patients). Nottingham's OoA registered patients were much more likely than day patients to be aged 25-44, with 56.2% OoA registered patients and 29.4% day patients. A majority of OoA registered patients were also in the 25-44 age group in Manchester (72.8%) and Salford (51.2%).

The distance between the patient's home address and the pilot practice was estimated using postcodes. For day patients, full postcodes were available; however, for OoA registered patients, only postal district (i.e. the first part of the postcode up to the space) was available for home address, so the distance data are a somewhat crude estimate for this group. For example, inner city residents visiting a GP practice close to their home address could have the same postal district as their pilot practice.

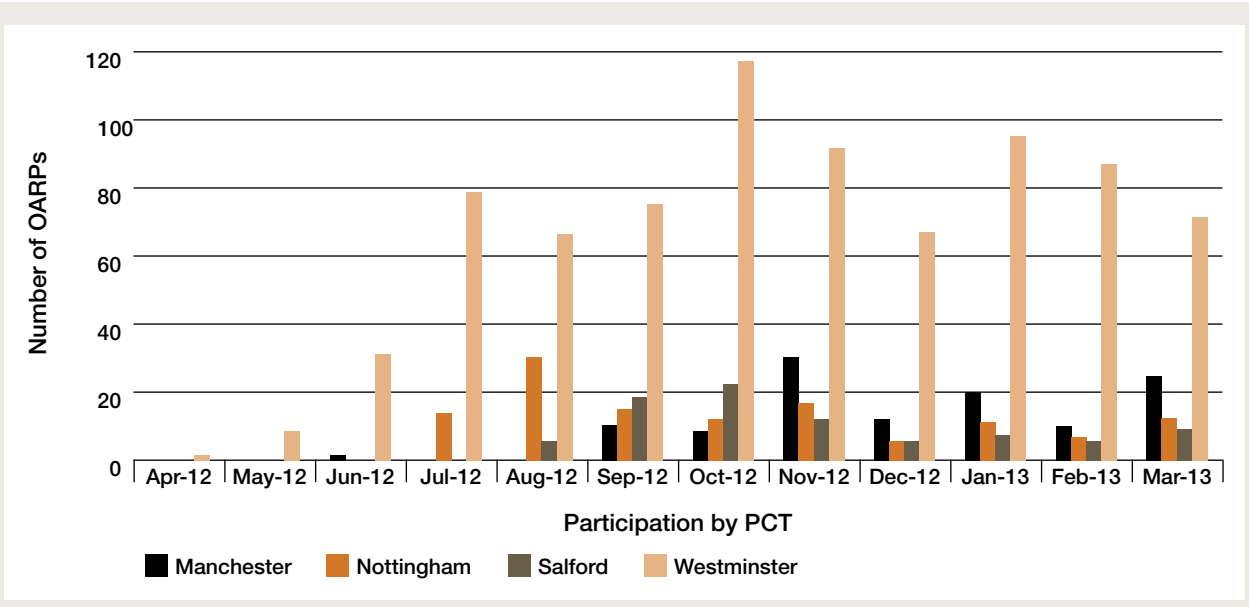
Overall, among OoA registered patients, those in Westminster were the most likely to live close to their out of area registered practice: 31.3% lived within two miles, compared with 19.8% in Nottingham,[13] 25.4% in Manchester and only 9.6% in Salford. Compared with OoA registered patients, day patients were much more likely to give an address either very close to the pilot practice (44.4% of day patients lived within one mile compared with 8.3% of OoA registered patients) or far away (25 miles or more) from the practice (22.4% lived 25+ miles away compared with 3.6% of OoA registered patients); the day patients' distance data are dominated by Westminster, as already highlighted.

Number of out of area registered patients

Manchester and Nottingham had similar levels of participation while Salford had lower overall participation (see Figure 5.1). Westminster dominated the OoA registered patient numbers throughout the pilot period. This was unsurprising as Westminster already had a list of patients, who had expressed interest in participating in the scheme ahead of the pilot, to be notified when the scheme began. Despite this, it took at least three months from the start of the pilot before new registered patient numbers rose appreciably.

13 In Nottingham, 41.3% of all OoA registered patients were from the same postcode area (based on the first 3 digits). We believe that most of these registrations are patients or staff of a residential drug and alcohol rehabilitation centre. This centre was not otherwise covered by a general practice and established an agreement with the pilot practice to provide care for all residents or staff of the centre under the scheme.

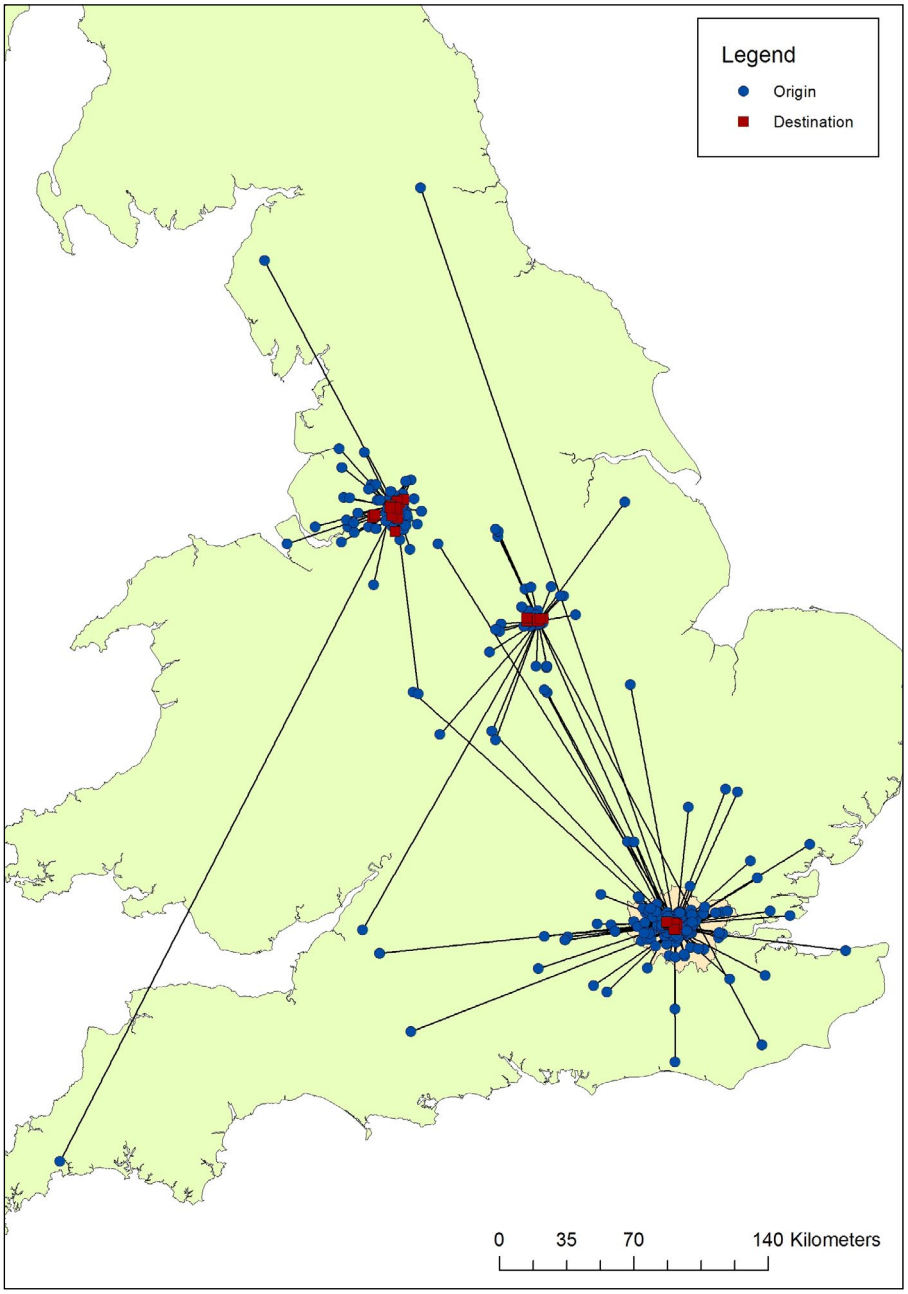
Figure 5.1 Number of out of area registrations by month (April 2012-March 2013)



Mapping out of area registered patients

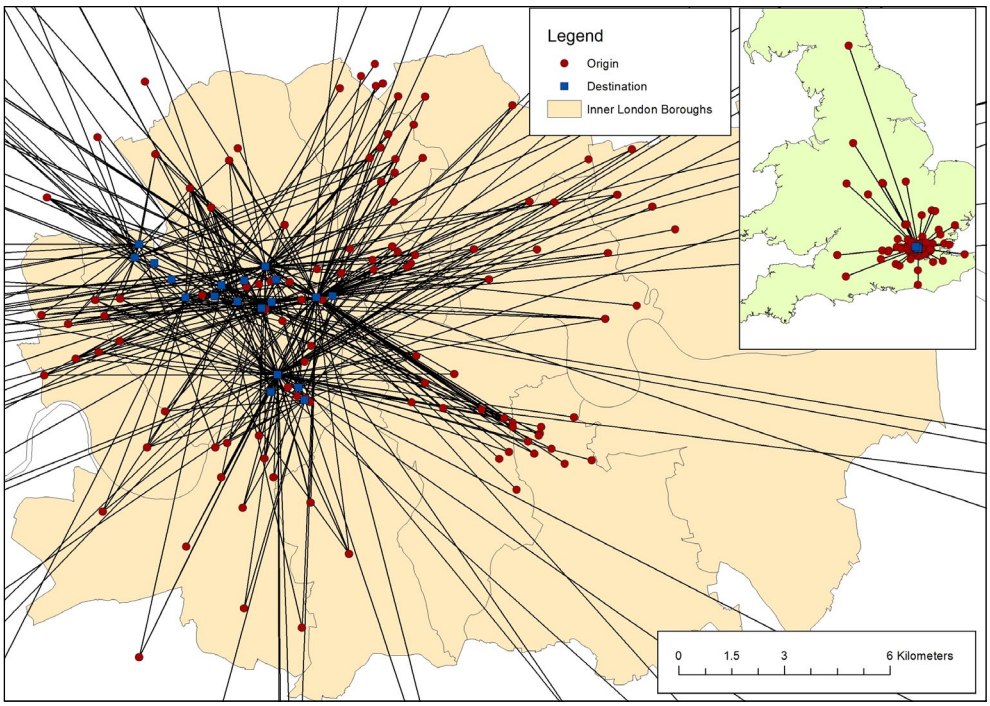
The majority of OoA registered patients lived in the area around Manchester, Nottingham City and London (see Figure 5.2). In all PCTs, some OoA registered patients lived in the surrounding commuter belt while a few were very far from their new practice (for example, Cornwall or Cumbria to Manchester, the Northwest or Gloucestershire to London).

Figure 5.2 OoA registered patients, England



In Westminster, the majority of OoA registered patients lived within London's inner boroughs, with many patients in the adjacent boroughs (see Figure 5.3).

Figure 5.3 OoA registered patients, London's inner boroughs



The characteristics and health of out of area registered patients and day patients

The analysis in Chapter 3 showed that patients in pilot practices were similar to patients in non-pilot practices in the pilot PCTs. But how did the OoA registered and day patients compare with existing patients in pilot practices? We compared OoA registered and day patients who completed our surveys (so only patients aged 18 and over) with all GPPS patients (administered to patients aged 18 and over) in pilot practices.

As Table 5.2 shows, OoA registered and day patients differed from pilot practices' ordinary patients in a number of ways:

- On average, OoA registered and day patients were much younger than other patients in the pilot practices (64.1% of OoA registered and 58.0% of day patients were aged 18-34 compared with 33.3% of GPPS patients in pilot practices)
- OoA registered and day patients were more likely to be in full-time work or education (65.8% and 9.5% for OoA registered patients and 65.6% and 8.2% for day patients compared with 46.9% and 5.1% of GPPS patients in pilot practices) and less likely to be retired (3.1% OoA registered, 8.2% day and 13.3% GPPS patients in pilot practices)
- Among those in work, OoA registered and day patients tended to have a longer commute time (66.2% and 60.0% respectively had a journey to work time of half an hour or more compared with 34.6%)
- OoA registered and day patients were much less likely to have dependent children under 16 (10.1% and 13.1% respectively compared with 23.6%) or to be an unpaid carer (3.8% and 8.3% respectively compared with 15.1%).

Table 5.2 Demographic characteristics of OoA registered and day patients compared with all GPPS patients[1] in pilot practices and with all GPPS patients in England

Aged 18+	All GPPS patients	GPPS patients in pilot practices	OoA registered patients	DPs
	%	%	%	%
Gender				
Men	48.9	52.4	47.0	35.5
Women	51.1	47.6	53.0	64.5
Age				
18-24	9.6	7.7	24.7	20.9
25-34	17.0	25.6	39.4	37.1
35-44	18.0	22.5	16.1	8.1
45-54	18.5	18.3	10.5	17.7
55-64	15.1	11.5	6.1	6.5
65+	21.8	14.4	3.1	9.7
Ethnicity				
White	87.2	76.1	77.4	77.0
Mixed	0.9	2.8	3.2	1.6
Asian	6.5	9.2	9.5	9.8
Black	2.7	5.6	3.8	3.3
Other	2.6	6.3	6.2	8.2
Economic status				
Full-time work	43.4	46.9	65.8	65.6
Part-time work	13.7	10.8	5.4	8.2
Full-time education	3.4	5.1	9.5	8.2
Unemployed	5.7	9.7	9.0	6.6
Sick/disabled	4.7	6.7	1.4	0
Retired	21.1	13.3	3.1	8.2
Looking after home	5.5	4.5	1.9	1.6
Other	2.4	3.0	3.8	1.6
Journey time to work (for those in work)				
Up to 30 minutes	59.4	57.9	30.5	40.0
31 minutes to 1 hour	24.8	28.8	52.7	37.8
More than 1 hour	10.1	5.8	13.5	22.2
Live on site	5.7	7.5	3.3	–
Parent				
Yes	26.5	23.6	10.1	13.1
No	73.5	76.4	89.9	86.9
Carer				
Yes	18.5	15.1	3.8	8.3
No	81.5	84.9	96.2	91.7

1. GPPS year 7, wave 1 (July to September 2012).

Table 5.3 compares the health status of OoA registered and day patients with GPPS patients from the pilot practices. Consistent with their much younger age profile, OoA registered and day patients were less likely than GPPS patients at the pilot practices to report: having a longstanding health condition (32.2% and 33.3% respectively compared with 42.6%); having any of the 16 medical conditions asked about in the questionnaire (67.9% of OoA registered patients and 57.7% of day patients had none compared with 50.1% of all pilot practice patients); or having a recent injury or illness (14.9% and 21.0% respectively, day patients not asked). Despite their younger age profile and better physical health, OoA registered patients were more likely than GPPS pilot practice patients to have visited a GP or nurse in the last 6 months (GP: 82.6% and 74.9%; nurse: 69.5% and 53.9%). This does not suggest, however, that OoA registered patients are more frequent attenders than other pilot practice patients; rather, this result is explained by the fact that most OoA registered patients would have come into the GP Choice Scheme as a result of their visit to the pilot practice. The survey does not in fact provide evidence on the frequency with which the OoA registered patients are likely to visit GPs or practice nurses. The qualitative interviews found that some OoA registered patients saw a GP and/or nurse 2-3 times in the past 6 months, but several of them said this was highly atypical for them and spurred by an acute health condition.

Table 5.3 Health status and GP visits of OoA registered and day patients compared with all GPPS patients[1] in pilot practices and with all GPPS patients in England

Aged 18+	All GPPS patients	GPPS patients in pilot practices	OoA registered patients	DPs
	%	%	%	%
Longstanding health condition				
Yes	43.5	42.6	32.2	33.3
No	52.5	51.3	64.6	61.9
Don't know	4.0	6.1	3.2	4.8
Recent illness/injury				
Limited a lot	4.4	5.9	4.2	*not asked*
Limited a little	13.8	15.1	10.7	*not asked*
No	81.8	79.0	85.1	*not asked*
Any medical conditions				
None	49.8	50.1	67.9	57.7
Last visit to GP				
Past 3 months	54.7	56.5	58.1	*not asked*
3-6 months	17.4	18.4	24.5	*not asked*
6-12 months	13.5	12.7	7.1	*not asked*
More than 12 months	13.0	10.1	4.6	*not asked*
Never seen GP	1.3	2.4	5.7	*not asked*
Last visit to nurse				
Past 3 months	35.5	36.5	45.6	*not asked*
3-6 months	17.0	17.4	23.9	*not asked*
6-12 months	16.1	14.2	9.9	*not asked*
More than 12 months	23.9	21.3	8.6	*not asked*
Never seen nurse	7.5	10.5	12.0	*not asked*

1. GPPS year 7, wave 1 (July to September 2012).

Experiences and views of out of area registered patients

Reasons for joining the GP choice pilot

The postal survey of OoA registered patients asked for the main reason patients had left their previous GP practice as well as why they had chosen the particular out of area practice they registered with.

Nearly two in three (68.3%) OoA registered patients said they had not changed their GP practice. It is likely that some of these people had not previously been registered (e.g. because they had recently moved to England), though there was no direct question on this in the survey. Of the rest, the main reasons given for leaving their previous GP were:

- The GP practice was not conveniently located (10.8% of OoA registered patients)
- They were not satisfied with the quality of the service at last GP practice (7.7%)
- The last practice did not have convenient opening hours (2.4%)
- Difficulties getting an appointment at the last practice or long waiting times (3.4%)
- The last GP had retired or died (0.5%)
- They wanted specialist care that the last practice had not provided (0.4%).

In the survey, the reasons given for choosing the current out of area GP practice included:

- Convenient location for place of work or study (42.6%)
- Convenient location for home (17.5%)
- The practice had been recommended by other health professionals, family, or friends (who may already have been registered there) (10.7%)
- Ability to be seen by the same GP every visit (5.3%)
- Liking the services and facilities offered by the practice (3.5%)
- Being able to make appointments at convenient times/convenient opening hours (3.8%)
- Short waiting times for appointments (0.7%).

Responses from these two questions were combined in order to categorise OoA registered patients into a number of types of users of the GP Choice Scheme:

Type 1: Patients who moved house but did not want to change their GP. This group comprised about one in four OoA registered patients (26.2%). From the interviews it was clear that many of these patients had longstanding relationships with their GP practices (up to 30 years in one case) that they wished to maintain after moving house. Some of these patients had moved out of the area some time ago without notifying their GP because they would have been forced to change practice if they had done so. A Type 1 patient who was interviewed said “I’ve been in this practice since I moved to the north… 18 years now” and “I was diagnosed with diabetes and I knew I’d be having a lot more contact with doctors… I thought I should tell them that I’d moved out of the area [over a year ago]” (patient interview, Manchester). A few of these OoA registered patients also said they would be reluctant to leave their GP practice unless they moved across England or to another part of the UK. One such Type 1 patient who was interviewed said “it was ludicrous for me to cancel my doctor with them, to find, to go and find a doctor nominally where my house is… in terms of one’s lifestyle, the common denominator is the Westminster area” (patient interview, Westminster).

Type 2: Patients who chose their practice for reasons of convenience (e.g. close to their workplace). This is the largest group, and includes one in three OoA registered patients (32.6%). One of the Type 2 patients who was interviewed said the scheme suited him "because this way, I don't have to take time off work to see my GP… now I can walk to the surgery within ten minutes, it's extremely convenient" and "I can go and see my doctor and be back at the office within half an hour, maybe 45 minutes… it is great for me, it is great for my employer" (patient interview, Westminster). Some of these Type 2 patients may have recently moved to the city (often from abroad or from elsewhere in the UK), and so may not have left a previous GP elsewhere in England.

