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## Patients' experiences of the choice of GP practice pilot, 2012/13: a mixed methods evaluation

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14 **Patients' experiences of the choice of GP practice pilot, 2012/13: a**  
15 **mixed methods evaluation**  
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## Abstract

### *Objectives*

To investigate patients' experiences of the choice of GP practice pilot.

### *Design*

Mixed-method, cross-sectional study.

### *Setting*

Patients in the UK NHS register with a general practice responsible for their primary medical care and practices set geographic boundaries. In 2012/13, 43 volunteer general practices in four English NHS primary care trusts (PCTs) piloted a scheme allowing patients living outside practice boundaries to register as an out of area patient or be seen as a day patient.

### *Participants*

Postal survey of adult day (64/188, 34%) and out of area registered (315/886, 36%) patients; comparison with general practice patient survey (GPPS); analysis of routine data; semi-structured interviews with 24 pilot patients.

### *Results*

Pilot patients were younger and more likely to be working than non-pilot patients at the same practices and reported generally more or at least as positive experiences than patients registered at the same practices, practices in the same PCT and nationally, despite belonging to sub-groups of the population who typically report poorer than average experiences. Out of area patients who joined a pilot practice did so: after moving house and not wanting to change practice (26.2%); for convenience (32.6%); as newcomers to an area who selected a practice although they lived outside its boundary (23.6%); because of dissatisfaction with their previous practice (13.9%). Day patients attended primarily on grounds of convenience (68.8%). 51.6% of the day patient visits were for acute infections, most commonly upper respiratory infections (20.4%). 66.0% of day patients received a prescription during their visit

### *Conclusion*

Though the 12-month pilot was too brief to identify all costs and benefits, the scheme appeared to provide a positive experience for participating patients and practices.

*Keywords:* primary health care, general practice, access, choice, practice boundaries

Abstract: 275 words

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3 Strengths and limitations of this study

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- There is very little evidence either from the NHS or other systems on the costs and benefits of widening patient choice of general practice, and specifically the effects of removing geographic boundaries outside the current evaluation of the choice of GP practice pilot.
  - This study reveals that patients reported high satisfaction with their experience in a short-term pilot. Most patients joined the pilot on grounds that the pilot practice was more convenient than their previous source of primary medical care.
  - A strength of the study is that it compares pilot patients' characteristics and experiences with those of all patients in the GP Patient Survey registered in the same practices and nationally. Survey response rates were similar to those for GPPS in the same PCTs. Semi-structured interviews assisted in the development pilot-specific survey questions and interpretation of the results.
  - The study is limited by the structure of the pilot itself, which took place in relatively few, self-selected practices and could not be widely promoted, so it is not possible to estimate the likely patient participation rate when rolled out nationwide.
  - In the 12-month pilot, it was not possible to identify the impact of removing practice boundaries on, for instance, referrals, overall use of primary and secondary care, costs to commissioners, equity of access, or practice patient mix.

## Introduction

Giving patients more choice over where they access care has been central to reforms in England's National Health Service (NHS) since the late 1990s<sup>1-3</sup>. In normal circumstances, NHS patients are expected to seek their primary medical care from the practice with which they are registered and practices generally only accept patients who live within their geographic boundaries. Geographical boundaries in primary care were developed in the 1980s in response to the scattering of practices' patients which hampered home visits and linkages to community nursing organized on a patch basis.

A 2009 public consultation on increasing choice of GP practice found that 18% of respondents were likely to register with a different practice within their local area (i.e. outside their current practice's boundary) if the option to do so was available<sup>4</sup>. From 2012, general practices have been able to register patients that live beyond their 'normal' practice boundary as 'outer boundary' or 'fringe' list patients. However, practices are required to provide all care, including home visits, to these patients<sup>5</sup>. In other circumstances, practices have the discretion to allow any patient to register, but may choose not to offer services such as home visits to distant patients.