Type 3: Patients who had recently moved to the neighbourhood and had registered with a practice nearby, but who lived outside its catchment. They comprised about one in four OoA registered patients (23.6%). As for Type 2, some of these patients had come from abroad or from elsewhere in the UK, and did not change registration. (This is in line with the distance data shown in Table 5.1, with over one in four OoA registered patients giving a home address within two miles of their practice, and nearly half within three miles.)

Type 4: Patients who were dissatisfied with their previous practice or, alternatively, gave a positive reason for choosing their current out of area practice (e.g. liking the services offered). They made up about one in seven OoA registered patients (13.9%). In the interviews, some of these patients said they had previously tried to change to another practice in the area where they lived but were either unable to find, or be accepted by, one. One patient said the scheme allowed her to leave the only GP practice in the area that covered her address. She actively tried to change practice because she was uncomfortable seeing her registered GP and had developed a cancer that required monthly visits to a GP and was unable to leave that practice until she learned about the scheme. Another was unable to register at another local practice: "I've been there for a number of years now and was never really that happy and there was nowhere in my vicinity where I lived that I could move to…in theory there should have been three other practices that were within my catchment area that I could've registered with, but all three of them said they weren't accepting new patients. Even though, in two cases, NHS Choices had listed them as accepting new patients." He felt the practices in his local area operated" some sort of informal agreement not to accept each other's patients" because they "frequently claimed that there was no right to change your GP practice" (patient interview, Westminster). Other patients said they chose their new practice because they were able to see the same GP on each visit, which helped them manage a chronic condition.

Type 5: A small number of OoA registered patients who could not be classified, mostly because of missing data in their answers to the questionnaire (3.8% of OoA registered patients in the dataset).

Younger OoA registered patients (ages 18-34) were most likely to fall in Type 2 (40.2%); OoA registered patients in the middle age group (35-54) were most likely to be Type 1 (38.7%), as were OoA registered patients aged 55 and over (30.4% were Type 1).

These categories were not mutually exclusive; the qualitative interviews illustrated that there was some overlap between types. For example, one patient who could be classified as a Type 2 or Type 3 patient had recently moved to a new area and chose a practice that was geographically close "from work, it's probably half a mile, and from home it's probably two and a half miles," because "my life is kind of based around the city, the centre of the city, and work, which is near the centre of the city. So it's more

convenient, and it has better opening hours and it's a bigger practice, and I like a bigger practice because there's more diversity, and more doctors, which can possibly specialise" (patient interview, Manchester).

When asked how they first heard of the GP Choice Scheme, many OoA registered patients could not remember how or even whether they had heard of the Scheme (23.9%). The most common response was to have been told about the Scheme by the practice when the patient first visited or called (35.6%), which was also commonly reported during the qualitative interviews. About one in five (19.5%) heard about the Scheme from other health professionals, family or friends. Given the minimal levels of publicity about the Scheme, it is not surprising that only small proportions of OoA registered patients mentioned any of the more traditional means of advertising:

- Reading about the Scheme on a website – either the pilot practice's own site (8.7%), the NHS Choices website (6.9%) or the PCT website (0.5%)
- Seeing a poster/leaflet (4.5%) or news report (3.6%).

In the qualitative interviews, OoA registered patients mentioned consulting NHS Choices, other internet sources and colleagues. A few visited multiple practices in the area before deciding which to register with. One OoA registered patient reported learning about the scheme at a local NHS walk-in clinic and another reported hearing about the scheme following a politician's speech and followed it up with the PCT.

The demographic and health characteristics of the four OoA registered patient types described above (leaving out the unclassifiable type) are shown in Table 5.4. Type 2 (convenient for work) and Type 3 (local outside boundary) were the most likely to be in the younger age group (18-34) while Type 4 (not satisfied with last GP) was the least likely to be in this age group (78.6%, 72.9% and 44.6% respectively). Given the definition of the Type 2 category, it is not surprising that they were the most likely to be in work or in full-time education (96.9%).[14] Types 3 and 4 were the least likely to be in work (about half of each type), but were the most likely to be in full-time education (13.1% and 16.6% respectively) or unemployed (17.2% and 13.5% respectively). Type 4 and Type 1 (did not change GP) were the most likely to report a longstanding health condition (38.6% and 36.6%) and to have one of the medical conditions asked about.

14 Out of Area registered patients in full-time education accounted for 9.5% (n=30) of all respondents and were found in all four patient types so are not identified as a separate type.

Table 5.4 Demographics, health status and GP visits by OoA registered patient type

Aged 18+	T1: Did not change GP	T2: Convenient for work	T3: Local but outside boundary	T4: Not satisfied with last GP	All OoA registered patients
	%	%	%	%	%
Gender					
Men	49.2	49.7	41.4	43.9	47.0
Women	50.8	50.3	58.6	56.1	53.0
Age					
18-34	50.3	78.6	72.9	44.6	64.1
35-54	39.1	16.4	16.6	42.4	26.6
55+	10.7	4.9	10.4	13.0	9.2
Economic activity					
Paid work	75.7	90.9	49.6	50.8	71.2
Full-time education	7.6	6.0	13.1	16.6	9.5
Unemployed	7.8	3.0	17.2	13.5	9.0
Permanently sick	1.6	–	1.5	4.9	1.4
Retired	3.1	–	7.4	3.0	3.1
Other activity	4.1	–	11.2	11.3	5.7
Has long-standing health condition					
	36.6	31.8	22.2	38.6	32.2
***None* of the listed medical conditions**					
	58.7	61.9	75.1	47.4	67.9
Visited GP in last 6 months					
	82.4	82.6	83.1	79.1	82.6

Out of area registered patients' views and experiences of care in pilot practices

OoA registered patients were asked to rate the importance to them of 11 aspects of a GP practice. In order of importance, their rating was as follows (the number in brackets is the percentage rating that aspect as 'very important'):

- Able to make appointments at time wanted (78.1%)
- Quality of the service (74.5%)
- Friendly/helpful staff (67.9%)
- Convenient opening hours (64.8%)
- Short waiting times for appointments (61.6%)
- Good reputation (46.4%)
- Convenient to place of work/study (44.0%)
- Quality of hospitals in area (44.0%)
- Being able to see same GP each visit (40.3%)
- Specialists or facilities available in surgery (31.9%)
- Convenient to home (21.9%).

As is clear from this ranking, there is a strong emphasis on convenience, service quality and helpful staff, all of which are similar to characteristics that people generally rank highly with respect to any type of consumer experience. This suggests that, at

least for this sample of OoA registered patients, patients seem to think of their GP practice in similar terms to other services they use, including those they pay for. It is also interesting, but not surprising for this particular group, that convenience to home was ranked at the bottom of the list; what may be more surprising is that, even for patients who chose to register out of area, over one in five (21.9%) still rate convenience to their home as very important.

Given the importance placed on being able to make appointments at convenient times, it is reassuring that over nine in ten OoA registered patients said the last appointment at their practice was very or fairly convenient (Table 5.5). While the proportion saying it was 'very convenient' is somewhat higher than all GPPS patients in pilot practices (52.5% and 46.6%), it is not so much higher to suggest they received a different standard of service (which is confirmed by the similarity in the length of time both these groups waited for their appointment). But OoA registered patients certainly had better perceptions of the overall experience of making their last appointment, with nearly half (47.1%) rating it as 'very good', compared with just over one-third (37.4%) of all patients in pilot practices.

Table 5.5 Making appointment at GP practice: Views of OoA registered and day patients compared with all GPPS patients[1] in pilot practices and with all GPPS patients in England

Patients aged 18+ that made an appointment to see/speak[2] with GP or nurse	All GPPS patients	GPPS patients in pilot practices	OoA registered patients	DPs
	%	%	%	%
How long after contact before appointment				
Same day	36.2	27.4	29.6	53.2
Next working day	13.7	14.2	10.3	12.8
Few days later	33.1	35.7	35.6	19.1
Week or more later	13.8	19.0	21.6	–
Can't recall	3.3	3.8	2.9	14.9
How convenient was appointment				
Very convenient	47.6	46.6	52.5	63.8
Fairly convenient	45.3	45.3	41.6	25.5
Not very convenient	6.2	7.2	3.8	6.4
Not at all convenient	0.9	0.9	2.2	4.3
Overall experience of making an appointment				
Very good	36.7	37.4	47.1	59.6
Fairly good	41.1	39.4	37.2	27.7
Neither	12.8	13.6	8.0	8.5
Fairly poor	6.2	6.5	5.5	4.3
Very poor	3.2	3.1	2.2	–

1. GPPS year 7, wave 1 (July to September 2012).
2. DPs were only asked if they saw a GP or nurse.

In the qualitative interviews, OoA registered patients referred to how accessible and accommodating their new practice was in comparison with their previous practice. They felt waiting times for appointments were reasonable and did not find it difficult to make an appointment at the time of their choice at short notice (same day or within two days) or several weeks in advance. These patients valued ease of access, and short waiting times for appointments. One chose his practice because reception said they were "happy to accommodate appointments with fairly short notice" (patient interview, Westminster).

Turning to patient experiences during the last appointment (either in person or by telephone) with a GP, OoA registered patients' views were very positive. As the results in Table 5.6 show, OoA registered patients were a bit more likely than all GPPS patients in the same pilot practices to pick the highest category of 'very good', but the differences were not statistically significant and both groups held very positive views. (The analysis in Table 5.6 is restricted to patients who had a GP appointment in the last 6 months.)

In interviews, OoA registered patients valued the quality of the service at their new practice and were happy with, and trusted, the care they received from GPs and nurses. One reported that "the nurses are fantastic. The GP, she sorted me out right away with my endometriosis… they really take their time with you as well. Nothing's rushed…" (patient interview, Nottingham).

Compared with all GPPS patients at the same pilot practices, OoA registered patients give more positive views of the practice overall. The results are shown in Table 5.7, again limited to patients who had visited (or spoken to) a GP or nurse within the last 6 months.

Table 5.6 Patient experience of the most recent GP appointment in the last 6 months: Views of OoA registered and day patients compared with all GPPS patients[1] in pilot practices and with all GPPS patients in England

Patients 18+ that saw/ spoke[2] to GP in last 6 months	All GPPS patients	GPPS patients in pilot practices	OoA registered patients	DPs
	%	%	%	%
How good was the GP at…				
Giving you enough time				
Very good	53.8	53.1	56.0	63.6
Good	35.0	33.0	33.3	30.3
Neither	7.7	9.1	5.4	3.0
Poor	2.2	2.7	2.3	30.
Very poor	1.0	1.9	1.8	–
Not applicable	0.3	0.2	1.2	–
Listening to you				
Very good	56.2	54.9	60.6	66.7
Good	33.8	32.5	30.9	30.3
Neither	6.5	8.0	5.2	3.0
Poor	2.3	2.7	1.2	–
Very poor	1.1	1.7	1.8	–
Not applicable	0.2	0.1	0.4	–
Explaining tests/treatments				
Very good	51.0	51.7	54.2	51.5
Good	34.4	32.6	30.9	39.4
Neither	8.9	10.0	8.0	6.1
Poor	2.0	2.4	1.2	–
Very poor	0.9	1.2	2.2	–
Not applicable	2.7	2.1	3.6	3.0
Involving you in decisions				
Very good	44.3	45.2	50.5	56.3
Good	34.8	32.4	29.7	25.0
Neither	11.5	12.0	10.4	12.5
Poor	2.7	3.3	2.0	3.1
Very poor	1.3	2.3	3.0	–
Not applicable	5.4	4.8	4.3	3.1
Treating you with care/concern				
Very good	51.4	51.6	59.3	60.6
Good	34.6	32.2	29.4	27.3
Neither	9.1	9.7	5.6	12.1
Poor	2.5	3.4	3.1	–
Very poor	1.4	2.3	1.9	–
Not applicable	1.0	0.7	0.8	–
Did you have confidence/trust in the GP				
Definitely	67.8	64.7	71.1	63.6
To some extent	26.6	28.2	22.2	30.3
Not at all	4.1	5.4	3.7	3.0
Don't know	1.6	1.8	3.1	3.0

1. GPPS year 7, wave 1 (July to September 2012).
2. DPs were only asked if they saw a GP or nurse.

Table 5.7 Overall experience of registered practice: Views of OoA registered and day patients compared with all GPPS patients[1] in pilot practices and with all GPPS patients in England (for those who had had a practice appointment in previous 6 months)

GPPS and OARPs aged 18+, who saw/spoke[2] to GP/nurse in last 6 months, DPs registered with a GP practice	All GPPS patients	GPPS patients in pilot practices	OoA registered patients	DPs
	%	%	%	
Satisfied with practice's opening hours				
Very satisfied	43.3	46.4	48.5	30.3
Fairly satisfied	40.1	37.0	39.3	45.5
Neither	7.8	8.6	5.2	12.1
Fairly dissatisfied	4.9	4.6	3.3	6.0
Very dissatisfied	2.0	1.6	2.4	3.0
Don't know	1.9	1.8	1.4	3.0
Are practice opening hours convenient				
Yes	80.6	80.9	86.2	71.9
No	15.1	14.2	10.1	25.0
Don't know	4.3	4.9	3.6	3.1
Overall experience of practice				
Very good	48.6	47.1	57.3	*not asked*
Fairly good	40.3	41.6	36.0	*not asked*
Neither	7.3	7.0	3.2	*not asked*
Fairly poor	2.9	3.3	1.0	*not asked*
Very poor	0.9	1.0	2.6	*not asked*
Recommend practice to others				
Definitely	53.4	54.3	61.2	*not asked*
Probably	29.0	28.5	28.3	*not asked*
Not sure	9.7	9.0	6.5	*not asked*
Probably not	4.5	4.3	1.4	*not asked*
Definitely not	2.4	2.6	2.6	*not asked*
Don't know	0.9	1.2	0.0	*not asked*

1. GPPS year 7, wave 1 (July to September 2012).
2. DPs were only asked if they saw a GP or nurse.

Although the differences in Table 5.7 are not large, it is an important finding in view of the much younger age profile of the OoA registered patients and the knowledge that younger patients tend to be more critical of their GP practice (Kontopantelis, Roland and Reeves 2010). This age gradient is found within the OoA registered patients but, as Table 5.8 shows, within each age band, OoA registered patients are much more likely to have positive views than all GPPS patients in pilot practices.

Table 5.8 Overall experience of practice: Views of OoA registered patients compared with all GPPS patients[1] in pilot practices, by age

Patients aged 18+ who saw/spoke to GP/nurse in last 6 months	GPPS patients in pilot practices			OoA registered patients		
	18-34	35-54	55+	18-34	35-54	55+
	%	%	%	%	%	%
Overall experience						
Very good	40.4	51.2	61.3	54.0	58.1	80.9
Fairly good	46.2	37.4	33.5	39.0	33.7	16.7
Neither	8.4	6.6	4.1	2.9	4.2	2.4
Fairly poor	4.0	3.4	0.7	1.2	1.0	–
Very poor	1.0	1.3	0.4	2.9	3.1	–
Recommend practice						
Definitely	49.3	57.7	63.2	55.2	67.5	80.9
Probably	32.8	24.2	23.5	34.3	20.1	12.0
Not sure	9.2	9.7	7.7	7.0	5.4	7.1
Probably not	4.9	4.0	3.1	0.6	3.9	–
Definitely not	3.0	2.8	1.0	2.9	3.1	–
Don't know	0.9	1.6	1.4	–	–	–

1. GPPS year 7, wave 1 (July to September 2012).

OoA registered patients were asked whether they thought their new out of area practice was better than their last practice. Among those who changed practice, three in five said their new practice was much (46.5%) or somewhat (14.5%) better than their previous one and one in four (23.8%) that it was about the same. Only a small minority said it was somewhat (3.0%) or much (2.6%) worse than their previous practice (with 1.6% saying in was better in some ways but worse in others and 8.0% not able to give an opinion). Among Type 4 (not satisfied with last GP) patients, three in four (73.2%) said their new practice was better, 16.8% said it was about the same, and only 2.0% said it was worse.

In interviews, some OoA registered patients who changed their registration said their new practice was better than their previous practice: "If I'd changed and it was like the practice I'd just come from I would have wanted to change immediately again." The pilot gave patients "access to a good quality practice which I wouldn't have if I could only register with the practice near where I live" (patient interview, Westminster). OoA registered patients who did not change practice said that the pilot enabled them to stay with a practice that was convenient and trustworthy. They felt confident that their practice was better because they are "quite diligent on check-ups every so often, on medication… in terms of its competence and management, I think it's first-class" (patient interview, Westminster).

Younger OoA registered patients who were interviewed did not hesitate to provide detailed descriptions on the quality of service offered. One who changed practices qualified his answer on overall satisfaction: "I think I've been three times, and one of the doctors I really like, and I really get on with, and one of them I didn't get on with so well, I felt he had less empathy" (patient interview, Manchester). Another said that her overall experience was good, but "my last appointment with my doctor, I don't believe I was given very good family planning advice, and I was waiting on a phone call, actually, from _____, that I've not yet had" (patient interview, Nottingham). Not surprisingly,

OoA registered patients who moved but did not change practice (Type 1), also held positive views of their GP; one young Type 1 patient said he did not change GPs because he was satisfied with the service received, "it's about the individual, rather than just being a number, rather than just being a bit of funding" and other GPs "are rushing you in and out, they don't have time for your problems, they throw a generic solution at a problem [depression]" (patient interview, Manchester).

Use of out-of-hours care

As described in Chapter 3, pilot practices are not responsible for the out-of-hours care of their OoA registered patients. However, given that many OoA registered patients live only a short distance from their registered practice (and within the same PCT), even if not strictly within its catchment area, this is not relevant to many OoA registered patients, since they will be covered by the same out-of-hours arrangements that would apply if they had registered with a practice within their catchment area (see Figures 5.2, 5.3 and Appendix 12). This no doubt partly explains why only a minority of OoA registered patients recalled being told that their registered practice was not responsible for their out-of-hours care (36.4%) or recall receiving a letter from the NHS about the out-of-hours GP service (26.5%). Many of the rest did not recall either of these: 34.9% did not recall being told, and 33.0% did not recall whether they received a letter.

During the interviews, OoA registered patients were asked about changes to their out of hours care arrangement. Many understood the changes, although a few said they could not remember or they did not know. Some recalled discarding or not opening letters from the PCT after changing their registration. Some OoA registered patients thought the out of hours provisions were helpful but unnecessary; they believed that they would receive better quality care at A&E if it were so urgent that it could not wait until working hours. Some OoA registered patients offered the view that expecting a 24-hour family doctor was outmoded. Several OoA registered patients were aware that out of hours care was contracted by the PCT so their registered GP was unlikely to provide out of hours care for them and felt it was not a justifiable reason to prevent people from accessing a GP practice outside the immediate area where they live. One felt the requirement for out of hours care was an insufficient argument against the pilot scheme, saying, "if there's something you need to go to the GP for, it's not something that's so bad you can't travel at all" (patient interview, Westminster).

In the survey, only a very small percentage of OoA registered patients (5.1%) reported using an out-of-hours GP service since registering with this practice (and no OoA registered patients in the qualitative interviews did). Of those who used an out-of-hours service, 73.3% said it was very or fairly easy to make contact with the service by telephone and 64.9% said the time taken to receive care from this service was about right. Among this small group, 56.5% rated the out-of-hours service as very or fairly good, 30% said it was neither good nor poor, and 13% rated it as fairly or very poor.

Experience of referrals

OoA registered patients were also asked whether their GP referred them to a range of services since registering out of area. In the survey, a majority (56.1%) of OoA registered patients had not had any referrals. The most common referrals were for x-rays or other tests (27.8%), a physiotherapist (6.2%) and sexual health services (5.7%).

In the interviews, none of the OoA registered patients who had changed their registration received a referral to secondary care. OoA registered patients who had not changed practice continued to see the same specialist or team for on-going

treatment (e.g. monitoring cancer in remission, chronic conditions). Some of those who were referred had private medical coverage and any ongoing treatment was not disrupted as a result. Others who were referred reported no difficulty in accessing the providers they were referred to.

Attending practices as a day patient

Under the GP Choice Scheme, patients may be a day patient before registering out of area, or they may be both an OoA registered patient and a day patient at another practice. In our survey of OoA registered patients, nearly one in five said they had also been a day patient, 11.5% at the practice they then registered with and 8.0% at another GP practice (although we are not able to tell if this was before or after they became an OoA registered patient). Over two-thirds (68.5%) said they were not a day patient, while 12.1% did not know or could not remember if they were.

Use of other local services

In interviews, OoA registered patients were asked about their experiences with other local services since enrolling at their new practice, or in the past year if they did not change their registration. Some patients had visited A&E for acute conditions (such as a sprain or bone fracture). A few OoA registered patients who changed their registration used a Walk-in Centre before their new registration was complete or were informed about the pilot scheme at a Walk-in Centre. Patients who did not change their registration reported using a Walk-in Centre outside of normal working hours because their practice was closed or they were temporarily away from the area where they lived. Some patients called NHS Direct or 111 for reassurance when they had the flu or gastroenteritis. One patient went to Boots, because it was more conveniently located at a local train station, for a flu jab and paid a "very small fee" (patient interview, Westminster).

In participating and non-participating PCTs, several OoA registered patients encountered difficulties communicating with, or accessing, local services for non-urgent care in the area where they lived. Local practices (correctly in terms of the pilot) told these patients they could not access any services at their local GP practices unless they changed their registration back to a local practice. In one case, a patient living in Westminster conducted a phone consultation with her registered GP in Nottingham. The registered practice told her to contact a local practice to issue the prescription on their instruction, but all local practices contacted said this was impossible unless she re-registered. Ultimately, she sought a Walk-in Centre to resolve the issue. This patient could have been referred to a practice accepting day patients or an out of hours service. In another case, the patient explained the scheme to a local practice in a non-participating PCT, but "got a very abrupt response saying 'Absolutely not. You either register here or there is nothing we can do.'" He felt that this was "bizarre" since he was aware of "provision for occasional or urgent requests" when people visit relatives or holiday in seaside towns. It was also possible that the practice he was registered with did not explain the changes to his care in the area where he lived (patient interview, Westminster). These cases suggest that there may be a role for the day patient option, or a walk-in service, to be available in all areas for OoA registered patients.

Perception of local practices

In interviews, patients were asked to describe what they would do if the scheme was not available to them. Most said they would register with a local practice if forced to but described them in disparaging terms, for example, "the local practice is a one, if that (on a scale of one to ten)", (patient interview, Westminster) or "heard not such

great reports of some of the doctors nearby here" (patient interview, Manchester). They described local GP practices as difficult to access, having rude or unhelpful staff or providing poor quality care (for example, failing to organise annual health checks for patients aged 40+). Many OoA registered patients who did not change their registration referred specifically to their partner's or family's experiences at local practices, as places where they do not receive "very good health care" (patient interview, Westminster) or faced major barriers to access, saying: "at one point we had to go to the emergency room for him to see a doctor because he really didn't have access to his own" (patient interview, Westminster).

Negative perceptions are not unexpected from those who changed their registration because they were dissatisfied with their previous local practice. One of these patients said his negative experience with a local practice was hardly surprising because "to be fair to them they were also overwhelmed with demand in the local area [referring to an area of high deprivation]" (patient interview, Westminster).

However, some OoA registered patients who did not change practice expressed neither positive nor negative sentiments if forced to change to a local practice. They felt that having to change to a local practice would be inconvenient given their lifestyle, but they were willing to do so if the pilot did not exist. Others felt the local practice, while geographically closer, was inconveniently located given local transport linkages (e.g. trains to London are more frequent and accessible than local buses in London's outer boroughs).

Out of area registered patients' views on the benefits of the scheme

From interviews, OoA registered patients described the main benefits and drawbacks of the scheme in relation to continuity, convenience and choice of where to access services.

Continuity of care

OoA registered patients who did not change said the scheme enabled them to stay with a practice that they trusted and is sensitive to their health status. Continuity of care was important to patients who had a serious health incident, chronic condition, bereavement or major life transition. Some examples:

- One had recently suffered a stroke and felt that his practice helped to "draw out that [his] levels of fear and anxiety are above the norms" (patient interview, Manchester) instead of just prescribing statins.
- One has a history of depression and felt he benefitted from staying at a practice where "they could see by my mood, my state of mind, that [an antidepressant] wasn't working – in fact, having a stimulant anti-depressant as opposed to a sedative anti-depressant was probably causing me to be worse" (patient interview, Manchester).
- One was recently widowed for the second time and praised the personal support he received from a practice where he had a long-term relationship.
- One patient recently retired but still volunteers with his former employer. He chose to remain with a practice that was familiar with his medical history, his complications from drug interactions and the hospital where he received cancer care and which continues to monitor his remission. He felt the scheme had "on-going health benefits to me to continue remaining active in an environment which is good for me" (patient interview, Westminster) in reference to his transition to retirement and move away from central London.

Retired OoA registered patients believed the pilot afforded them greater continuity of care. They expressed anxiety about a "massive switch to possibly a new structure and a new time table" (patient interview, Westminster) if they had to move away from the practice where they had a pre-existing relationship. Others seemed more anxious about being "forced to stay" in a local practice that is "not to your liking" (patient interview, Westminster) than in having access to a practice near one's home.

Patients who changed their registration also valued seeing the same GP at each visit. At previous practice(s), one said "I never saw the same doctor twice, I think, in 10 years," (patient interview, Westminster) while another encountered health complications related to multiple chronic conditions from never seeing the same GP "because I've seen a different doctor every time when I kept going back because obviously you can't get to see the same doctor when you ring up for emergency appointments. All of them did different things. They said different things. And advised me differently as well what to do" (patient interview, Nottingham).

Convenience

The GP Choice scheme was largely targeted at working age commuters and, as the survey showed, many OoA registered patients valued attending a practice that was convenient for their working hours or location. In interviews, most OoA registered patients who were still working identified convenience as a major advantage of the scheme. In all areas, the scheme seemed especially suitable for patients who lived in outlying suburbs but worked in the city; in Westminster, many patients also lived in an inner London borough. Some of these patients commuted for 45 to 75 minutes each way and said it was inconvenient to take a morning off work for a short appointment at a GP practice near their home. OoA registered patients who commuted felt they could only visit the GP near their home at the start or end of each day. Even if they booked the first appointment at 9am, they would still be unable to reach work until 10:00 at the earliest. Having a GP practice close to work, however, meant they could book an appointment any time in the day and only lose 30-45 minutes rather than an hour or, often, considerably more (depending on how early they normally start work).

The scheme was also suitable for patients with multiple work locations. One patient with two office locations felt that the benefits of the scheme far outweighed any drawbacks because it ensured that she was eligible to receive care in the PCT where she lived although she was registered near her other office location since work required her to spend "two nights away a week, three days. I don't think that would be tenable without this… if you're in two places regularly then having been registered at one doctor and not being able to access services in the other, it doesn't really work." Otherwise she would be "locked out of any London kind of services" (patient interview, Nottingham). This belief was shared by other interviewees whose work requires them to be highly mobile for three to five days of the working week, or have to move around on short-term working contracts while linked to a 'head' office's main location.

This was particularly important for some patients with chronic conditions who needed to make regular visits to the practice and felt the scheme afforded greater privacy since they no longer needed to take long periods off every three to four weeks. One patient said "you want to keep those things private, it's just easier if nobody knows you're actually going to the doctors" (patient interview, Nottingham).

Some OoA registered patients who were retired appreciated being offered a choice of practice for reasons of convenience, e.g. those who still did a bit of part-time work or who volunteered (e.g. in the city centre). Some lived on the outskirts of London, but

because they had free public transportation (Freedom Pass), cost was not a barrier for older people who wished to remain with a practice in central London with whom they had a longstanding relationship. One patient lived next to a National Rail station with direct services to London, which he found more convenient than using the several buses needed to reach his local practice. These experiences may be unique, but not limited, to London's commuter belt where patients have access to frequent, rapid train services. Meanwhile in Nottingham and Manchester, convenience varied outside of regular commuting hours. For example, patients said that commuter trains run during peak hours but not during the working day so it is not possible for patients to get into those cities using public transportation during off peak hours, necessitating more time away from work, arranging for someone to drive them, having access to a vehicle or booking a full day off.

One OoA registered patient said her working hours are long and not flexible and even practices with extended hours are closed before and after her working day. The pilot scheme allowed her to visit the GP during lunch so she decided to stay with the city centre GP practice near her workplace, even though she recently moved from the city centre. She foresaw drawbacks to this arrangement during her upcoming maternity leave, but didn't feel she would change practices during her year on leave. Although she had moved out of the practice's catchment area, her new home was not so far away that her referrals for a chronic condition or midwifery services shifted.

Exercising choice

The ability to choose a high-quality service was valued by OoA registered patients. Some Type 4 patients that changed their registration felt the scheme allowed them to leave a practice they would otherwise be tied to or did not want to be registered with. They believed they had exhausted all their local options. Although patients have recourse to the PCT when no local practices will accept them, it appears that many patients are unaware of, or reluctant to use, this.

Out of area registered patients' views on the drawbacks of the scheme

Most patients viewed not having access to home visits as the main drawback of the scheme. No patients who were interviewed felt that this was a sufficient drawback to discourage them from taking part in the scheme. Patients in all age groups did not think they were likely to need a home visit unless they were incapacitated.

A few patients experienced drawbacks with the scheme, with several choosing to leave after initially registering as an OoA registered patient. For example, one survey respondent left the scheme after falling ill at home. This patient used NHS Direct for advice and reassurance while ill, but then decided that having a GP near their home was preferable (survey respondent, from free-text box at end of survey).

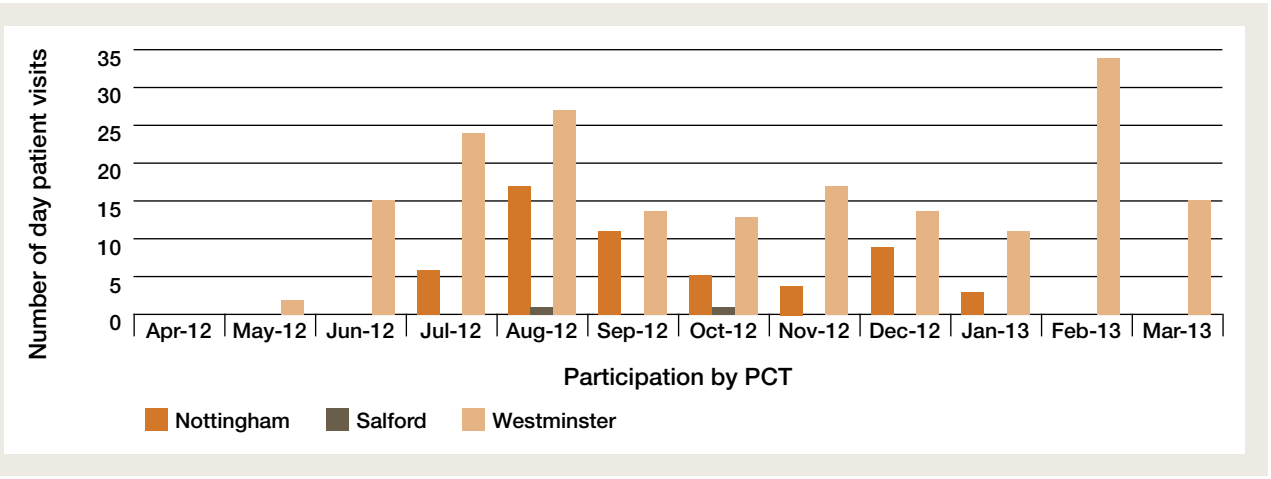
Despite the short period the pilot scheme has been available, a few patients had already experienced some drawbacks. These patients chose to remain or leave the pilot after assessing the situation. This indicates that users with multiple chronic conditions or ones requiring frequent care need to assess how suitable the scheme is in meeting their continued health needs. In the short period of the pilot, no patients reported adverse events.

Experiences and views of day patients

Number of day patient visits

There were many fewer day patients than OoA registered patients, with none in Manchester and only two in Salford. In Nottingham, most day patient visits occurred between August and December 2012. Westminster dominated day patient numbers throughout the pilot period, though even here, there were large monthly fluctuations in numbers of attendances over the year. Figure 5.4 shows monthly participation numbers for day patients for each PCT reporting day patients.

Figure 5.4 Number of day patient visits by month, April 2012 to March 2013



Profile of day patient visits from administrative data

Each day patient visit generated a day patient form which was provided to the PCT to enable the practice to be paid for the visit. This form included information about the reason for the visit, whether the patient was given a prescription, and whether a referral was made (see Appendix 3). As shown in Table 5.9, over two-thirds (66.0%) of day patients received a prescription during their visit. Referrals were less common, with only one in ten (10.1%) day patients referred by the GP for tests or other services. Some referrals were for routine blood tests. Most referrals were for MRIs (for knee or back injuries) or physiotherapy; several day patients, many of whom presented in Westminster, had access to private health insurance following a NHS GP referral.

In terms of the reason for the day patient visit, half (51.6%) were for acute infections, most commonly upper respiratory infections (20.4%). Other acute conditions accounted for a further one in five (21.2%) day patient visits, followed by medication issues (7.6%) and chronic conditions (5.2%). This contrasts with the overall pattern in general practice where around 80% of GP consultations are for ongoing or chronic conditions (Wilson, Buck and Ham 2005). A relatively small percentage of visits did not require any treatment, or were to obtain reassurance or a second opinion (8.4%). Most day patients receiving reassurance were parents of small children or babies.

Based on the administrative data, there was no evidence that any day patients had used the services of more than one of the pilot practices. However, 9 (14.1%) of the day patients in the survey reported visiting more than one practice as a day patient.

This may be explained by practices not processing the paperwork to claim the day patient fee or by patients confusing the Walk-in Centre option available at many GP-led health centres (several of which also participated in the scheme) with the day patient option.

Table 5.9 Reason for day patient visits, prescriptions and referrals from administrative data by pilot area

	Westminster[1]	Nottingham[1]	Manchester	Salford[2]	Total
Total number	196	52	0	2	250
	%	%	%	%	%
Prescription given					
Yes	66.8	61.5	–	[2]	66.0
No	33.2	38.5	–	–	34.0
Referral					
Yes	11.9	3.9	–	–	10.1
No	88.1	96.1	–	[2]	89.9
Reason for presentation					
Acute infections (all)	54.1	44.2	–	–	51.6
• *Urinary tract infection*	4.6	3.8	–	–	4.4
• *Upper respiratory infection*	23.5	9.6	–	–	20.4
• *Lower respiratory infection*	7.7	13.5	–	–	8.8
• *Skin infection*	8.2	7.7	–	–	8.0
• *Eye infection*	3.1	3.8	–	–	3.2
• *Sexually transmitted infection*	2.0	–	–	–	1.6
• *Gastro-intestinal*	3.1	1.9	–	–	2.8
• *Other*	2.0	3.8	–	–	2.4
Acute conditions	21.9	17.3	–	[1]	21.2
Chronic diseases	5.1	5.8	–	–	5.2
Medication issues	6.6	9.6	–	[1]	7.6
Reassurance or second opinion (no treatment)	5.6	19.2	–	–	8.4
Insufficient information to determine	6.6	3.8	–	–	6.0

1. Day patients who visited a practice more than once are coded for their last visit to the practice.
2. Because of the small number of patients in the base, the numbers are shown in brackets instead of percentages.

Mapping day patients

Many day patients lived in the areas surrounding Nottingham City and Central London. There were a considerable number of day patients coming from longer distances across the country, and in a few cases, from Scotland and Wales (see Figure 5.5). In London's inner boroughs, it is clear that most of the day patients lived in Westminster with the remainder scattered in other boroughs (see Figure 5.6).

Figure 5.5 Day patient visits, England

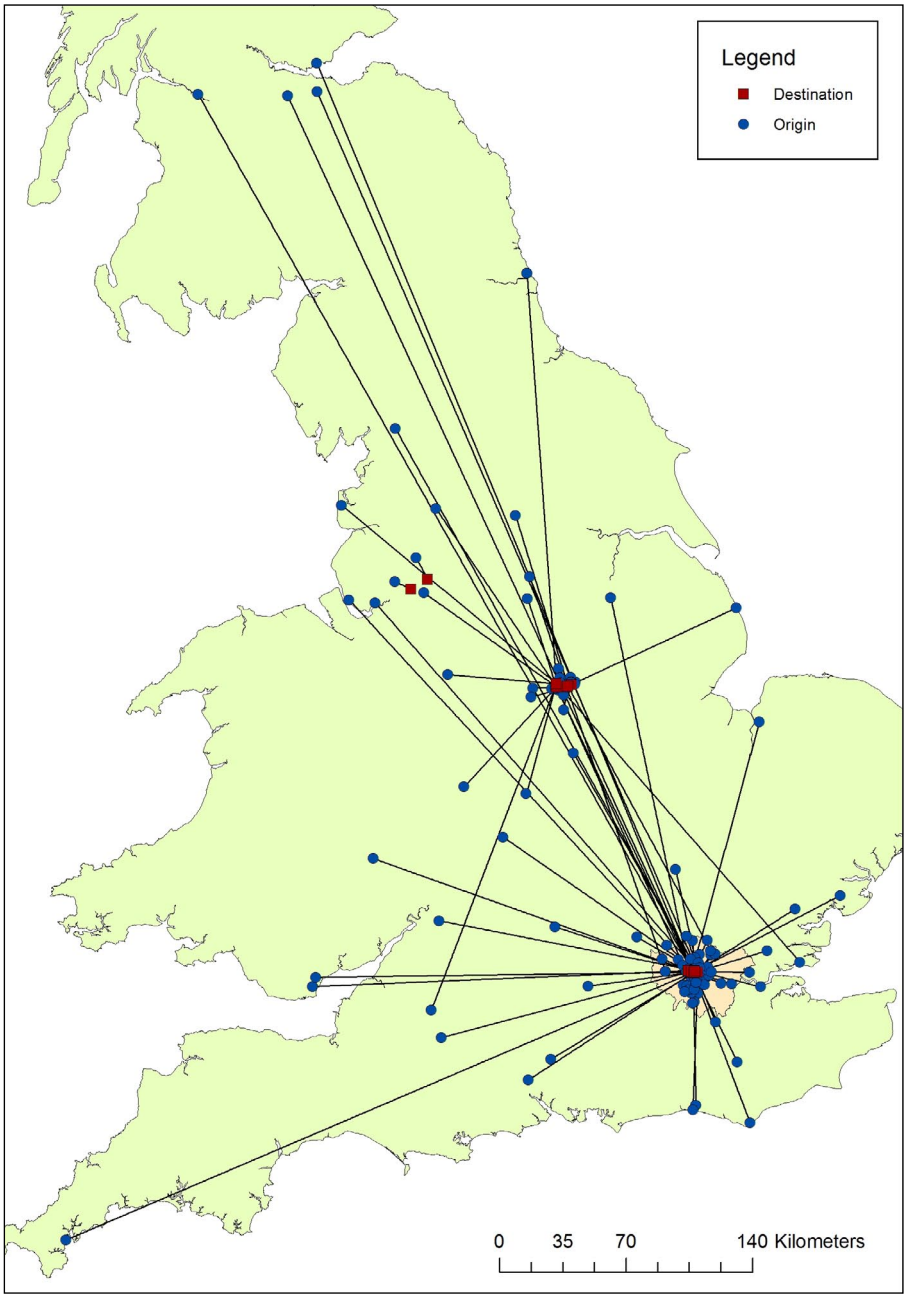
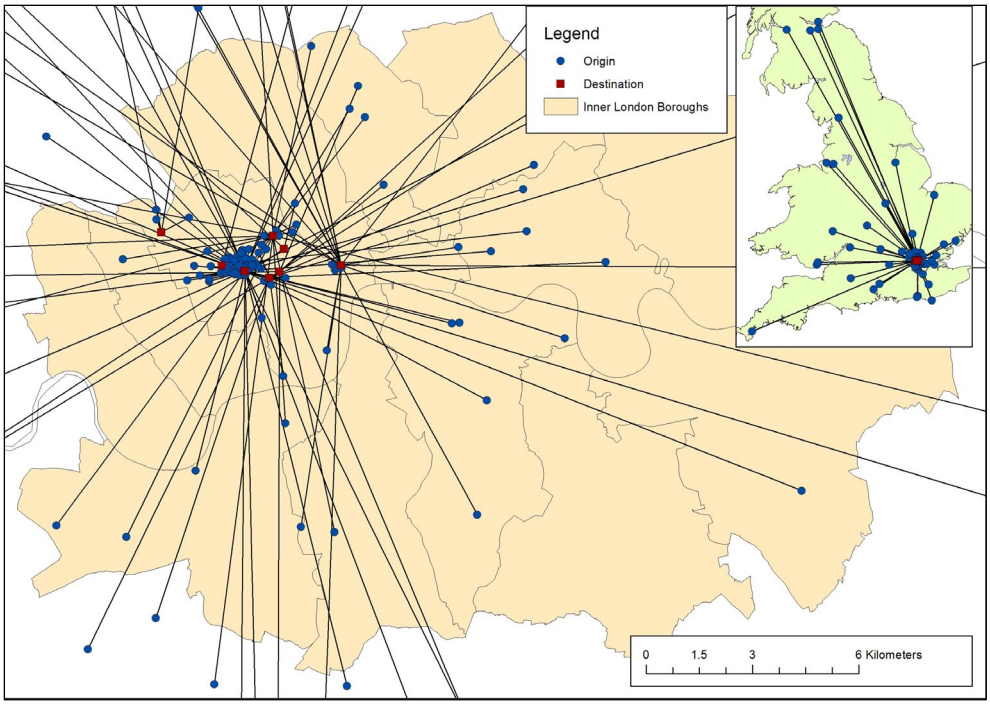