As part of the Coalition government's pledge to increase patient choice and improve access, a 12-month choice of GP practice pilot was implemented in four primary care trusts (PCTs). The pilot allowed patients to either register at a volunteer practice as an out of area patient, with access to all primary medical services, except home visits, or to see a GP or nurse as a day patient at a volunteer practice, for routine or non-urgent care, while remaining registered with their current GP practice<sup>6</sup>. Unlike the 'outer boundary policy', home visits for out of area registered patients were to be provided by the home PCT. The pilot did not alter the existing arrangements for providing GP care to Temporary Residents or those requiring 'Immediate and Necessary' care. However, access was intended to differ in the pilot in that day patients were not required to show that they were living temporarily in the area and did not necessarily need to present with 'immediate and necessary' needs for care. In the case of out of area patients, the practice had access to patients' usual electronic records, but this was not so for day patients, (information on whose visits were expected to be shared with the patients' registered practice). Participating practices were paid a £12.93 fee for each day patient visit. When an out of area patient registered with a pilot practice,

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3 the global sum funding for that patient was transferred to the pilot practice for the following  
4 year or the next payment period.  
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8 The pilot was intended to improve access for people such as workers finding it difficult to  
9 visit their regular practice during working hours, long-haul commuters or those wishing to  
10 register at another location (e.g. near a family member). Very little is known of the  
11 consequences of removing or flexing practice boundaries. This paper describes patients' self-  
12 reported experiences of being an out of area patient or a day patient, drawn from the wider  
13 evaluation of the choice of GP practice pilot <sup>7</sup>.  
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## 18 **Methods**

### 19 *Study design*

20 Mixed-method cross-sectional study.  
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### 23 *Routine data*

24 Basic quantitative profile and clinical data were collected for all 1358 patients who used the  
25 pilot between April 2012 and March 2013 since all day patient visits were separately  
26 recorded for payment purposes. For out of area patients, more limited administrative  
27 information was available through the National Health Authority Information System (NHAIS,  
28 now Connecting for Health) on age, gender, new practice code and the first 3-4 digits of the  
29 patient's home address post code. It was not feasible given the short duration of the pilot to  
30 negotiate permission to extract clinical data on out of area patients' use of their new  
31 practices from practice computer systems. For day patients, data were available on the  
32 number of visits, along with the reason and consequence of each.  
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### 42 *Interviews with patients*

43 Semi-structured telephone interviews were undertaken with 18 out of area registered  
44 patients and six day patients chosen, as far as possible, for maximum variation in terms of  
45 age and occupation, in order to explore why patients used the pilot scheme, their  
46 experiences, and the perceived benefits and drawbacks of the scheme. All interviews were  
47 recorded and transcribed. Transcripts were analysed thematically and coded in NVivo 10.  
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### 53 *Patient survey*

54 We conducted a postal survey of all day (64/188, 34% response rate) and out of area  
55 registered (315/886, 36%) patients aged 18 years and over and with a permanent address in  
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3 the UK. Of the 284 pilot patients not included in the survey, 260 were aged under 18 (n=222  
4 for out of area registered patients and n=38 for day patients, and 24 day patients did not  
5 have an available UK address.  
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10 The patient survey questionnaire was modelled on that used for the national GP Patient  
11 Survey (GPPS) (<http://www.gp-patient.co.uk/questionnaires/>), and results were compared  
12 with GPPS results for year 7 wave 1 (July to September 2012) for the same PCTs and  
13 practices. In order to account for varying probabilities of selection and differential non-  
14 response (e.g. by age and sex), the GPPS results were weighted (by Ipsos MORI, the  
15 organisation that carries out the GPPS) to be representative of all registered patients (aged  
16 18+ years) within a practice, a PCT and nationally ([http://www.gp-  
17 patient.co.uk/results/download/\\_y6q2/y6w2\\_AnnualTechnical.pdf](http://www.gp-patient.co.uk/results/download/_y6q2/y6w2_AnnualTechnical.pdf)). The data for the out of  
18 area registered patients were corrected for non-response and weighted so that the achieved  
19 sample matched the age distribution for all out of area patients aged 18+ years. Due to  
20 small numbers, the day patient survey data were not weighted for non-response. Further  
21 details of the pilot patient survey methodology can be found in  
22 [http://www.piru.ac.uk/assets/files/General%20Practice%20Choice%20Pilot%20Evaluation.p  
23 df.](http://www.piru.ac.uk/assets/files/General%20Practice%20Choice%20Pilot%20Evaluation.pdf)  
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34 The survey data were analysed using SPSS 20. Descriptive statistics are presented in Table 1.  
35 All differences between the pilot patients and GPPS highlighted in the Results are  
36 statistically significant at the 95% level.  
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## 39 40 41 **Results**