Figure 5.6 Day patient visits, London's inner boroughs



Reasons for joining the scheme as a day patient

The postal survey of day patients asked whether they were registered with a GP practice, the main reason they visited as a day patient instead of visiting their registered practice, whether they tried to make an appointment at their registered practice, and for them to compare the practice they visited with their registered practice.

The vast majority (77%) did not try to make an appointment at their registered practice before their visit as a day patient. The reasons patients chose to attend a surgery as a day patient instead of visiting their own practice were:

- Would need to take (more) time off work to visit registered practice (15.8%)
- Practice has more convenient hours than registered practice (5.3%)
- Waiting times at registered practice are too long (1.8%)
- Not easy to get convenient appointment at registered practice (8.8%)
- Prefer this surgery to registered practice (5.3%)
- Work or study nearer this practice than registered one (15.8%)
- Away from home (33.3%)
- Not satisfied with quality of service at registered practice (1.8%)
- This practice provides specialist care or advice my registered practice does not (3.5%)
- Not registered with a GP (7.0%)
- Don't know (1.8%)

As for OoA registered patients, responses from this question were combined with free text responses to a number of other survey questions in order to categorise day patients into a number of user types:

Type 1: Patients motivated by convenience. This group comprised the vast majority of day patients (68.8%). It was clear that many patients chose to use the scheme because it was convenient for their lifestyle or place of work. One such patient said "I think this is an excellent scheme and very common sense. It makes visiting a doctor a much more convenient thing for someone who works a lot and is not able to visit doctors near their home because of working hours" (survey respondent, Westminster). Type 1 patients were largely aged under 35 years (67.5%), in work or full time employment (90.7%) and with few reporting any long term conditions (26.2%).

Type 2: Patients who could have been registered as Temporary Residents. This group represented nearly one in five (18.8%) day patients. Patients were placed in this category if any of their responses to the other questions in the survey indicated they were in a practice's area for more than 24 hours but not ordinarily resident in that area. Some of the Type 2 patients were referred to the scheme by a hotel, or said that they lived in another part of the UK but used the scheme while on holiday or were from abroad and visiting relatives in London. Others were registered at a local practice and made use of the GP Choice Scheme while based in London for a fixed period of time (answers ranged from 2-3 days to 2 months), for example: "I used to be registered when I lived by _____ but left when I moved away. I came as a day patient when I was staying nearby again for 2 months" (survey respondent, Westminster). One patient returned to their family's home for "8-12 weeks a year" (survey respondent, Nottingham).

Type 3: Patients who prefer a specific practice. This comprised a small number (7.8%) of all day patients. This category included any patients who expressed a preference for a specific practice, said they received specialist care that their registered practice did not offer or were not satisfied with the quality of care received at their registered practice.

Type 4: A small number of day patients could not be classified due to missing data (4.7%).

It was impossible to ascertain whether any of the day patients could have been seen as Immediate and Necessary.

When asked how they had learned about the GP Choice Scheme, many day patients could not remember when or if they had ever heard about the scheme (31.3%). The most common response was to have learned about it when they called or visited the practice (32.8%). Some learned about the scheme through the internet on the NHS Choices website (9.4%), the Primary Care Trust (PCT) website (1.6%) or the GP surgery website (3.1%). Some learned about the scheme through other health professionals (Walk-in Centres), friends, family members or colleagues (14.1%). Others learned about the scheme through news reports (newspaper, TV, radio) (3.1%) or leaflets, booklets, posters (including those in GP surgery) (12.5%).

When asked what they would have done if the day patient option had not been available, many (42.4%) said they would have visited the A&E department, an NHS Walk-in Centre or an NHS urgent care centre. Over a quarter (28.8%) would have visited their registered surgery, a quarter (25.4%) said 'other' or 'don't know' while

a few (3.4%) would have called an out of hours GP service. Given that day patients tended to be young and unlikely to have long-term health conditions, it is surprising that many reported previous experiences with a range of primary and urgent care services, including: an A&E department (68.6%), NHS Walk-in Centre (54.9%), NHS Direct or NHS 111 (49.0%), the out of hours GP service (21.6%), minor injuries unit (9.8%) or NHS urgent care centre (3.9%).

In the qualitative interviews, day patients felt the registration process was relatively straightforward and that receptionists were well informed about the scheme.

Day patients' views and experiences of care in pilot practices

Day patients were asked to rate the importance to them of 12 aspects of a GP practice. In order of importance, their rating was as follows (the number in brackets is the percentage of day patients rating that aspect as 'very important'):

- Quality of the service (87.3%)
- Able to make appointments at time wanted (82.8%)
- Short waiting times for appointments (71.4%)
- Friendly/helpful staff (68.8%)
- Doctors having ready access to my medical records (61.9%)
- Convenient opening hours (60.9%)
- Quality of hospitals in area (54.0%)
- Good reputation (50.8%)
- Convenient to place of work/study (46.0%)
- Specialists or facilities available in surgery (41.3%)
- Convenient to home (39.7%)
- Being able to see same GP each visit (33.3%).

Day patient views were similar to OoA registered patients in that both groups ranked service quality, convenience, short waiting times and helpful staff highly. Interestingly, more than half of respondents considered it important for doctors to have ready access to their medical records and one in three patients valued being able to see the same GP on each visit.

As shown in Table 5.5, day patients, who valued being able to make appointments at convenient times, were able to do so, as nine in ten day patients (89.3%) said their last appointment was very or fairly convenient. Some day patients (19.0%) had tried to make an appointment at their registered practice. As most day patients learned about the scheme from walking in or calling a pilot practice, it is unsurprising that half of patients (53.2%) received an appointment on the same day they contacted the practice. Day patients had positive perceptions of the overall experience of making their last appointment, with over half (59.6%) rating it as 'very good' (compared with just over one-third (37.4%) of all patients in pilot practices).

As with OoA registered patients, day patients' views of their experiences during the last appointment (either in person or by telephone) with a GP were very positive (see Table 5.6.) compared with GPPS patients in the pilot practices.

Table 5.7 shows that one in four (25.0%) day patients felt their practice's opening hours were not convenient, which is more than twice as high a proportion as among OoA registered patients (10.1%). This is unsurprising given that most day patients were choosing to attend a practice which was more convenient for their work or lifestyle.

Overall experience and views of the GP Choice Scheme

The majority of patients viewed the surgery they visited as a day patient to be comparable to or better than their registered practice (patients who were not registered with a GP were removed from this analysis). Table 5.10. shows that two in five patients considered the practice they visited as a day patient to be about the same (40%) as their registered practice, while one in three (34.6%) felt it was much or somewhat better. Only 9.1% thought it was worse than their registered practice.

Patients interviewed felt they could not compare the practice they visited with their registered practice in terms of attributes such as the services offered, whether there were extended hours or if their registered practice could have done anything to help them avoid their day patient visit. This suggests that the day patient option was used to gain access to primary or urgent care rather than to 'doctor shop.'

Table 5.10 Day patient experience and views of the GP Choice Scheme

Day patients registered with a GP	%
Visit as a day patient was...	
Much better than registered surgery	18.2
Somewhat better than registered surgery	16.4
About the same	40.0
Somewhat worse than registered surgery	9.1
Much worse than registered surgery	–
Better in some ways, worse in others	–
Can't say	16.4
View on GP/ nurse having access to medical history for last consultation	
Very important	22.6
Fairly important	18.9
Not very important	43.4
Not at all important	15.1
Knowing if registered practice was notified of day patient visit	
Yes	20.0
No	9.1
Don't know	70.9

Nearly three-fifths of day patients (58.5%) did not think it was very, or at all, important for a GP or nurse to have access to their medical history during their last consultation as a day patient (which appears to contradict the more general view expressed by 57.4% of day patients that it is 'very important' for doctors to have ready access to their medical records). This could be explained by the fact that the vast majority of day patient visits were for acute infections or conditions (see Table 5.9).

Pilot practices were obliged to pass details of day patient visits to the person's registered practice. The evaluation could not measure the extent to which this was done. In the day patient survey, however, only 20% said they knew that their registered practice had been notified of their visit, with the vast majority (70.9%) saying they did not know if this had occurred.

Day patient experiences of referral and prescribing
There were no reported difficulties with prescribing and referrals among the small number of day patients interviewed. At one practice, a day patient was referred back to her registered GP for mole removal while another was offered a referral to an ENT specialist. There was variation between, and within, pilot practices over what routine care or referrals day patients could expect from the scheme. See Chapter 4 for a description of the practice-level implementation issues surrounding day patients.

Choosing to be a day or out of area registered patient
Many (38.7%) day patient survey respondents were aware that they could register at the practice they attended as a day patient. The qualitative interviews found that day patients exhibited a good understanding of how the scheme operated. They were able to explain both aspects of the scheme ""You can either do five visits or you can change your GP from ____ to ____ and you can take that one as your temporary, you know, health facility which is in ____" (patient interview, Nottingham).

Fewer than one in six day patients (14.5%) transferred their registration to the pilot practice they visited. Reasons given in the survey by day patients for not registering were that the practice they attended as a day patient was too far from their home, or that they preferred to remain registered with a local practice although the pilot practice was convenient for their lifestyle.

The day patients interviewed gave a number of reasons for not transferring their registration including: being satisfied with their registered GP, rarely using GP services, wanting to maintain a longstanding relationship with a GP near their home, commuting long distances between work and home but preferring to be registered near their home, working on short, fixed-term contracts in different parts of the country, and intending to register near their home practice but were unable to register at the time of interview due to long working hours.

For others, the day patient option was most suitable and provided a degree of continuity for patients with multiple home addresses. One survey respondent lived in two locations and "would like to be registered at both places – perhaps registered primarily at one and have "regular visitor" status at the other (rather than 'day patient'). This is very important at my age – I risk being 100 miles away from my GP" (survey respondent, Westminster).

6. Patients' preferences for GP practice choice

Introduction

While a pilot in four PCTs with volunteer practices can help inform future policy on the choices to be made available to NHS patients when seeking general practice care, it has inevitable limitations, most obviously in relation to the relatively small sub-section of the population which was included in the pilot. The rest of the GP Practice Choice pilot evaluation provides some evidence on the reasons why, and circumstances under which, patients would choose to either register with an OoA practice or use such a practice as a day patient. In this way, it can inform some of the managerial and logistical challenges involved in loosening GP practice boundaries. However, due to its narrow geographic scope and the relatively low awareness that people living or working in these areas may have had of its existence, it is difficult to draw conclusions from the uptake of the pilot to the potential behaviour of the general population. In particular, it is not possible to determine if, and to what extent, the appetite for OoA registration observed in the pilot was due to the uniqueness of the situations of the sub-groups of the population and practices included in the pilot areas and the specific way that the pilot was implemented (e.g. the fact that it was difficult to publicise the pilot extensively), or whether a similar level and nature of interest is likely to exist in other groups of the population in England.

To further inform the decision as to whether to continue or extend the choice of general practice pilot and to better estimate the potential pattern of demand for a wider choice of general practice care, it is helpful to understand the preferences of the general population in relation to different ways of accessing GP services. We sought to explore the determinants of choice of practice registration in the general population in England, with a view to estimating the relative importance of factors (including practice location, opening hours and perceived quality of care received) on practice preferences. This part of the study focuses on preferences for local versus out of area registration, not the factors that might influence people's decisions to seek GP care as a day patient.

We used a Discrete Choice Experiment (DCE), a stated preference technique that enables the quantitative evaluation of the relative importance of different service attributes on choice behaviour (Louviere, Hensher et al. 2000). DCEs have been extensively used to understand the determinants of the choice of different ways of accessing GP services. In the UK, this work was done mostly to inform changes to GP working hours and access to out-of-hours care in the mid-1990s. For example, two studies looked at the preferences of patients for different models of GP out of hours care in Scotland (Scott, Watson et al. 2003) and in England (Gerard, Lattimer et al. 2006). Other studies have looked more broadly at patients' preferences for primary care services, with a view to understanding the relative importance of convenience and quality of primary care consultations in shaping preferences (Longo, Cohen et al. 2006; Caldow, Bond et al. 2007; Cheraghi-Sohi, Hole et al. 2008). So far, DCEs have not been used to investigate the factors potentially shaping choice of registered practice, either in England (presumably because practice choice was relatively constrained locally), or in other countries.

DCEs are based on the assumptions that interventions, services or policies can be described by characteristics, and that their value to responders depends on the levels of these characteristics. Responders are presented with a number of choices that involve different levels of these characteristics or attributes. For each choice they are asked which option they would choose. Making choices involves trade-offs between attribute levels. One of the advantages of DCEs is the explicit consideration of trade-

offs that have to be made in real life decisions. Individuals typically want the best of everything, but in a world of limited resources trade-offs have to be made. Patients may value easier and more rapid access to a source of care near where they work, but they might give an even higher priority to seeing the same doctor very quickly, or seeing a doctor who knows them well. Such trade-offs are not always recognised in policy initiatives if they are not made explicit. For efficient decision making, and to inform the design of cost-effective policies, it is critical to know how patients and the public would trade between various strategies to make GP services more convenient, and how they would trade more convenient access with other aspects of care. With a sufficiently large sample, a DCE also allows comparisons between the preferences of different sub-groups of the population.

As detailed in Chapter 2, we used a labelled DCE that included six attributes, as shown in Table 6.1 below.

Table 6.1 Design of the Discrete Choice Experiment

	Levels	
Attributes	**Practice in your neighborhood**	**Practice outside your neighborhood**
1. Whether the practice is open on Saturday and Sunday morning (8am-12pm)	• Yes • No	• Yes • No
2. Whether the practice is open at lunchtime (12-2pm)	• Yes	• Never open at lunchtime • Sometimes open at lunchtime
3. Whether the practice has extended opening hours – either 7-8am or 6-8pm	• Yes • No	• Yes • No
4. How quickly you can normally be seen by a GP in this practice	• Same day • Next day • A few days later • A week or more	• Same day • Next day • A few days later • A week or more
5. Whether the practice meets your specific health needs	• Yes • No	• Yes • No
6. How well the practice knows the health care services (e.g. hospital, community nurses, etc.) in your neighbourhood	• The practice has previous experience with most of the health care providers in your neighborhood	• The practice has previous experience with most of the health care providers in your neighborhood • The practice does not have previous experience with most of the health care providers in your neighborhood

Preferences for GP practice choice within the English population

A simple analysis of the DCE responses shows that 14.2% of respondents chose the practice inside the neighbourhood systematically throughout the 16 choice sets presented (see Appendix 10.5). While this result suggests that some respondents have a strong preference for a local GP practice, it also shows that many other respondents made trade-offs between the different options, providing data that allow us to estimate their relative preferences for different service characteristics. Table 6.2 shows the results of the analysis of preferences for the general population sample (see Chapter 2 for details of the methods used).

Table 6.2 Preferences for registration with a practice in or outside neighbourhood in England estimated with a Random-Parameter Logit model

	Parameter estimates	95% confidence intervals
Characteristics of practice		
Practice in neighbourhood		
Practice has extended hours [no extended hours]	0.810 ***	(0.705 , 0.915)
Practice is open on Sat/Sun morning [not open]	0.123 ***	(0.035 , 0.211)
Usually get appointment next day [same day]	-1.054 ***	(-1.247 , -0.862)
Usually get appointment in a few days [same day]	-1.990 ***	(-2.192 , -1.788)
Usually get appointment in > a week [same day]	-2.686 ***	(-2.911 , -2.461)
Practice meets your specific health needs [does not meet your needs]	0.984 ***	(0.860 , 1.109)
Practice outside neighbourhood		
Alternative-specific constant (mean)	-2.384 ***	(-2.796 , -1.971)
Alternative-specific constant (standard deviation)	1.419 ***	(1.342 , 1.496)
Practice is open at lunchtime [not open at lunchtime]	1.413 ***	(1.305 , 1.521)
Practice has extended hours [no extended hours]	0.736 ***	(0.640 , 0.832)
Practice is open on Sat/Sun morning [not open]	0.433 ***	(0.343 , 0.523)
Usually get appointment next day [same day]	-0.587 ***	(-0.692 , -0.481)
Usually get appointment in a few days [same day]	-1.294 ***	(-1.391 , -1.198)
Usually get appointment in > a week [same day]	-3.294 ***	(-3.474 , -3.113)
Practice meets your specific health needs [does not meet your needs]	1.119 ***	(0.960 , 1.278)
Practice knows your local services	-0.273 ***	(-0.381 , -0.165)
Individual characteristics associated with preference for practice outside neighbourhood		
65 years and over	-0.192 *	(-0.402 , 0.017)
Lives in London, Birmingham or Manchester	0.029	(-0.154 , 0.212)
Full-time worker	0.008	(-0.165 , 0.182)
Has caring responsibilities	-0.213 *	(-0.458 , 0.031)
Self-reported long standing health condition	-0.113	(-0.258 , 0.032)
Has used GP services in past 12m	-0.042	(-0.165 , 0.082)
Has been with GP for 5+ years	-0.141	(-0.315 , 0.032)
Dissatisfied with GP practice	0.578 ***	(0.399 , 0.757)

Number of respondents: N=1,706 ; Number of observations: N=27,296 ; % predictions correct: 76.4% ; AIC/N= 0.96 ; *** p<0.01, ** p< 0.05 , * p<0.1.
Reference level is indicated in brackets

The main findings emerging from the estimated coefficients associated with the different practice characteristics are described below.[15]

First, the negative coefficient associated with the out-of-neighbourhood alternative-specific constant suggests that, in general, practices inside the neighbourhood are favoured over practices outside the neighbourhood.