### 42 *Pilot practice characteristics*

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44 In the four PCTs, 43 general practices out of 269 eligible practices volunteered for the pilot  
45 (with 20/53 (38%) of practices in Westminster, 7/63 (11%) in Nottingham, 8/102 (8%) in  
46 Manchester, and 8/51 (16%) in Salford). Pilot and non-pilot practices were similar in terms  
47 of list size, Quality and Outcome Framework (QOF) scores, and patient experiences and  
48 views in the GPPS. There was no evidence that pilot practices were obviously 'better'  
49 practices.  
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### 55 *Pilot patient characteristics*

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3 1108 patients registered at a pilot practice away from the area where they lived, while 250  
4 patients saw a GP or nurse as a day patient. The vast majority of patients registered with, or  
5 attended, a pilot practice in Westminster (71% of out of area registered patients and 78% of  
6 day patients).  
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11 When compared to GPPS patients from the same practices, Table 1 shows that out of area  
12 registered and day patients were much younger than other patients in the pilot practices  
13 (64.1% of out of area registered and 67.3% of day patients were aged 18-34 compared with  
14 33.3% of GPPS patients in pilot practices). They were also more likely to be in full-time work  
15 (65.8% for out of area registered patients and 65.6% for day patients compared with 46.9%  
16 of GPPS patients in pilot practices). Among those in work, out of area registered and day  
17 patients tended to have a longer commute (66.2% and 60.0% respectively had a journey to  
18 work time of half an hour or more compared with 34.6% of GPPS patients in pilot practices).  
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26 Out of area registered patients were more likely to be in education (9.5% for out of area  
27 registered patients compared with 5.1% of GPPS patients in pilot practices) and less likely to  
28 be retired (3.1% out of area registered compared with 13.3% GPPS patients in pilot  
29 practices). Out of area registered patients were much less likely to have dependent children  
30 under 16 (10.1% compared with 23.6% of GPPS patients in pilot practices) or to be unpaid  
31 carers (3.8% compared with 15.1% of GPPS patients in pilot practices).  
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### 35 36 37 *Patients' reasons for taking part in the pilot*