Second, in choosing a practice, people feel most strongly about whether they can normally obtain an appointment with a GP relatively quickly (for both types of practice, the coefficients associated with obtaining a later appointment are the largest). When they cannot be guaranteed to obtain an appointment on the same day, people are less likely to register with the practice, whether it is inside or outside their neighbourhood. We also find that this preference to avoid inconvenient appointments seems stronger in the case of the practice inside the neighbourhood.[16]

Third, of all the ways in which access to GP practices can be made more convenient, it seems that the least important aspect is whether they are open on Saturday and Sunday (the size of the coefficients associated with that feature are the smallest). This is true for both practices in and outside the neighbourhood.

Fourth, ensuring that their GP meets their needs well is important to respondents. Although it is less important than making sure that they can be seen on the same day if they need to, it is as important as having a practice providing extended opening hours (both in the case of practices in and outside the neighbourhood) and much more important than having a practice open at the weekend.

Fifth, for practices outside the neighbourhood, it is important for respondents that the practice is open at lunchtime. This is probably because people want to be guaranteed good access during the working day, especially those who work.

Finally, and unexpectedly, respondents do not seem to value whether or not a practice outside their neighbourhood is likely to know about the local services available where they live. In fact, in general they appeared to prefer that the practice outside their neighbourhood should not have good knowledge of the health services in the neighbourhood where they lived. This surprising result may be due to respondents seeing a contradiction between the appeal of a practice outside their neighbourhood and a local practice with good knowledge of local services, and infer that a practice that knows about their local services might be more likely to refer them locally when they are choosing a non-local practice precisely in order to get away from having to rely on local services. In any case, it seems that the knowledge of local services that a GP practice outside the neighbourhood could have was probably not interpreted as a guarantee that the practice would be able to make appropriate referrals based on good knowledge (i.e. a measure of continuity of care as we had intended it to be).

The bottom section of Table 6.2 shows how individuals with different observable socio-demographic characteristics value the option to register with a practice outside their neighbourhood. We find that older people (65 years and older) and those with caring responsibilities are less likely to choose a practice outside their neighbourhood. By contrast, those who are dissatisfied with their current GP practice are more likely to value the possibility of registering outside their neighbourhood. Interestingly, we did not find that people working full-time or those living in the three largest urban centres in England had a different preference from those who were not in paid work or who lived elsewhere, and preferences did not depend on educational level for those who were in work.

15 Each parameter estimate associated with a practice characteristic can be interpreted as the impact of that characteristic on the utility associated with the practice.

16 A Wald test showed that the coefficients associated with the different types of appointment available in the practice inside or outside the neighbourhood were different.

Based on the estimates obtained from the model presented in Table 6.3, we can predict how respondents would choose to register if they were given a hypothetical choice of two practices, one located in their neighbourhood and one outside their neighbourhood, under different scenarios (see Chapter 2 for more details). The results of these simulations are presented in Figure 6.1 and Table 6.3.

In the base scenario, we assume that individuals can choose between two fairly similar GP practices, with attributes typical of many practices.[17] Under such circumstances, we find that about one third (33.5%) of the English population would choose to register with a practice located outside their neighbourhood. While this figure might seem high considering the relatively negative attitude towards a practice outside of the neighbourhood that we found in the previous results, it is important to remember that this absolute number should be interpreted with caution. It should not be interpreted as the likely uptake of that option if the scheme were to be rolled out nationally (see the Methods chapter for a more detailed explanation of this caveat), but instead as a baseline from which to consider the impact of likely changes in the offer of choice of GP practices. These changes are the focus of Figure 6.1.

Table 6.3 Predicted uptake of registration with a practice inside or outside the neighbourhood, under various scenarios

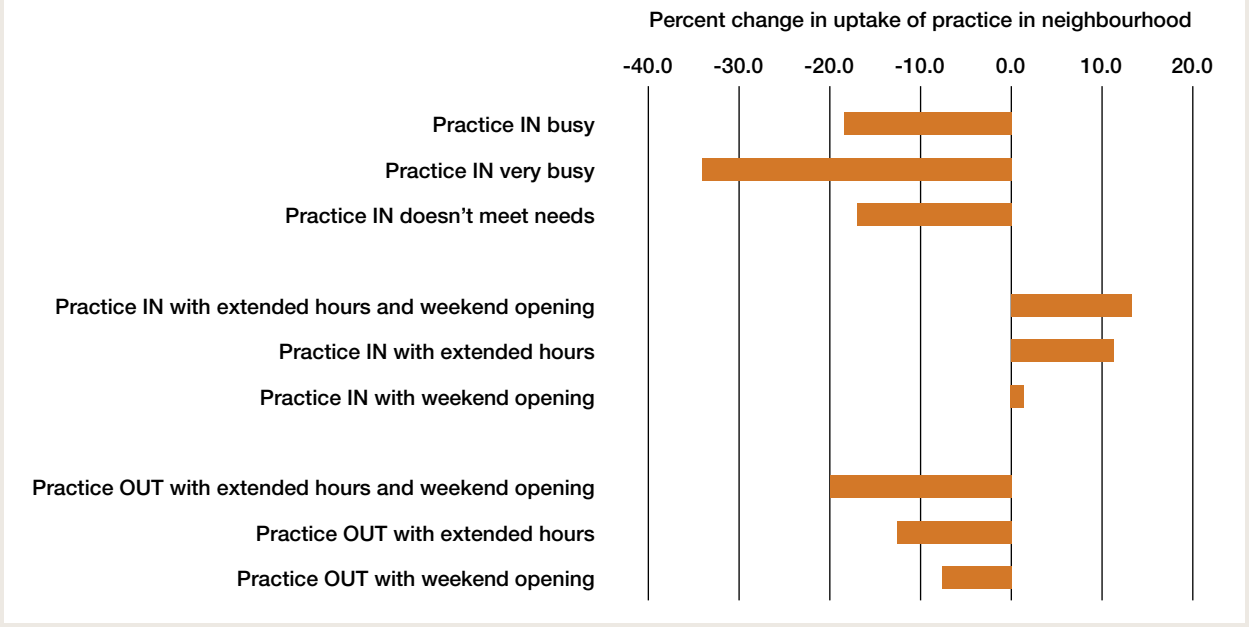
Scenario	Predicted % registration with practice inside the neighbourhood	Predicted % registration with practice outside the neighbourhood
Choice of two 'typical' practices	66.46	33.54
Busy practice inside neighbourhood	48.10	51.90
Very busy practice inside neighbourhood	32.03	67.97
Practice inside neighbourhood doesn't meet specific health needs	49.35	50.65
Practice inside neighbourhood with extended hours and weekend opening	79.88	20.12
Practice inside neighbourhood with extended hours	78.33	21.67
Practice inside neighbourhood with weekend opening	68.43	31.57
Practice outside neighbourhood with extended hours and weekend opening	46.05	53.95
Practice outside neighbourhood with extended hours	53.79	46.21
Practice outside neighbourhood with weekend opening	59.14	40.86

If the practice inside the neighbourhood had poorer access, and in particular if it could not guarantee that patients would obtain an appointment quickly, a higher proportion of respondents would switch to register with a practice further away (about 20% of respondents would do so if the practice inside their neighbourhood could only give an appointment the next day, and about 40% would do so if the practice inside their neighbourhood was even busier and could only give appointments in the next 2-3 days). If the practice in their neighbourhood was not responsive to their needs, about 20% would choose to shift away from it and register with a practice further away. However, we find that when access to the practice inside the neighbourhood is more convenient, this would induce 10-15% of the population to move away from practices outside their neighbourhood. As expected, if the practice in the neighbourhood was typical of many practices (see description in the base

17 Both practices offer same day appointments and are responsive to patients' specific needs, but neither one offers extended opening hours although both are sometimes open at lunchtime.

scenario), but they could choose a practice further away providing more convenient access, more people would register with the practice outside their neighbourhood. Specifically, 46% would choose a practice outside their neighbourhood if it had extended opening hours and 54% if it was also open at weekends. Finally, if we assume that individuals can choose between neighbourhood and non-neighbourhood practices that both offer equally convenient access, there are only minor changes in the relative uptake of practices inside and outside the neighbourhood.

Figure 6.1 Predicted change in registration with a practice inside the neighbourhood, under various scenarios



"Practice IN" means practice in the neighbourhood, "Practice OUT" means practice outside the neighbourhood

How heterogeneous are preferences for choice of GP registration?

The results presented above are for the general population. To investigate the heterogeneity of preferences for GP practice choice, we conducted two series of analysis. First we used a latent-class model to identify patterns within the general population, and then we conducted a separate analysis for three specific groups within the English population: workers, people aged 65 and over, and individuals living in large urban areas (Birmingham, London and Manchester).

Identifying patterns of preferences

The results of the latent-class model are presented in Table 6.4. The model identified three groups[18] (classes) of individuals who have distinct preference patterns. We labelled these groups as follows: the first group consists of people with moderate preferences ('the moderates'), a second group gathers people who have strong views about convenience of GP practice ('convenience shoppers') and the third group consists of people valuing convenience as well, but with a positive bias towards practices inside their neighbourhood ('demanding local loyalists').

18 Alternative models with two and four classes were also run, and were rejected based on goodness-of-fit measures in favour of the model with three classes.

The 'Moderates', representing a quarter (25%) of the population, are characterised by relatively similar and moderate preferences for each of the different characteristics of GP practices presented in the choice experiment.

For both practices in or outside their neighbourhood, people in this group regard obtaining an appointment the next day or in a few days in the same way, and, compared with the other two groups, they feel less strongly against waiting times of a week or more (though they still value long waits negatively, but are three times less likely than the 'demanding local loyalists' and nearly six times less likely than the 'convenience shoppers' to do so); they value extended hours in both types of practices equally, but their preference is much weaker than those of the other two groups. They are indifferent to local practices being open at weekends, and for practices outside their neighbourhood, they value this feature less strongly than other improvements (e.g. nearly half as much as a practice open at lunchtime and less than a practice with extended hours). Finally, in relation to how much they value the characteristics of the practice outside their neighbourhood, the 'moderates' express the weakest *a priori* opposition to practices outside their neighbourhood (i.e. the negative alternative-specific constant is relatively small compared with the coefficients associated with other preferences for practice characteristics).

The 'convenience shoppers', representing nearly half (47%) of the population, are referred to in this way as they seem to be looking for a practice with convenient access above all else. Compared with the other two groups, in their choice of practice, they feel much more strongly about having convenient access to GP services: they have the highest valuation of whether GP practices have extended hours and are open at the weekend, and they have very strongly negative views about practices that cannot offer appointments on the same day. Their lack of preference for inconvenient practices is particularly strong for practices in their neighbourhood. They are similar to the other two groups in not wanting to have a practice outside their neighbourhood without extended hours or one that can only offer appointments the next day. Compared with the 'moderates', 'convenience shoppers' are less likely to live in urban centres and to have caring responsibilities, but they are more likely to be older (65 years or more).

The 'demanding local loyalists', making up about a quarter (28%) of the population, feel more strongly than the 'moderates' about convenient access to local GP services, but not as strongly as the 'convenience shoppers'. They are indifferent to the possibility of having practices open at weekends or to having to wait one more day to obtain an appointment in practices outside their neighbourhood. With a strong reluctance to choose a practice outside their neighbourhood and placing a high value on having convenient local GP services, we call this group 'demanding local loyalists'. Compared with the 'moderates', 'demanding local loyalists' are less likely to be dissatisfied with their current GP practice and to have caring responsibilities, and they are more likely to report suffering from a long-standing health condition and to have been with their GP practice for the past five years or more.

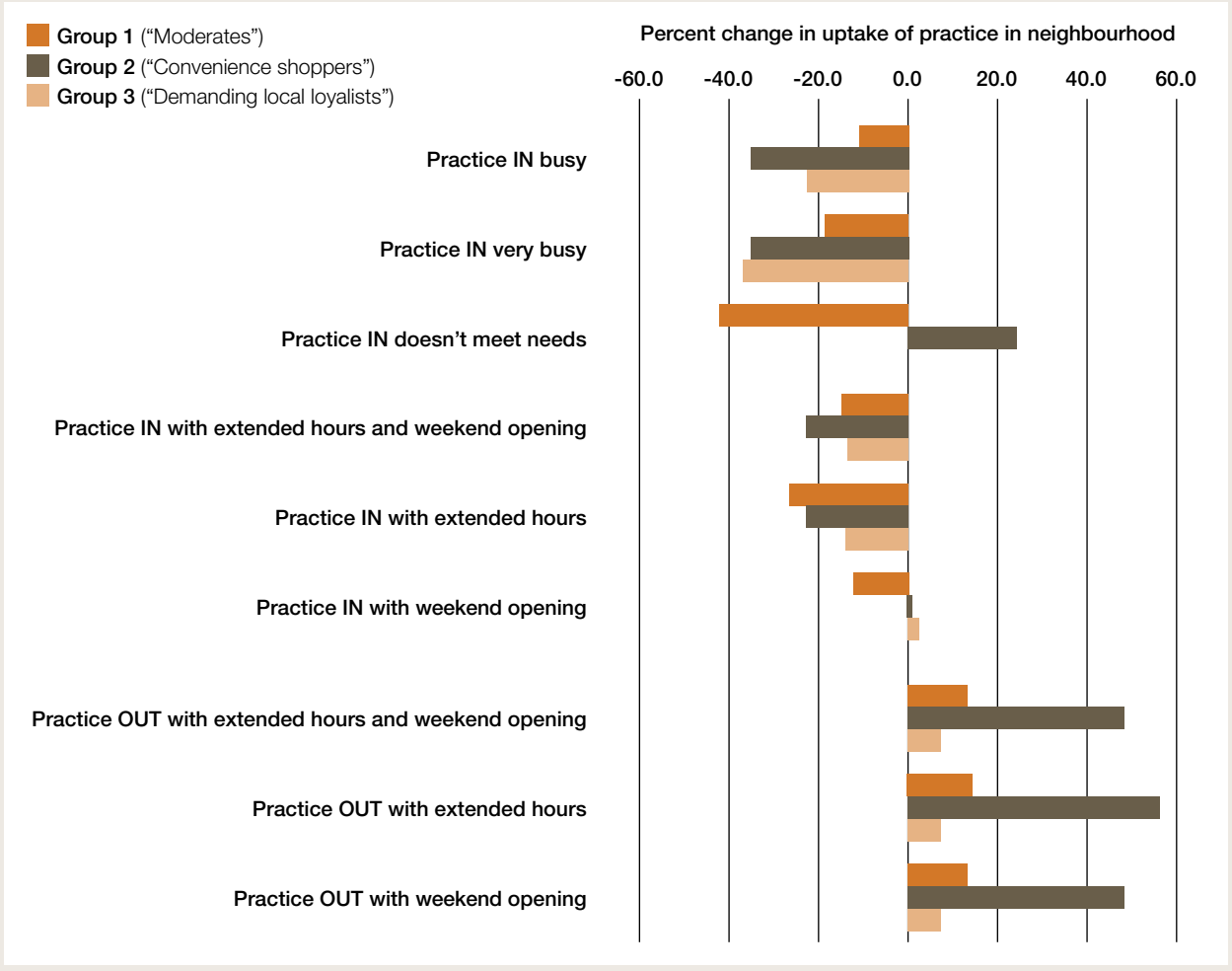
Table 6.4 Latent-Class Model of preferences for registration with GP practice in neighbourhood versus outside neighbourhood, in England

	Group 1 ("Moderates")		Group 2 ("Convenience shoppers")		Group 3 ("Demanding local loyalists")	
	Coefficients	95% CI	Coefficients	95% CI	Coefficients	95% CI
GP practice characteristics						
Practice in neighbourhood						
The practice has extended hours	0.554 ***	(0.381 , 0.726)	2.185 ***	(1.870 , 2.499)	1.324 ***	(0.600 , 2.048)
Practice is open on Sat/Sun morning	0.085	(-0.082 , 0.252)	0.671 ***	(0.483 , 0.860)	0.005	(-0.485 , 0.495)
Normally can get appointment next day	-0.421 ***	(-0.650 , -0.192)	-4.645 ***	(-5.390 , -3.900)	-1.490 ***	(-2.604 , -0.375)
Normally can get appointment in a few days	-0.725 ***	(-0.982 , -0.469)	-5.938 ***	(-6.736 , -5.140)	-2.073 ***	(-3.329 , -0.816)
Normally can get appointment in > a week	-0.994 ***	(-1.248 , -0.740)	-7.181 ***	(-8.038 , -6.324)	-3.254 ***	(-4.591 , -1.917)
Practice meets your specific health needs	1.958 ***	(1.747 , 2.169)	-0.975 ***	(-1.343 , -0.608)	-0.041	(-0.640 , 0.559)
Practice outside neighbourhood						
Alternative-specific constant	-0.856 ***	(-1.190 , -0.523)	-6.067 ***	(-7.030 , -5.105)	-5.322 ***	(-6.747 , -3.896)
Practice is open at lunchtime	0.999 ***	(0.845 , 1.153)	2.762 ***	(2.446 , 3.079)	1.463 ***	(0.919 , 2.007)
Practice has extended hours	0.604 ***	(0.432 , 0.776)	1.368 ***	(1.159 , 1.578)	1.072 ***	(0.573 , 1.571)
Practice is open on Sat/Sun morning	0.497 ***	(0.339 , 0.655)	-0.019	(-0.215 , 0.176)	-0.226	(-0.858 , 0.407)
Normally can get appointment next day	-0.321 ***	(-0.528 , -0.115)	-0.457 ***	(-0.680 , -0.235)	-0.388	(-0.989 , 0.214)
Normally can get appointment in a few days	-0.347 ***	(-0.558 , -0.135)	-2.187 ***	(-2.431 , -1.944)	-0.776 ***	(-1.223 , -0.329)
Normally can get appointment in > a week	-1.291 ***	(-1.527 , -1.056)	-6.380 ***	(-6.935 , -5.825)	-3.470 ***	(-4.636 , -2.303)
Practice meets your specific health needs	1.486 ***	(1.284 , 1.689)	2.926 ***	(2.457 , 3.394)	1.579 ***	(0.557 , 2.601)
Practice knows your local services	-0.070	(-0.246 , 0.106)	-1.153 ***	(-1.354 , -0.952)	-0.640 **	(-1.278 , -0.002)
Characteristics associated with group membership [group 1 as comparator]						
Constant			0.697 ***	(0.304 , 1.090)	0.228	(-0.169 , 0.625)
Works full-time			0.111	(-0.216 , 0.439)	-0.022	(-0.364 , 0.321)
65 years and over			0.373 *	(-0.017 , 0.763)	0.354 *	(-0.050 , 0.758)
Lives in London, Birmingham or Manchester			-0.444 ***	(-0.772 , -0.116)	-0.257	(-0.604 , 0.089)
Has caring responsibilities			-0.442 ***	(-0.744 , -0.141)	-0.485 ***	(-0.802 , -0.168)
Self-reported long standing health condition			0.251	(-0.201 , 0.704)	0.423 *	(-0.047 , 0.893)
Has used GP services in past 12 months			0.029	(-0.205 , 0.264)	0.082	(-0.162 , 0.326)
Has been with GP for 5+ years			0.115	(-0.193 , 0.423)	0.310 *	(-0.027 , 0.646)
Dissatisfied with GP practice			0.049	(-0.277 , 0.375)	-0.964 ***	(-1.346 , -0.581)
Class probabilities	0.248		0.472		0.28	

Number of respondents: N=1,706 ; Number of observations: N=27,296 ; % predictions correct: 91.9% ; AIC/N= 0.824 ; *** p<0.01, ** p< 0.05 , * p<0.1.

As before, based on the estimates obtained in the model, we predict how each group would choose to register if they were presented with a series of hypothetical choices of two practices. Figure 6.2, which shows the relative change in the uptake of practice inside the neighbourhood according to different scenarios (the corresponding figures can be found in Appendix 10.6), illustrates the distinct traits of each group clearly.

Figure 6.2 Predicted change in registration with a practice inside the neighbourhood, under various scenarios



"Practice IN" means practice in the neighbourhood, "Practice OUT" means practice outside the neighbourhood

It is apparent that the 'convenience shoppers' value convenience above all: within that group, a change in convenience of opening times or longer waiting times to obtain an appointment triggers a large shift in favour of the other practice. For example, more than 30% of that group moves away from the practice in the neighbourhood if appointments can only be typically obtained for the next day, but on the other hand a practice in the neighbourhood that has extended hours will attract an additional 40% of 'convenience shoppers'. This group also displays a relative bias in favour of practices inside their neighbourhood, which they probably see as more convenient. This is obvious in the final two scenarios where similar improvements

in both types of practices (extended hours, with or without weekend opening) yield a larger increase in uptake of the local practice. Finally, a surprising reaction of that group is seen when the practice in the neighbourhood does not meet their needs: this feature unexpectedly attracts an additional 20% of respondents.

As mentioned before, the moderates react relatively little to changes in practice characteristics (in general less than 20% of that group shifts from one practice to another after a change occurs), except when the practice in their neighbourhood no longer meets their health needs, in which case slightly more than 40% of them move away from it. They are moderate, but with a high sensitivity to how well their needs are met.

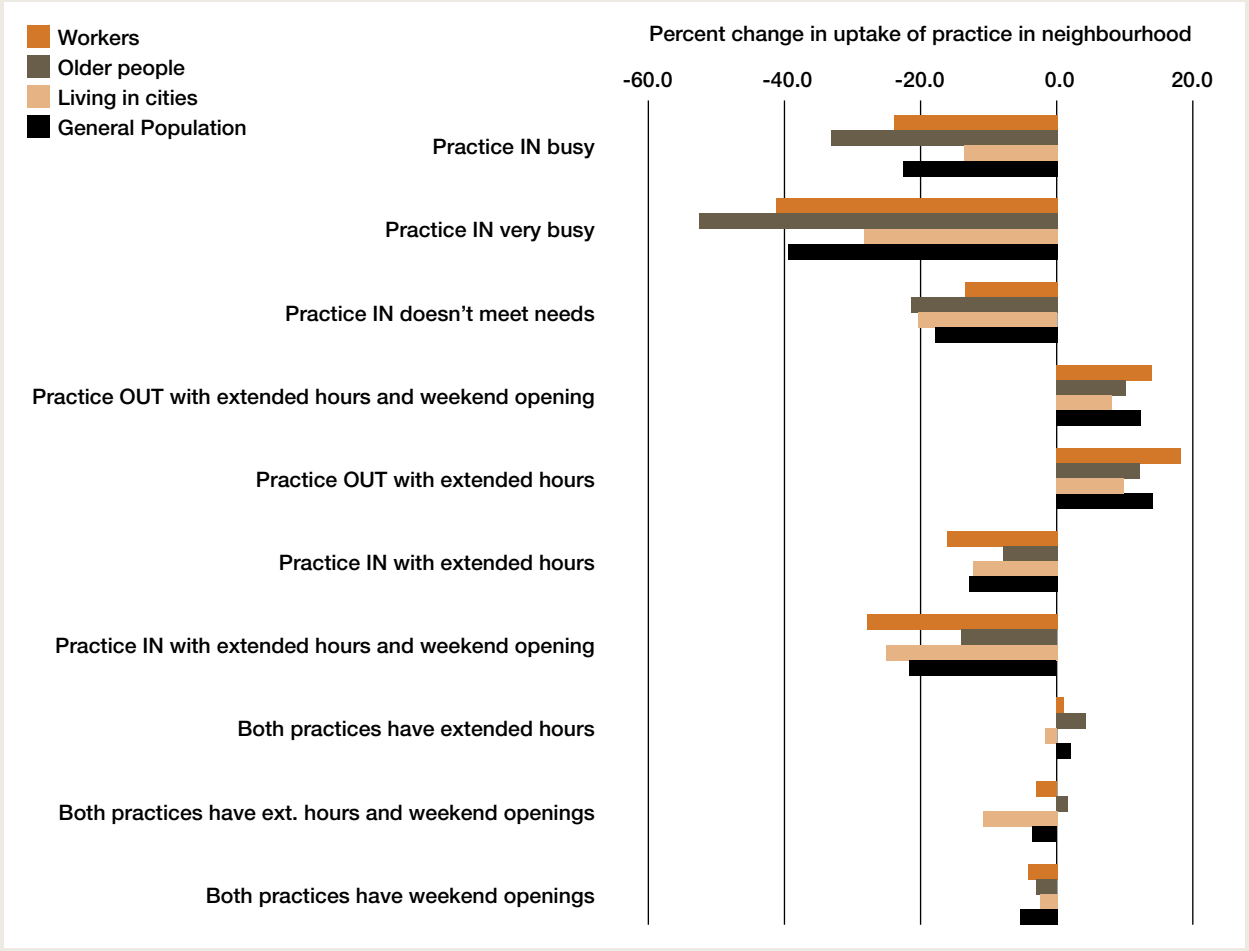
Finally, the last group of 'demanding local loyalists' will only alter their initial preference for a practice in the neighbourhood when they have to face longer waiting times for appointments, in which case 20-40% of this group will shift away from the practice in their neighbourhood.

Preferences of specific sub-groups of the population

While a latent-class model lets the model find the three different groups based on their preference patterns, it is possible to look at preference heterogeneity by comparing the relative appetite for different options of specific sub-groups of the population. For three specific sub-groups (workers,[19] people aged 65 and over, and individuals living in Birmingham, London and Manchester), we ran a similar RPL model as the one presented for the general population in the previous section (the detailed results of the three models can be found in Appendix 10.7). Based on these models, we simulated, for each sub-group, their hypothetical choices of registration with a practice outside their neighbourhood, based on the four types of scenarios presented in the methods in Chapter 2. The results of these simulations are presented in Figure 6.3, along with the same simulation results obtained for the general population.

19 This includes full-time and part-time workers.

Figure 6.3 Predicted change in registration with a practice inside the neighbourhood, under various scenarios



"Practice IN" means practice in the neighbourhood, "Practice OUT" means practice outside the neighbourhood

The results show that waiting to obtain an appointment deters those working and those aged 65 and over from registering with a practice in their neighbourhood. Specifically, more than 20% of each group would choose to register with a practice outside their neighbourhood instead of their default preference for the practice in their neighbourhood, if they had to wait to get an appointment until the next day, and more than 40% of each group would have the same reaction if they had to wait even longer. In comparison, the reaction of other groups to similar changes is much more moderate. The results show that all groups would respond, on average, in a similar way if the practice in their neighbourhood happened to be unresponsive to their needs. About half would then choose to register with a practice further away (which is similar to the national average).

Overview of findings on preferences

In general, the results of the DCE show that there is some appetite for OoA registration, at least hypothetically, but this preference is not widely shared across the population. In particular, some sub-groups, either because they are less mobile (e.g. older people and those with caring responsibilities), or because they are satisfied with their local services, have a negative a priori position vis-à-vis the idea of registering at a practice outside their neighbourhood. The DCE survey also showed that in choosing a practice, people feel most strongly about obtaining an appointment with a GP as quickly as possible. This is more important than any other aspect of GP services that was included in the survey (e.g. extended opening hours or a practice responsive to their needs). The results also showed that most people did not regard GP practices open at the weekend (Saturday and Sunday) as an important characteristic in determining their choice of practice. The analysis also highlighted the heterogeneity in the way that the general population values various aspects of GP practice choice. Some people, in particular those who work and older people, feel strongly about having responsive services that have extensive opening hours, whether it means that they have to register with a practice locally or not.

An online survey undertaken in November 2009 showed that a small sub-group of individuals in the general population would take up an offer of greater choice of general practice. The survey found that 18% of respondents were likely to register with a practice outside their current practice's catchment if the option to do so was available (Department of Health 2010b). The predictions based on the current analysis are not strictly comparable since the DCE makes some very strong assumptions about the choices faced by individuals (see below). However, our results seem to suggest, similarly, that there is a minority of the population who would be willing to register with a practice outside their neighbourhood provided that there was such a practice available that was more convenient for them, for one reason or another. In another question, we asked participants where they would register with a practice out of their area, if they had, or wanted, to. Eighteen percent said near their work, 5% said near relatives/parents or friends, and 52% said close to where they lived, but outside their current practice boundaries (this proportion is even larger amongst those aged 65 or over). These responses, shown in detail in Table 6.5, confirm the heterogeneity of situations and preferences highlighted both in the analysis of the DCE responses and in the findings from pilot patients reported in Chapters 4 and 5. Specifically, this is consistent with our findings that individuals who move house a short distance in the same broad area would prefer a wider range of choices, or 'looser' practice boundaries so that moving house would not automatically mean having to change practices. It may be that the new Outer Boundaries policy announced in 2012, whereby patients who move to a new house a short distance away from their old one are able to continue to be registered with the same practice even if they now live outside the practice catchment (Department of Health 2012a), would meet these patients' needs. These results also suggest that the offer of choice of practice would in fact not be taken up only by workers and/or commuters, but that such a scheme would likely be of most benefit to people wanting to use a practice just a short distance outside their immediate neighbourhood and thus outside the boundaries of their current practice.

Table 6.5 Hypothetical location of out-of-area practice where respondents might consider registering

Where people would want to register if they registered outside their neighbourhood	All respondents	Respondents aged 65 years or over	Respondents living in B/L/M[1]
	%	%	%
Near work	18.4	4.1	25.3
Near children's school	1.7	0.2	0.7
Near parents, relatives or friends	4.9	2.5	4.7
Close to where you live, but outside current area	51.6	69.4	46.9
Somewhere else	4.7	6.1	3.8
Not sure	18.6	17.7	18.5

1. Birmingham/London/Manchester

Limitations of the DCE

The results of the DCE should be interpreted cautiously in light of several limitations. First, the survey was administered to an online panel, which is not necessiarly representative of the general population, even though we purposefully adjusted the sample to reflect the main socio-demographic categories of the population. As access to the internet is a pre-condition of being a member of an online panel, some groups of the population are likely to be excluded (in particular in the older age groups). In addition, our sampling adjustment for age and gender was not perfect for the youngest age groups, and the sample we used for the analysis under-represents young men. It is unclear whether or how these weaknesses might have influenced the results. While we could hypothesise that young men are probably not large consumers of health care and might be relatively indifferent to various options for improving health care services, it is likely that this is not the case for older groups. Those excluded from the sample (due to lack of access to the internet) might be systematically different from those with access, and their preferences might differ.

Furthermore, the data were obtained from a stated preference survey, whose results have to be interpreted with the usual caution for such surveys. A traditional criticism made of stated preference data is that they do not necessarily reflect people's actual choices. While this is true, many surveys used to inform policy also rely on people's self-reported intentions, and not on their actual behaviour. Unlike simple questions in many surveys, DCEs seek to capture the complex trade-offs that people are likely to make in real life where they can rarely obtain everything that they would want. Our results illustrate how DCEs can estimate the relative importance for different types of people of different aspects of access to GP services. Since the survey was conducted online, we were able to record the time spent by respondents on the questions and thus how much care they took in arriving at their judgements. We found that, on average, respondents spent 22.6 seconds on each choice question before making a decision, and the quickest 10% of the sample chose a response in just less than 7 seconds on average (see Appendix 10.8). This suggests that respondents engaged with the scenarios presented to them.

Another potential limitation of the DCE is that the choice sets could not possibly capture the complexity and heterogeneity in decision-making processes and circumstances in the population. A DCE survey is particularly sensitive to this issue if individuals take other aspects into account that were not specifically included in the choice attributes. Here, because the DCE survey was designed to inform policy options, the choice of

attributes was not meant to reflect exhaustively all of the reasons why people might choose one practice over another. Although the qualitative work informing the design of the DCE sought to determine whether important aspects had been omitted,[20] there is evidence suggesting that some people look for specific services when choosing a GP practice, such as the availability of a specialist nurse or a female doctor. While one generic attribute was meant to cover these issues ("whether or not the practice is responsive to the patient's needs"), it is possible that some respondents will not have found a specific description of what mattered to them. Although we have highlighted the choice attributes that may be important to people registering as OoA patients, there are other factors which may have importance for GP patients, such as the overall quality of service (or attributes of quality).

Finally, it is important to be aware that the modelling of the hypothetical uptake of practices in and outside the neighbourhood is not meant to predict precisely the proportions of the general population who would register with practices outside their current practice boundaries and those who would not. The simulations aim to provide an illustration of the relative strength of preferences people in England have for different aspects of GP practices. First, as mentioned before, these simulations assume that all individuals in the population face exactly the same choices (e.g. a busy practice inside the neighbourhood versus an 'average' practice outside the neighbourhood). This is obviously not the case in real life, where the market for general practice care will differ from one neighbourhood to the next (and even individuals living in the same area might perceive the same offer of GP services differently). Second, some of the regression results (specifically, the alternative-specific constant for the out-of-area alternative) partly reflect the scope of the choice sets presented in the DCE survey. Thus, the simulation results partly reflect the 'market' of GP practices presented in the choice sets, not the ones that might be offered to respondents in future in real life. In general, it is good practice to re-calibrate the constant terms so that the results of the simulations, in absolute terms, have more external validity.[21] However, in this case it is not possible to do so, since there are currently no data available on the relative uptake of practices in or outside of the neighbourhood in the general population. Nevertheless, this study, with its large sample and ability to study preferences amongst different sub-groups, is an important and first attempt at understanding and quantifying the determinants of choice of GP practice in the general population. As such, it is useful in informing the design of any future policies introduced to improve access to GP services and GP choice.

Implications for policy

Notwithstanding these caveats, the results of the DCE survey with a sample of the general population, indeed, a much larger sample than those exposed to the pilot, raise important issues for the future development of policies designed to improve access to GP services through the removal or relaxation of GP practice boundaries, as well as other policy options recently suggested by the Government (such as 7-day working).

First, we found no obvious evidence that residents of large urban centres are any more likely to register outside their neighbourhood than other sub-groups of the population when the practice inside the neighbourhood is not offering convenient services. This weaker sensitivity to inconvenience might be due to the fact that people living in large urban centres are the most likely to already have the options to move practice or exercise choice due to having a greater number of practices within close reach, often with overlapping practice boundaries (e.g. a London resident can easily be in the catchment area of 4-5 practices).

20 There was a consensus that the main aspects were covered.

21 Because the strength of DCE surveys is to capture the trade-offs that people make between different choice characteristics, the results of the simulations are still informative in relative terms, i.e. they provide information about the relative impact on the demand for GP practices when different aspects are changed.

Second, we found some evidence that those who tend to use more primary care services (e.g. people with caring responsibilities, presumably mainly parents with children, and people who are older) are more likely to be interested in staying with their local practice. If it was confirmed that healthier groups (who use fewer services) were more interested in convenient GP practices outside their neighbourhood, this could raise complex issues in terms of equity of access to services and imbalances in the case-mix of practice lists, putting increased pressure on the fairness of the weighting for patient need that produces the per patient practice capitation payment. On the one hand, in areas attracting a lot of "healthy" commuters, the registration of this population could potentially crowd out local residents with higher needs, though the incomers would tend to be lower users of services if they were healthier. On the other hand, in areas where only residents might be interested in registering with practices (i.e. because they do not offer particularly convenient services for anyone but local people, for example, if they do not attract commuters), the practices might be left with a relatively unbalanced case-mix, with only the less mobile and sicker residents, while the more healthy local groups would have elected to register elsewhere. If the GP Practice Choice pilot scheme was to be rolled out nationally, these two issues would have to be carefully monitored and their overall consequences ascertained.

Finally, one of the main findings of the DCE relates to the hierarchy in preference for different options to make GP practices more convenient and accessible. We found that all respondents viewed the speed at which they could be seen by a GP as the most crucial aspect, followed by extended opening hours. However, the DCE results showed that opening a GP practice at the weekend would have a very marginal impact on hypothetical registration choices. Overall, this suggests that there would be more benefit from extended opening hours Monday to Friday than weekend opening. Given that encouraging practices to have extended opening hours is likely to decrease the average waiting time for a patient to get an appointment, it looks like this would be preferable to any other improvement to GP access, especially weekend opening.

7. Views on the pilot scheme and its future

Pilot patients' views of the scheme

Out of area registered patients' views on the scheme and suggested improvements

OoA registered patients offered a broad range of opinions in patient interviews and in the postal survey's free-text box on stopping or extending the scheme. Most OoA registered patients held positive views of the pilot scheme and were eager for it to continue. They felt the pilot scheme was appropriate to the characteristics of the area and for their health needs. Some patients thought that the scheme benefitted "modern lifestyles" (patient interview, Westminster) in many different segments of the population, including commuters (e.g. from Reading to London, or Leicester to Nottingham), caregivers and parents of school-aged children. One said, "I think it's suitable for some sort of patients, patients, like myself, who broadly speaking are healthy, in work and only needing the GP occasionally. But when they do need them they do prefer them to be available sooner rather than later. I don't think it's – it's probably not suitable for people who need regular visits to their GP or who mind travelling, or find it difficult, for example, mums with small children or elderly people" (patient interview, Manchester).

Several OoA registered patients felt the scheme provided flexibility for a changing labour market. One patient thought it was suitable for an increasingly transient workforce, for example, if a London-based person was relocated to another city for a six-month contract, but maintained a permanent address in London and frequently returned home for weekends. One OoA registered patient said the scheme was beneficial for patients who worked in more than one location: "if you're in two places regularly then having been registered at one doctor and not being able to access services in the other, it doesn't really work…I officially have the right when I'm in London to go and get treatment at a GP, whereas I kind of, at that point was, I was like fallen out of the net" (patient interview, Nottingham).

One OoA registered patient thought the scheme was suitable for those that moved a short distance and were now just outside of their practice's catchment area, "It seems a little unfair that without this scheme, a small move (of less than a mile) meant that I would have to go to all the trouble of finding and re-registering with a new GP when I was already with one I was happy with" (survey respondent).

A few OoA registered patients thought the scheme could motivate general practices in areas with a high outgoing commuter population to improve their services.

One OoA registered patient thought the scheme was a better initiative than extended and weekend hours in improving access to general practice. A few patients said their commute or working hours meant extended hours did not improve access, "with my commute I would find it difficult to attend my local GP (leave at 7am, home anytime after 7.30pm)" (survey respondent). Another patient's practice was only open one Saturday each month, which did not reliably improve access.