38 We identified four types of out of area registered patients based on two survey questions  
39 that asked their reasons for participating in the pilot and for choosing the particular practice  
40 they were now registered with (see <sup>8</sup> for details of questions). About a quarter (26.2%) had  
41 moved house and wished to stay with the same practice. About a quarter (23.6%) had  
42 recently moved into the area and had registered with a local practice despite being outside  
43 its catchment. Around a third (32.6%) chose their practice for convenience (e.g. near their  
44 workplace); one such patient said the scheme was suitable "because this way, I don't have  
45 to take time off work to see my GP... now I can walk to the surgery within ten minutes, it's  
46 extremely convenient" and "I can go and see my GP and be back at the office within half an  
47 hour, maybe 45 minutes...it is great for me, it is great for my employer "(patient interview,  
48 London). Some (13.9%) chose their practice because they were dissatisfied with their  
49 previous GP or sought services that their previous practice could not provide. (A small  
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3 proportion of out of area registered patients could not be classified, mostly because of  
4 missing data (3.8%).) Box 1 presents two different patient profiles from the qualitative  
5 interviews.  
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10 We identified three types of day patients based on survey questions about the main reason  
11 they had visited as a day patient instead of visiting their registered practice, whether they  
12 had tried to make an appointment at their registered practice, and how the practice they  
13 had visited compared with their registered practice (see <sup>8</sup> for the questions). Day patients  
14 generally attended pilot practices because they were convenient (68.8%). The interviews  
15 revealed some confusion among practices between the day patient option and existing  
16 provisions for urgent appointments in primary care, namely Temporary Resident status and  
17 those requiring 'Immediate and Necessary' care, as it appears that nearly one in five (18.8%)  
18 day patients would have been more appropriately categorised as one of these types of  
19 patients. A small number of patients preferred a specific practice or a specific doctor (e.g., if  
20 they had been registered at one practice before moving house and wanted to see their  
21 former GP while remaining registered with a local practice), received specialist care that  
22 their registered practice did not offer, or were not satisfied with the quality of care received  
23 at their registered practice. One such day patient said the day patient option made seeing a  
24 GP easier as "the opening hours are good and the first time I went before work which was  
25 really useful – 8 o'clock, I think, and the second time I went in, somebody saw me right away"  
26 (patient interview, Nottingham). A small percentage of day patients could not be classified  
27 due to missing data (4.7%). Most day patients (77%) had not tried to make an appointment  
28 at their registered practice before their visit. Box 2 provides a vignette from a day patient  
29 interview.  
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#### 32 *Day patients' reasons for consulting a pilot practice*

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34 Half (51.6%) of the visits were for acute infections, most commonly upper respiratory  
35 infections (20.4%). Other acute conditions accounted for a further one in five (21.2%) day  
36 patient visits, followed by medication issues (7.6%) and chronic conditions (5.2%). A  
37 relatively small percentage of visits did not require any treatment, or were to obtain  
38 reassurance or a second opinion (8.4%). This pattern of use contrasts markedly with the  
39 overall pattern in general practice where around 80% of GP consultations are for ongoing or  
40 chronic conditions <sup>9</sup>.  
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3 Two-thirds (66.0%) of day patients received a prescription during their visit. Referrals were  
4 less common, with only one in ten (10.1%) day patients referred by the GP for tests or other  
5 services. Some referrals were for routine blood tests. Most referrals were for MRIs (for knee  
6 or back injuries) or physiotherapy; several day patients, many of whom presented in  
7 Westminster, used their private health insurance following a NHS GP referral.  
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13 *Out of area registered patient experiences compared with all GPPS patients in the same  
14 practices*

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16 Out of area registered patients were more likely than all GPPS patients in the same pilot  
17 practices to describe the overall experience of making an appointment and their most  
18 recent visit to their practice as 'very good' (47.1% and 57.3%, respectively, of out of area  
19 registered compared with 37.4% and 47.1%, respectively, of GPPS patients in pilot practices)  
20 (see Table 2). In general, out of area registered patients reported better experiences than  
21 non-pilot GPPS patients. This is notable given the much younger age profile of pilot patients  
22 and the well-supported finding that younger patients tend to be more critical of their GP  
23 practice<sup>10</sup>. They valued the quality of the service at their new practice and were happy with,  
24 and trusted, the care they received from GPs and nurses.  
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33 Patients who did not change practice held positive views of their GP practice and said the  
34 scheme had enabled them to stay with a practice that they trusted and which was sensitive  
35 to their health needs. Continuity of care was also important to those out of area patients  
36 who did not change practice and who had had a serious health incident, chronic condition,  
37 bereavement, or major life transition.  
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43 Among those who had changed practice, three in five said their new practice was much  
44 (46.5%) or somewhat (14.5%) better than their previous one and one in four (23.8%) that it  
45 was about the same. Only a small minority said it was somewhat (3.0%) or much (2.6%)  
46 worse than their previous practice. One interviewee who was dissatisfied with her previous  
47 practice and who had a positive reason for choosing an out of area practice said the pilot  
48 gave "access to a good quality practice which I wouldn't have if I could only register with the  
49 practice near where I live" (patient interview, Nottingham).  
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55 *Day patient experiences*  
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3 Day patients were more likely than all GPPS patients in the same pilot practices to describe  
4 their overall experience of making an appointment as 'very good' (59.6% of day patients  
5 compared with 37.4% of GPPS patients in pilot practices). The majority of day patients  
6 viewed the practice they visited as a day patient to be comparable to (40%), or better than  
7 (34.6%), their registered practice. Only 9.1% thought it was worse than their registered  
8 practice. In the interviews, day patients explained that their decision to visit a practice as a  
9 day patient was not a reflection of dissatisfaction with the type or quality of service at their  
10 registered practice, or even the superiority of the practice they visited as a day patient (they  
11 had very limited knowledge of the practice they had visited as a day patient) as much as the  
12 fact that the practice they visited as a day patient had been more convenient.  
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## 22 Discussion