Most OoA registered patients understood the change to their out of hours care brought about by being registered out of area. Although none of those interviewed had used an out of hours service, they identified this as a potential drawback as they could foresee a time when it might be necessary. Some said the out of hours care model was out-dated and considered any concerns about out of hours care to be an insufficient argument against continuing the pilot scheme. A few patients suggested that out of hours care providers could expand their geographic range and widen access to out of hours care as a way to mitigate concerns over access to out of hours care.

After only 12 months, OoA registered patients could not identify any major reasons for not continuing the scheme from their perspective. However, they raised the following concerns if the scheme were rolled out across England:

- Some thought the scheme was more appropriate for metropolitan areas receiving commuters rather than small towns or remote rural areas.
- One patient was concerned that local practices, in conurbations or any area outside a large commuter area, would oppose the scheme if it was voluntary because they might fear being inundated with their local residents registered out of area but still needing immediate and necessary care locally (for example, if a local resident fell ill while home and was too ill to travel to their OoA registered practice but required a prescription) for which they would neither receive a fee nor a capitation payment (e.g. in Essex or Kent).
- One patient expressed concerns about the capacity of practices in cities with high inflows of commuters to absorb extra OoA registered patients.
- One felt that the scheme should be targeted at those with low health needs by making "clearer the difficulties that would arise for other groups if they wanted to register away" (patient interview).

Since the scheme had only been in existence for 12 months, few OoA registered patients had experienced significant difficulties while registered in the scheme and no adverse events or formal complaints were reported in the data collected. However, distance may be a factor for patients with high health needs. For example, one patient outside Manchester lived 18 miles from his practice, but left the scheme to register at a local practice because he required regular repeat prescriptions for several chronic conditions, but the practice felt that these needed to be renewed in person on a monthly basis. After several months, he chose to join a practice in the area where he lived to ensure that he did not fall behind on his medications. This patient felt that potential participants should be advised on how the scheme might affect their care and whether it would be appropriate for their health needs. One survey respondent had left the pilot scheme after falling ill at home. In this case, although NHS Direct had provided useful advice, the patient felt that an out of area practice was not an adequate substitute for having a GP near home. Another survey respondent suggested that more information be available on how the scheme affects access to community services, district nursing or community rehabilitation services.

A few patients said better publicity was needed and that it was difficult to find a practice participating in the scheme. This was a direct result of the way the pilot was implemented and the fact that it could not be widely publicised since it was only available in four areas and only from volunteer practices.

Day patients' views on the scheme and suggested improvements

Day patients differed from OoA registered patients in their perceptions of the benefits of the scheme. While day patients, like OoA registered patients, thought the scheme was suitable for a transient workforce, they differed over which groups could benefit most from the scheme. A few day patients thought the scheme was beneficial for those without job stability, for example, those on short-term contracts (two of the six day patients interviewed worked on 1-3 month contracts) or for patients who live a long distance away from their place of work making it difficult to take a morning, or day, off work to see a GP.

One patient with a long commute (over 100 miles) had found it difficult to make time to see his/her registered GP: "I used to not book my normal check up appointments

with my GP because of the time element, you know, taking time off from work and then spending only one hour at GP and then you can't just travel the same day to come there" (patient interview, Nottingham).

Day patients interviewed felt the scheme lacked clarity. "They just need to be clear whether or not they're going to see you .... as a walk-in patient on a temporary basis, because they weren't really sure whether they could see me or not, because I didn't live locally, and I was already registered with a GP at home... it was quickly cleared up, but they need to have a policy in place really, for people like me" (patient interview, Nottingham).

Day patients thought there needed to be more publicity about the scheme, especially through major employers.

One patient was concerned lest their visit information failed to be shared with their registered practice. If it was not, the patient was concerned that it could disrupt continuity of care. Another patient had similar concerns about data sharing and information transfer in future.

Two patients thought five visits each year was too restrictive or expressed anxiety that their usage was capped. One patient felt that five was more than the average patient would use, but that the option of more was desirable. A second patient suggested that a limit of five visits per health issue was appropriate. This would be difficult to police (and in all likelihood, unnecessary), but this was the view of a patient who visited multiple times to get test results and treatment options for an acute infection.

Commissioners' views on whether the pilot should be stopped or extended

Commissioners in pilot PCTs identified a broad range of practical concerns and potential weaknesses of the scheme:

- There were concerns that practice choice would lead over time to certain PCTs and practices recruiting a disproportionate number of healthier patients, leaving other practices with sicker, more costly patients. As one PCT manager said, "The fundamental aspects of commissioning of local services become very difficult when you have a population that is either predominantly healthy and then able to register remotely, or not predominantly healthy in which case you have a higher disease burden to commission for locally… You won't have the healthy people subsidising the practice that provides for a broader population."
- Similarly, commissioners in the pilot areas were concerned about the impact on rural or commuter belt practices of "losing significant numbers of their patients" (PCT manager), the consequent business continuity issues for the practices and the cost implications for the local PCT. In addition, business planning in the receiving practices would be difficult as the list could grow very quickly.
- One commissioner described the demand for out of area primary care as a South East England problem and thus not relevant to the rest of the country. "This is the wrong solution to what is a relatively minor problem, and the consensus is that this is a solution to a South East problem, so the South East should sort it… nothing to do with the North" (PCT manager).
- One commissioner was concerned that the day patient option was "nudging people all towards walk in, which doesn't always work" (PCT manager). In other words, if day patient access became the norm, this could have an adverse effect on continuity and quality of care.

- One commissioner suggested that the same results could be achieved by pursuing alternatives including:
  - Further extending GP practice opening hours
  - Extending practice catchment boundaries
  - Having much wider practice boundaries (e.g. all South East England) whereby practices arrange themselves into networks and coordinate home visits among themselves, or, in the future, larger organisations could own chains of practices over a wide area and enable patients to be seen at any of their practices.

Were the pilot to be extended, commissioners were further concerned:

- That the management of referrals for out of area patients could become increasingly problematic as numbers of patients choosing out of area registration grew. If the pilot "were to be extended, the complexities of arranging referrals across the country could potentially grind the thing down. It needs to be seamless, you should not have to query it, negotiate it, or look up details on the internet" (PCT manager).
- About the capacity of the new Local Area Teams of NHS England to support practices and to establish home visiting arrangements across the country.
- That the identification of day patients, and monitoring of their use of services and quality of care would be difficult as they could effectively present anywhere in the system, without there currently being any way of tracking them.

In addition, one PCT manager was concerned about the management of violent patients if they went out of area. Currently "there is a local system for managing those patients, but if they go elsewhere that could be a problem. We have about 30 of those patients…" (PCT manager). Commissioners suggested a period of one month be allowed for each practice to attend training, set up and become familiar with the processes and documents, before going "live."

Practices' views on extending or stopping the scheme

Fourteen of the twenty-three pilot practices (61%) that responded to the survey of practice managers/lead GPs stated that they would be fairly likely, or very likely, to continue their involvement in the scheme if it were to be continued. An additional two practices might continue, but only if the scheme were altered (see below). One practice that was very keen for the scheme to continue indicated that they would do more publicity if it were extended. During an interview one practice manager said: "I casually mentioned at the clinical meeting last Monday that I was meeting you and they said 'Can you please tell her how much we love it, and that we want it to continue, and that the patients love it'… That was three doctors."

Were they to continue with the scheme, practices indicated they had capacity for up to 2000 additional OoA registered patients.

Five of the twenty three practices (22%) that responded to the survey would be very unlikely to continue with the scheme. Reasons for not continuing with the scheme included:

- A drop in GP capacity within the practice
- The administrative burden and difficulties coordinating care
- The lack of proven need for the service.

It was pointed out that the scheme is not right for all practices and that involvement in any roll out of the scheme should be voluntary. Were the scheme to be continued,

practices suggested that a Local Enhanced Services contract (LES) might be an appropriate mechanism for offering the option to take part. Practices also noted that "it would fit in nicely as part of the APMS offer" (GP). However, one practice suggested the scheme be mandatory, because "patients should be able to get the same services no matter where they live" (Practice manager).

Practices value being able to refuse a patient on clinical grounds, if their needs are considered to be too complex for out of area care.

PCT and practices' views on whether any future scheme should include both day patients and out of area registered patients

Some practices that wished to continue with the scheme had a preference for OoA registered patients over day patients. These practices wanted their existing patients who move out of area to be able to remain registered with them.

Where there were Walk-in Centres nearby, practices did not anticipate much, if any, demand for day patient services, and they were less interested in providing the service, particularly given the administrative burden and the modest fee for seeing day patients. The administrative requirements of handling day patients were off-putting. "It's difficult to monitor, it's difficult to claim for… there's no Read codes loaded into the system… In theory it's a good idea. In practice it doesn't really work at the moment" (Practice manager).

One practice manager was concerned that the day patient option might provide "too much choice… I don't think it would be a tragedy if that went". Whereas, the out of area registration patients, "just fit in perfectly, that's a great idea. It doesn't bother us, it's no issue. It's great, it works" (Practice manager).

While commissioners appreciated the convenience to the patient of the day patient option, they were concerned about managing demand. "The question will be where would that patient go if that wasn't accessible to them?... we've taken the view that the more services you provide, and more access points… it's the lanes on the motorway argument" (PCT manager).

In contrast, one commissioner could still see value in the day patient option, as long as registered care continued as usual, because the out of area home visiting arrangements were not required and referrals to community services were more straightforward. The need to provide referrals for day patients was also questioned. "I think you are more likely to need prescribing costs than referral costs" (PCT manager).

Were the day patient option to continue, many practices considered a maximum of 5 visits per year to be appropriate. While some practices considered the day patient fee to be about right, the majority of practices considered the day patient fee of £12.93 was too low and that a more appropriate fee was generally considered to be in the range of £15 to £25.

PCT and practices' views on home visits in any future scheme

Commissioners noted that while there had been a significant reduction in home visits in recent years, GPs provide home visits for palliative care. Nevertheless, even if there were no demand for home visits because the OoA registered patients were not ill at home, home visiting had still to be commissioned and provided. Practices are contracted to provide home visits when and if they are clinically required, and emphasised the necessity of home care for OoA registered patients, with one GP

noting "If the back end of the pilot stops, if there is no home care in place, then we can't do it".

Out of hours care is more straightforward, with commissioners suggesting that the patient simply ring 111 (PCT manager).

PCT and practices' views on referrals in any future scheme
Practices and commissioners were very clear that the practice that makes the referral should pay for the referral. While referrals to secondary care were very straightforward and managed through Choose and Book, referrals to community health services could be more problematic, especially where the practice did not have an existing relationship with the provider. The benefit of OoA registered patients having a referral for community health services near home was questioned (although practices suggested this might be appropriate for services such as district nursing).

Where a practice did not have an existing relationship with the provider, one potential solution was to use a hospital-based version of the service (e.g. physiotherapy) and arrange it through Choose and Book. The practice manager that suggested this approach acknowledged this might be more than the patient needed, and an expensive option. Were this option to be widely adopted with larger numbers of out of area patients, the costs across the NHS could be significant.

Suggested Improvements were the scheme to be extended

Day patient arrangements
Practices were very clear that communication with the home practice had to be streamlined if the scheme was to continue to allow day patient visits. Suggestions for improving communication included:

- Electronic communication between practices rather than a paper-based system
- If a paper form is necessary, a two part form similar to the Temporary Registration form whereby the front section is sent to the administrator and the back section is sent to the home GP to ensure that non-clinical staff do not receive clinical information
- Provision of a shadow or second registration on the Exeter system, so that practices could send notes for day patients in the same way that they currently do for patients that are de-registered and re-registered elsewhere
- To assist with receiving day patients, one practice suggested read-only access to the Exeter system would enable them to find patient details more easily.

One practice manager also suggested that the doctor could make a clinical decision on whether communication with the home practice is required, or communication could be batched and sent once a week, unless urgent.

Changes to the QOF arrangements for day patients were suggested, whereby home practices would be able to remove patients from their denominator, if the patient has received a service elsewhere (Practice manager).

Provision of guidance
Were the scheme to be rolled out more widely, commissioners suggested clearer guidance on the differences between a day patient, a temporary resident and an "immediate and necessary" patient would be important as this had caused problems initially and could become a much bigger issue in future given the difference in payment between the options. Practices also suggested that comprehensive

guidance for practices be supplied, so that reception staff who did not attend initial training would be able to refer to guidance materials.

Practice managers would also welcome guidance on, or the development of, specific read codes for day patients and OoA registered patients.

Existing patients who become out of area registrations
A simpler system for de-registering and re-registering existing patients who moved house but wished to stay with the same practice would be welcomed in some areas, as some practices were currently required to send hard copy notes of de-registered patients that were re-registering with the same practice, to the PCT patient data teams.

Publicity
Many of those interviewed suggested increased publicity of the scheme would make it more successful. While a national campaign and standard patient leaflets were suggested, one commissioner suggested that patient communication be managed locally, perhaps through a Patient Advice and Liaison Service (PALS), so that the communications could be tailored to the local population.

Home visiting
Commissioners suggested that development of a standard scheme and standard payment for the home visiting arrangements would be very helpful.

One practice noted that they would like to know which practices should be responsible for the home visits for each of their out of area patients, suggesting that if a list of home visit practices in each area could be circulated annually, this would help them identify a suitable practice.

Communication
One commissioner suggested an email group or electronic forum of commissioners that are accepting out of area patients might be useful in the future, as they benefited from communication with peers during the pilot. It was also suggested that a forum for practices that accept out of area patients might be helpful in future.

Funding
Reduction of the lag in funding following patients would be welcomed. While some practices have quarterly adjustments, others have annual adjustments which would make it very difficult to provide for a significant increase in patient list size within the year. In addition, one practice manager described a requirement within their current contract to accommodate an incremental increase in list size of 5% with no increase in funding. Practices that anticipate high demand noted that investment up front would be required to enable them to increase capacity.

One practice suggested a separate additional prescribing budget would make practices more likely to accept out of area patients.

8. Discussion

Overview of findings

Pilot patients and their experiences

Implementation of the GP Practice Choice pilot began in April 2012 and was limited to 12 months. Practices were recruited in four PCT volunteer areas – Westminster, Salford, Manchester and Nottingham City. A total of 43 practices participated in the pilot, with approximately half of the practices located in Westminster. However, 11 of the 43 pilot practices recruited no patients during the 12 months of the pilot.

Within the four pilot PCTs, the pilot and non-pilot practices were very similar in terms of features such as list size, QOF scores, and patient experiences and views assessed using the GPPS. It also appears that the practices were quite typical of the average patient experience throughout England. This means that pilot patient reports can generally be attributed to their experience of the pilot, as opposed to simply attending a better practice.

Before the pilot, practices were using a range of mechanisms to provide services to out of area patients, including as temporary residents, or as patients with needs that were 'immediate and necessary', or via an 'outer boundaries' arrangement. Practices also accepted patients that lived beyond their boundaries at their discretion. Some practices accepted patients under the pilot who would otherwise have been accepted under these other mechanisms.

Pilot practices generally preferred to register pilot patients rather than see them as day patients because less administrative work was required and out-of-area registration involved the same process as normal registration. Were the pilot to be extended, some practices indicated they would not continue with the pilot unless the administrative process for day patients had been streamlined.

A total of 1108 patients registered with pilot practices as OoA registered patients, and an additional 250 patients attended pilot practices as day patients. It was not possible to calculate a participation rate as there is no known denominator (and it is not possible to estimate one as anyone who can register with a practice, including those moving into England, is the base). It is not known how many of the 1108 had presented as potential day patients and were then registered before using the practice. The vast majority of both day patients (78%) and OoA registered patients (71%) attended pilot practices in Westminster, where nearly half of participating practices were located (20/43, 46.5%). There are a number of potential reasons why Westminster dominated the pilot such as: a large number of inward commuters; a large number of people arriving in the area from other parts of the UK and overseas; and tight practice boundaries associated with high population density.

OoA registered and day patients were much younger and more likely to be in work than either the other patients in their practices or patients in the rest of the practices in the local PCT. Those in work were about twice as likely to have a more than 30-minute journey to work than other patients in the pilot practices. They had better self-reported health than other patients in the pilot practices.

The majority of OoA registered patients had chosen their pilot practice on grounds of convenience to home, work or education (60%). However, there were four types of OoA registered patients, based on their circumstances and main reason for registering with a pilot practice:

1. Patients who had moved house but did not want to change their GP. This group comprised about one in four OoA registered patients (26.2%).
2. Patients who had chosen their practice for reasons of convenience (for example, because it was close to their workplace). This was the largest group, and included one in three OoA registered patients (32.6%). Some of these patients may have recently moved to the city (often from abroad or from elsewhere in the UK), and so may not have left a previous practice elsewhere in the country.
3. Patients who had just moved to the neighbourhood and registered with a practice near their new home, but their home was outside the relevant practice's catchment area. These patients accounted for about one in four OoA registered patients (23.6%). Again, some of these patients came from abroad or from elsewhere in the UK, and thus did not change their registration.
4. Patients who were dissatisfied with their previous practice or, alternatively, gave a positive reason for choosing their current practice as an out of area patient (for example, because of the services offered). These patients accounted for about one in seven OoA registered patients (13.9%).

The majority of day patients chose to attend a practice they were not registered with for reasons of convenience but there were three types of day patients, based on their preferences and main reason for attending a practice they were not registered with as day patients:

1. Patients motivated by convenience in relation to their lifestyle or place of work (68.8%).
2. Patients who could have been registered as Temporary Residents (for example, because they fell ill while visiting family or staying at a hotel while on holiday) (18.8%).
3. Patients who preferred a specific practice because they wanted to see a particular GP, they received specialised care that their registered practice did not provide, or they were not satisfied with the quality of care at their registered practice (7.8%).

Although, as expected, a majority of OoA registered patients did not live close to their pilot practice, 27.8% lived less than two miles from their pilot practice. Day patients were more likely to live either very close, to or much further away from, the practices they visited in that almost half (48.4%) of the day patients lived within two miles and 22.4% lived 25 or more miles away.

It was not possible in the limited period of the evaluation to set up a method to extract data from pilot practice computer systems to describe the reasons for GP visits among the OoA registered patients. Some data were available for the day patients since practices had to complete a day patient form to claim payment for each visit and this form included simple information on the reason for the visit. Day patients generally attended practices for acute infections (51.6%), most commonly upper respiratory infections (20.4%). Other acute conditions accounted for a further one in five (21.2%) day patient visits, followed by medication issues (7.6%) and chronic conditions (5.2%). Over two-thirds (66.0%) of day patients received a prescription during their visit. Referrals were less common, with only one in ten (10.1%) day patients referred by the GP for tests or other services. Most referrals were for MRIs (for knee or back injuries) or physiotherapy, often obtained privately in the case of Westminster.

Most OoA registered and day patients were positive about the scheme and were eager for the scheme to continue. In terms of their experiences during their last appointment with a GP or a nurse (either in person or by telephone), OoA registered

patients' views were very positive. When describing the experience of their last visit to the practice, OoA registered and day patients were a bit more likely than all GPPS patients in the same pilot practices to pick the highest category of 'very good', but the differences were not statistically significant.

Compared with the other patients at the same pilot practices, OoA registered and day patients also gave more positive overall views of the practice. Although the differences were not large, this is important in view of the much younger age profile of the OoA registered patients and the fact that younger patients tend to be more critical of their GP practice (Kontopantelis, Roland and Reeves 2010). Among those OoA registered patients who had changed practice, three in five said that their new practice was much (46.5%) or somewhat (14.5%) better than their previous one and one in four (23.8%) that it was about the same. Among day patients, two in five day patients considered the practice they had visited as a day patient to be as good as (40.0%) their registered practice, while one in three (34.6%) felt it was much or somewhat better. Only 9.1% thought it was worse than their registered practice.

Convenience and continuity of care appeared to be the main benefits that OoA registered patients perceived. Existing patients who became OoA registered patients were positive about being able to remain registered with their practice when they moved home. The scheme also suited those commuters, including patients with long commutes (who leave home early and return home late) and/or the likely small proportion of workers whose jobs require them to work routinely in different places who had struggled to attend a practice even during the extended hours of their local GP practice. Day patients also valued a convenient location, ease of making an appointment and not taking more time out of work to see a GP. The scheme suited patients wishing to remain registered with a practice near their homes; among day patients, many (38.7%) were aware they could change their registration but fewer than one in six (14.5%) did.

Consistent with the short duration of the pilot, relatively few OoA registered patients used the GP out-of-hours service (5%), so their experience of the quality of coordination between their pilot practice and GP services where they lived was limited. However, 46% had had some sort of referral, most frequently for an X-ray or other routine test and they did not report major problems with this process. OoA registered patients were able to be referred to services near their home or near their pilot practice – practices found referrals to community health services near the patient's home to be problematic since they did not have a relationship with the community health services where OoA registered patients lived and the services would sometimes only accept referrals from local practices. Generally these issues were resolved as they arose, but practices and commissioners were concerned that referrals could be delayed, or be made to inappropriate providers.

It was possible that the scheme diverted some patients from other urgent or primary care services. If the scheme had not been available, many day patients (42.4%) claimed that they would have attended an A&E department, walk-in centre or urgent care centre. However, it seems unlikely that this would necessarily be the case in practice to any major degree. The literature review (see Appendix 1) of previous initiatives to expand access to, and choice of, primary and urgent care provider found no evidence that past efforts reduced use of, or demand for, A&E services.

It is not possible to explain definitively why OoA registered and day patients reported more positive views of their pilot practice than other patients at the same practice

or other patients nationally. They seemed to be registering with and attending pilot practices which were not consistently superior to non-pilot practices. Part of the explanation may lie in the value these patients ascribed to being able either to remain with a practice with which they were familiar or to choose a practice more convenient than their previous practice. In a much smaller proportion of cases, it may have been because patients and practices were better matched through the pilot than they might otherwise have been. As most day patients participated in the scheme by walking in or calling the practice to make a same-day appointment, it is unsurprising that they reported positive experiences.

Preferences for registration inside the neighbourhood versus outside the neighbourhood among the general public

In general, the results of the DCE show that there is some appetite for OoA registration in the general population, at least hypothetically, in that a minority of the population would be willing to register with a practice outside their neighbourhood provided that there was such a practice available that was more convenient for them. However, there is considerable heterogeneity in preferences in the population. In particular, some sub-groups, either because they are less mobile (e.g. older people and those with caring responsibilities), or because they are satisfied with their local services, are far less interested in the idea of registering at a practice outside their neighbourhood. Findings from the DCE also indicate that, in choosing a practice, people feel most strongly about obtaining an appointment with a GP as quickly as possible. This is more important than any other aspect of GP services to them (e.g. more important than extended opening hours or a practice responsive to their needs). Most people did not regard weekend opening (Saturday and Sunday) as an important characteristic in determining their choice of practice. Some people, in particular those who worked and older people, felt strongly about having responsive services that had extensive opening hours, whether it meant that they had to register with a practice locally or not. These findings are echoed in the results from the surveys of pilot patients.

Strengths and weaknesses of the study

The main strength of the current study lies in its ability to compare all pilot patients' experiences and views about their general practice care with non-pilot patients in the same PCTs using the GPPS, and GPPS questions in the surveys of pilot OoA registered patients and day patients undertaken for this study. The response rate to the OoA registered patients' survey was 36% which is better than the most recent GPPS response rate in the four PCTs taking part in the pilot (Ipsos-MORI GP Patient Survey 2013).

Another strength of the study lies in the inclusion of a DCE that provides an understanding of the preferences of members of the general population, not just the limited number of patients involved in the pilot, when faced with neighbourhood and non-neighbourhood general practices with different characteristics. This analysis sheds some light on the potential strength and pattern of demand for a wider choice of general practice beyond the pilot areas and patients.

The limitations of the study are as follows:

- Since the characteristics of patients entering the pilot were not known in advance, the numbers of patients in the pilot increased only gradually and there is no routine data source for primary medical services, it was not possible in the 12 months of the study to identify and recruit a matched group of non-pilot patients in order to compare their utilisation, costs and experiences with those of pilot patients. Thus the

current study cannot provide an estimate of the relative cost-effectiveness of the GP Practice Choice pilot versus GP services in the absence of the pilot. This is an intrinsically difficult undertaking (see below).

- The study relates to the four PCT areas in the pilot and to volunteer practices within each area, and looks at a maximum of 12 months of pilot activity (for many patients this was considerably less since take-up of the scheme was inevitably gradual). The study did not include interviews either with practices outside the pilot areas or those that had decided not to take part in the pilot. As a result, the study can only provide a preliminary indication of how the scheme might work if implemented more widely, in other areas with different patient populations, or much more widely, thereby enabling it to be much more intensively publicised, and over a longer period of time. In such circumstances, the numbers and types of patients involved could be significantly different (though the DCE gives some indication of what might happen). Also, the experience of OoA registered patients could conceivably be less positive over a longer period as they encountered more of the disadvantages of living in one place and being registered in another. Some OoA registered patients returned to their previous practices even during the short life of the pilot as they began to see disadvantages; with more time, this could become a bigger issue.
- It was not feasible to attempt to collect any data from the practices from which the day patients, and those OoA registered patients who moved practice, came (e.g. on whether they were high or low performers). These practices were only likely to have contributed a handful of patients each at the most to the pilot and were numerous. Also, currently, the NHAIS system over-writes details of a patient's previous registration as soon as a new one occurs, thereby making it impossible to find out which practice the patient has moved from. The only way that this could be done would be by asking the patient soon after the change of registration. The information might be contained in the patient's medical notes, but permission would need to be sought from the new practice and the practice would need to be willing to provide the information. It was decided that it was not feasible to collect any such data in the 12-month timescale of the study.
- It was not possible to look directly at the effect of the scheme on pilot practices' existing patients, given the limited numbers of patients in the pilot, and the short timescale of the pilot and the evaluation. This could be an important issue were the scheme to be extended to areas with large numbers of commuters and/or few general practices (e.g. the City of London and Canary Wharf).
- It was not possible to approach pilot patients directly for interviews due to limitations imposed by the NHS research ethics committee and, as a result, pilot practices had to volunteer to send out invitations to patients on behalf of the research team. This meant additional administrative work for practices which most were unwilling to carry out. As a result, it was necessary to contact a large number of practices and their patients in order to obtain interviews. It was impossible to obtain the planned range of interviewees in the time available using this method.
- A large proportion of pilot patients were in Westminster or using Westminster practices. Central London is widely regarded as one of the most difficult parts of England to conduct interview and questionnaire survey research; hence, for example, a large number of patients had to be approached in relation to the number of interviews achieved.
- It was considerably more difficult to collect survey data from day patients compared with OoA registered patients, in part, because their involvement with the pilot was more limited, in part because as many as a quarter of all day patients gave a hotel as their address and most likely should have been categorised as "temporary residents".

- The study was undertaken during the transition between PCTs and CCGs which adversely affected the ability of local managers of primary care to facilitate the study.
- With the resources and time available, it was not possible to undertake a detailed costing of the set up and management of the pilot. It was also not possible to cost the service use of the pilot OoA registered patients since this would have required setting up a system for monitoring their use of GP and other services and/or extracting data from their medical notes. It was possible to get a crude sense of day patients' use of services since each practice visit and any associated prescribing or referrals were meant to be recorded on the day patient form returned to the PCT for payment of the day patient visit fee. Given the short duration of the pilot, it is unlikely that the service use and cost data would have given any indication of the likely cost consequences for the NHS of extending the pilot.
- The DCE is large but the survey was administered to a volunteer internet panel rather than a random sample of the general population, and the choices it proposed to respondents were hypothetical and inevitably simplifications of the real world choices faced by patients.

Implications for future policy on GP practice choice

As part of the NHS General Medical Services Contract annual negotiations for 2014/15, NHS Employers, on behalf of NHS England, reached agreement with the General Practitioners Committee of the BMA for all GP practices to be able to register patients from outside their traditional practice boundary areas without any obligation to provide home visits for such patients. Practice participation will remain voluntary. NHS England will be responsible for arranging in-hours urgent medical care when needed at or near home for patients who register with a practice away from home. GPC and NHS Employers are working with NHS England to resolve any practical issues prior to implementation. Thus the OoA registration option in the pilot has been rolled out and the day patient option has been dropped.

To what extent do the findings from the current study support this decision? Overall, the findings from the evaluation of the limited 12-month GP Practice Choice pilot suggest that participating patients and practices judged the scheme superior to their previous situation and experience. The pilot was delivered with little sign of major increased cost to the NHS, at least in the short term and with the small numbers of patients involved, though no one indicated that it might generate any savings. The direct costs of setting up and managing the pilot both at PCT and practice level appeared to be small, though there was no detailed costing in the evaluation. Participants reported that costs were likely to be higher to implement the day patient option. There was some evidence that pilot patients were more satisfied with their GP services than similar patients at similar practices elsewhere in the country and non-pilot patients in the same practices, though the differences were modest. Thus there was a prima facie case for, at least, continuing the pilot and perhaps offering it in other selected places, though it was unlikely to be judged a top priority for additional funding in a period of NHS stringency since the health benefits are unknown and it does present some disadvantages for the NHS and for patients. To minimise the drawbacks, there are a number of practical issues that need to be resolved before extending the scheme. These are summarised below in relation to OoA registration. The practical drawbacks of the day patient option that would need addressing are not discussed since the Government has decided not to pursue this option in future.

As the number of pilot patients in the first 12 months was relatively small, and patients had participated in the pilot for less than 12 months in only four areas, it is too

soon to be able to reach definitive conclusions about the level of demand, benefits, disadvantages and service costs of the pilot were it to be extended throughout the NHS and for an indefinite period of time. Patient recruitment was almost certainly restricted by the fact that the pilot could not be widely or thoroughly publicised since it only applied to four parts of the country and only to a minority of volunteer GP practices in these areas. With greater publicity, more, but also probably some different kinds of patients would be likely to enter the scheme whose experiences could be different from those studied. The variation between the pilot PCT areas in the numbers of OoA registered patients and day patients suggests that the demand for GP Practice Choice is likely to be localised across the NHS since the four areas had been approached to take part on the grounds that they were likely to have higher than average demand for out of area choice of GP practice. The DCE suggested that demand for OoA registration is likely to come from a minority of patients, albeit a potentially considerable proportion. The DCE indicated that demand for OoA registration is not necessarily likely to be stronger in large cities than in other areas despite the choice of the four sites for the pilot. Demand may relate more particularly to the extent of commuting into an area as well as the rate of arrivals of newcomers to live in an area. Demand may also relate to whether there are alternatives to ordinary general practices locally (e.g. NHS Walk-in Centres, urgent care centres, etc.), how restricted practice catchments are and (relatedly) how much capacity ordinary GP practices in the area have.

While it is unsurprising that patients and practices (in the case of the out of area registration option, in particular, though not all pilot practices) were broadly positive about the scheme and about extending it in future, PCT managers interviewed were more cautious about a large-scale roll-out of the scheme. Particular concerns related to the risk with out-of-area registration that greater patient choice of practice could lead to more mobile, younger, healthier patients being recruited disproportionately to some practices, leaving less mobile, older, sicker patients with other practices such that, over time, practices' populations became much more segregated, putting increased pressure on the ability of the needs weighting in the capitation formula for practices to differentiate between different types of patients. There was some evidence from the DCE that those who tend to use primary care services more (e.g. people with caring responsibilities and people who are older) are more likely to be interested in staying with their local practice. Under current arrangements, it is difficult for practices to refuse patients that live within their practice boundary, whereas it would become far easier with the removal of boundaries for practices to select more attractive patients (e.g. those with greater potential to generate QOF points such as otherwise healthy diabetics) and refuse others. As a result, the more attractive patients might experience an increase in choice while the less attractive experience the opposite. There were related concerns about choice leading to some practices expanding while others ceased to be viable due to falling patient numbers, threatening access to care for less mobile populations. As the GP Practice Choice scheme is rolled out nationally, these sorts of trends will need to be carefully monitored and their overall consequences ascertained.

Another major concern, as more patients found themselves living outside the area where their general practice was located, related to making and managing referrals and their costs, as well as having to arrange out of hours care and home visits for OoA registered patients who could live anywhere in the country. It is worth recalling that there were good reasons at the time for the emergence of the notion of practice boundaries during the 1980s as a solution to the coordination problem between general practice and community health services posed by patients remaining

registered with practices in one area long after they had moved elsewhere. In the large conurbations and in the case of older patients, this could lead, for example, to GPs and community nurses needing to develop and maintain relationships with large numbers of counterparts in the other professional group over considerable distances.

While OoA registered patients represented competition between practices which could have adverse consequences for some, day patients represented a more fragmented approach to primary care which some managers felt could harm continuity and thus quality of care more directly. In the longer term, this could have become more of a problem. So far, in the pilot, patients had reported few problems of this type, possibly because they take time to emerge. There were also potential clinical problems if day patients were to make multiple visits for the same condition (e.g. the risk of over-dosing on different prescription drugs obtained from multiple GPs) as well as a likelihood of increasing the overall costs of primary care, although this was not detected in the current study. Such "doctor shopping" is a recognised downside of freer patient choice of general practice.

Finally, despite the decision to offer out of area registration across England from October 2014, there still remains the question as to whether the same or similar improvements in access and convenience could be obtained in other ways at similar or lower cost, such as by requiring practices to offer an Outer Boundary, or a wider overall boundary, or to extend their opening hours still further. According to the DCE in the current study, such extended hours should probably be offered Monday to Friday since Saturday or Sunday opening did not seem to be strongly supported. While all respondents to the DCE survey viewed being seen quickly by a GP as the most crucial aspect of their hypothetical choices, followed by extended opening hours, the availability of weekend opening appeared to have very little impact on their registration choices. This is noteworthy in light of the Government's plans, supported by a challenge fund, to test further innovative ways to improve access to general practice that include 8am-8pm, 7-day working (Prime Minister's Office 2013; NHS England 2013). Other options that could probably play a larger part in future include encouraging practices to offer patients the option to speak to a GP or practice nurse by phone or video link, or to consult by email.

It would seem sensible to take the opportunity of the extension of OoA registration to estimate its marginal cost-effectiveness on an expanded basis versus other options such as a modified Walk-in Centre programme, further extensions and/or changes to GP practice clinic hours in total and by time of day/week, and phone, video and email consultations. Such an analysis would need to take account of the fact that the same patients may well use more than one of these options to access first contact care, sometimes in close succession.

Now that it is clear that choice of GP practice broadly along the lines in the OoA option in the pilot is to be continued and expanded (i.e. effectively removing the notion in policy or practice of practice boundaries where practices volunteer to remove them), then the experience of the 12-month pilot suggests that the following issues need to be resolved:

1. How to improve the current arrangements in relation to OoA registered patients for: referrals to community health services near home, given that, over time and as the scheme grows, increasing numbers of practice and community health services are likely to need to find ways of working together, sometimes over considerable distances; and out of hours care and home visiting, despite likely very low levels of demand for the latter.

2. How to be able to routinely identify the practices from which OoA registered patients move under the choice scheme by adapting NHAIS to retain previous registration information.
3. How to ensure reliable, prompt and secure transfer of clinical information between practices and other service providers and also between practices for OoA registered patients when seen by the out-of-hours service or when they receive urgent care in the area where they live.
4. How to monitor the total cost to the NHS of providing out of area registration compared with previous arrangements (e.g. to be able to calculate the extent of any 'double dipping' and the extra costs involved in contracting for out of hours and home visiting services for OoA registered patients).
5. How to allocate the costs to commissioners of prescribing and referred services generated by patients who are not resident in a CCG's area.
6. Whether to enable participating practices to register more patients without any external limits versus setting limits (e.g. to prevent a situation in which local residents cannot register with a practice because it has so many OoA registered patients).
7. How to provide the necessary GP service capacity in parts of England where there may be strong demand for out of area GP practice care (i.e. "importing" areas), but very little existing capacity. Practices preparing for high numbers of out of area patients might require some financial support up-front to be able to participate (for example, to be able to invest in increased capacity before patients arrived), or quarterly rather than six-monthly adjustments to their capitation funding to recognise their increased lists.
8. How to monitor and, if necessary, manage and fund the demand for "immediate and necessary" from OoA registered patients in areas with large concentrations of such patients (i.e. "exporting" areas) such as potentially parts of Essex, Kent, Surrey, etc. (this relates to point 10 below, in that currently practices receive no payment for 'immediate and necessary' and temporary residents.
9. How to monitor the cumulative effect of patient choice of practice and practice choice of patient on the choices available to different types of patients and the needs profile of different practices to ensure that particular patient sub-groups and practices are not being discriminated against systematically.
10. Clarification of the distinction between the different ways in which NHS patients can be seen in general practice out-of-area (i.e. temporary resident, "immediate and necessary" and OoA registered) plus rationalisation of the way that they are reimbursed.
11. Whether it is necessary to provide more information for prospective patients on the staffing, services offered and quality of care of practices offering OoA registration given that the initial pilot relied entirely on patients' ability and interest to locate and interpret the variable amounts of information on practice websites and provided by PCTs.

Given the brevity of the initial pilot period, the limitations of the current study (e.g. not being able to look at longer term impacts on practices and patients, lack of a detailed costing of the management of the pilot and the service costs generated by pilot patients compared with non-pilot practices), and the difficulty of predicting the demand for, and costs and benefits of, a more generalised GP Practice Choice scheme, there is a strong case for putting in place a parallel evaluation now that the scheme is to continue at a larger scale. This will be challenging to design since the numbers and characteristics of OoA registered patients cannot be known precisely in advance (though the DCE provides an indication). The aim would be to design the evaluation as a matched individual level comparison between cohorts of out of area

registered and not out of area registered patients in similar practices and parts of the country. It might also be possible to include in such an evaluation a comparison between face to face, out of area GP practice care and a range of alternatives including phone, video and email consultations and less conventional sources of first contact care such as NHS Walk-in Centres. One way to approach this study would be to use propensity weighting to find a retrospectively matched comparison group at the end of a period when sufficient patients had been recruited to the scheme. Another approach might be to find a match for patients as they joined the scheme (e.g. taken from the practice they had left). In the case of patients who moved house but stayed at the same practice, it would be less obvious how to find a suitable comparison patient. Perhaps, this would have to be a similar patient who moved house and changed practice at about the same time. Despite the challenges, it would seem important to evaluate such changes to NHS services used by hundreds of thousands of people each week.

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Appendices (in a seperate volume)

1. Literature review on developments in primary health care in England
2. International comparison literature review
3. Day patient form, for practice use
4. Information for practice and PCT interviewees
5. Interview topic guides
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6. Information for patient interviewees
7. Practice survey
8. Out of area registered patient postal survey
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10. Discrete choice experiment

10.0. Online DCE choice questions
10.1. Descriptive statistics of the original study population for the DCE study
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10.3. Comparison of main socio-demographic characteristics of the sub-sample used in analysis and the general population
10.4. Technical appendix on the econometric analysis of DCE analysis
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10.8. Preferences for GP practice choice, estimated on the sample of those 90% who responded the slowest

11. GP practices participating in the pilot
12. Out of area registered patient maps for Nottingham, Manchester and Salford
13. Day patient maps for Salford and Nottingham

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