### 23 *Statement of the principal findings*

24 The pilot attracted a relatively small proportion of practices in the four pilot PCTs. There was  
25 no evidence that these were better performing practices. About half of out of area  
26 registered patients had made a positive decision to change practice, with 32.6% choosing a  
27 practice for convenience and 13.9% moving because they were dissatisfied with their  
28 previous practice or attracted to some feature of the new practice. Of the rest, about a  
29 quarter joined the scheme because they chose to stay with a GP practice after moving out of  
30 the catchment area (26.2%), while another quarter had moved to the area but had selected  
31 a practice which they would not normally have been able to register with (23.6%). Day  
32 patients joined the scheme mainly for reasons of convenience.  
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41 Participating patients were younger, more likely to be in work and had better self-reported  
42 health than other patients registered at the same practices. Despite these characteristics,  
43 out of area registered and day patients' assessments of their new practice and care were  
44 better than those reported nationally and in the same practices, and they generally  
45 expressed positive views of the scheme. These positive views are not surprising given the  
46 high proportion of pilot patients who had either stayed with an existing GP after moving  
47 house (presumably because they were satisfied with the practice), or had left a practice they  
48 were dissatisfied with, or had chosen their new practice for a particular reason. These  
49 findings suggest that the pilot of removing practice boundaries was successful in improving  
50 patient experience, at least in the short term. It is unclear whether these positive  
51 experiences could be maintained in the longer term  
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### *Strengths and limitations*

The main strength of this study is the ability to compare pilot patients' characteristics and experiences with those of all patients in the GPPS registered in the same practices and nationally. Survey response rates were equivalent to those for GPPS in the same PCTs. Another strength is that the semi-structured interviews helped identify additional questions to include in the survey and, afterwards, helped with the interpretation of the survey results.

However, there are several limitations to the study, primarily due to the form of the pilot. Firstly, the practices and patients were relatively few, self-selected and predominantly within Westminster PCT. Secondly, the pilot was not able to be widely promoted so patients often first learned about the scheme when they approached a new practice or notified their registered practice that they had moved house. As a result, it is impossible to estimate the likely patient participation rate were it rolled out nationwide and advertised. Thirdly, in the limited time of the Pilot, it was not possible to analyse the practices from which the pilot participants came. With a small number of patients coming from a large number of practices, it was not feasible to collect data about patient experience from the 'losing' practices. Fourthly, we are unable to interview staff to ascertain why many practices had chosen not to participate.

Finally, although patient experiences were largely positive, a 12-month pilot was insufficient to reveal the full range of possible adverse consequences of this programme. For example, it was not possible to identify the impact of removing practice boundaries on factors such as referrals, overall use of primary and secondary care, costs of information transfer or increased care coordination, equity of access, or practice patient mix. For instance, only two interviewed patients left the scheme during the pilot, one because she moved house (over 50 miles from the practice) and the other because the pilot practice did not meet his health care needs.

### *Comparisons with existing literature*

This is the first study on the removal of practice boundaries in the English NHS. Previous efforts to provide first contact care more conveniently, such as at NHS walk in centres, have tended to have high unit costs due to low take up and have tended to become additions rather than substitutes for previous sources of care<sup>3 11-13</sup>. The current pilot did not appear

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3 to incur significant additional costs <sup>7</sup>, primarily because it used existing practices, but  
4 demand was modest and it was run for too short a period to identify any substitution effects.  
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8 The findings resonate with what is known about patient behaviour in the UK where patients  
9 appear to value continuity of care highly, particularly those with long term conditions, and in  
10 discrete choice experiments, prioritise continuity of care over reduced waiting times or more  
11 convenient appointments <sup>14</sup>. This is consistent with our findings that one quarter of out of  
12 area registered patients entered the pilot to avoid changing practice. On the other hand,  
13 convenience does matter when waiting times lengthen <sup>15</sup> and this appeared to be the main  
14 motivation for a third of out of area registered patients and two-thirds of day patients  
15 joining the scheme.  
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22 Nearly one in seven pilot patients chose out of area registration because they were  
23 dissatisfied with their previous practice. This is consistent with the limited UK evidence on  
24 voluntary disenrollment from general practices which suggests that the small minority of  
25 patients who leave their current GP practice without moving house are leaving practices  
26 with relatively low levels of patient satisfaction, especially in terms of the quality of doctor-  
27 patient communication <sup>16</sup>.  
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### 33 34 *Implications for research and practice*

35 Since the pilot and its evaluation, NHS Employers, on behalf of NHS England, reached  
36 agreement with the British Medical Association (BMA), that all GP practices will be able to  
37 register patients outside their practice boundary on a voluntary basis from October 2014.  
38 Practices are not obliged to provide home visiting for such patients and NHS England will be  
39 responsible for arranging in-hours urgent medical care for participating patients. The day  
40 patient option will not be provided <sup>17</sup>. Given the small scale and limited duration of the pilot,  
41 the roll out should be accompanied by a longer term, fuller evaluation. It is possible that a  
42 range of drawbacks of the scheme will only emerge over a longer period. For example,  
43 when an out of area registered patient's circumstances change, how easily will they be able  
44 to find a practice near where they live? How easily will they be able to access urgent care  
45 near where they live while registered with a practice elsewhere? Could practices in  
46 commuter belts lose so many patients as to threaten their viability?  
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### Authors' contributions

ST and NM drafted the manuscript. ST was responsible for qualitative data collection. BE and ST were responsible for survey design and data analysis. Each of the authors was involved in data interpretation, critical review and refinement of the manuscript.

### Competing Interests

None

### Data Sharing Statement

No additional data available

1. Mays N, Dixon A, Jones L. Understanding New Labour's Market Reforms of the English NHS. London: King's Fund 2011.
2. Darzi A, Britain G. *NHS next stage review: interim report*: COI for the Department of Health, 2007.
3. Tan S, Mays N. Impact of initiatives to improve access to, and choice of, primary and urgent care in the England: a systematic review. Submitted for publication and under review.
4. Department of Health. Your choice of GP practice: A consultation on how to enable people to register with the GP practice of their choice. London: Department of Health, 2010.
5. Department of Health. Choice of GP practice: guidance for all PCTs – covering outer boundaries, open and closed lists and aspects of the patient choice scheme. London: Department of Health, 2012.
6. Department of Health. Choice of GP Practice: the patient choice scheme. Secondary Choice of GP Practice: the patient choice scheme 2012. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/152294/dh\\_133411.pdf.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/152294/dh_133411.pdf.pdf).
7. Mays N, Eastmure E, Erens B, et al. Evaluation of the choice of GP practice pilot, 2012-13: final report. Secondary Evaluation of the choice of GP practice pilot, 2012-13: final report 2014. [www.piru.ac.uk/assets/files/General%20Practice%20Choice%20Pilot%20Evaluation.pdf](http://www.piru.ac.uk/assets/files/General%20Practice%20Choice%20Pilot%20Evaluation.pdf).
8. Mays N, Eastmure E, Erens B, et al. Evaluation of the choice of GP practice pilot, 2012-13: final report, appendices. Secondary Evaluation of the choice of GP practice pilot, 2012-13: final report, appendices 2014. [www.piru.ac.uk/assets/files/GP%20Choice%20Pilot%20Evaluation-Appendices.pdf](http://www.piru.ac.uk/assets/files/GP%20Choice%20Pilot%20Evaluation-Appendices.pdf).
9. Wilson T, Buck D, Ham C. Rising to the challenge: will the NHS support people with long term conditions? *BMJ* 2005;**330**(7492):657-61.
10. Kontopantelis E, Roland M, Reeves D. Patient experience of access to primary care: identification of predictors in a national patient survey. *BMC family practice* 2010;**11**(1):61.
11. Coleman A, Checkland K, McDermott I, et al. The limits of market-based reforms in the NHS: the case of alternative providers in primary care. *BMC health services research* 2013;**13**(Suppl 1):S3.
12. O'Cathain A, Coster J, Salisbury C, et al. Do walk-in centres for commuters work? A mixed methods evaluation. *The British Journal of General Practice* 2009;**59**(569):e383.
13. Coster J, O'Cathain A, Nicholl J, et al. User satisfaction with commuter walk-in centres. *The British Journal of General Practice* 2009;**59**(569):e390.
14. Cheraghi-Sohi S, Hole AR, Mead N, et al. What patients want from primary care consultations: a discrete choice experiment to identify patients' priorities. *The Annals of Family Medicine* 2008;**6**(2):107-15.
15. Lagarde M, Erens B, Mays N. Preferences for GP practice in England: evidence from a Discrete Choice Experiment. Submitted for publication and under review.
16. Nagraj S, Abel G, Paddison C, et al. Changing practice as a quality indicator for primary care: analysis of data on voluntary disenrollment from the English GP Patient Survey. *BMC family practice* 2013;**14**(1):89.
17. NHS Employers. Summary of 2014/15 GMS Contract negotiations. Secondary Summary of 2014/15 GMS Contract negotiations 14 November 2013 2013. <http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/GMSContractChanges/Pages/Contractchanges201415.aspx#8>.

## Tables and boxes

### Box 1. Two out of area registered patient vignettes

Male, age 49 years, in full-time employment, with chronic condition. He has been registered with the same practice for 18 years but moved out of the catchment area several years ago (now 15-20 minute drive away). He revealed his current address to the practice after he was diagnosed with Type 2 diabetes because he anticipated “stepping up” his interactions with health services. He wished to stay with this practice for continuity and cited negative experiences with previous GPs who were closed to discussions of health problems based on his sexuality.

Female, age 40 years, in full-time employment, with multiple chronic conditions. She joined the pilot after enquiring at a practice near her office. She felt “the doctors where I live [are] absolutely horrendous and it would take me days or weeks to get an appointment.” She reported health complications related to multiple chronic conditions “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.” She felt her new practice was much better because “the nurses are fantastic. The GP, she sorted me out right away... they really take their time with you as well. Nothing’s rushed...”

### Box 2. Day patient vignette

Male, age 33 years, in full time employment, no chronic conditions. He learned about the pilot through his work and visited as a day patient for an acute infection. He found the service convenient because he could see a GP before, during or after work, in contrast to his registered GP, where he would need to take time off work or arrange to work at home because his train to work only ran during peak hours and it would be “a bit of a nightmare having to get back into work after doing something out of the ordinary.” He felt the quality of service was comparable to his registered practice, but voiced concerns over data-sharing between the two practices, specifically “how are these GPs accessing my medical data to understand perhaps historic things that might aid in the resolution of a particular case diagnosis?”



**Table 1. Demographic and health characteristics of out of area registered and day patient survey respondents compared with all GPPS patients in pilot practices.**

<i>Base: aged 18+</i>	<b>All GPPS<sup>1</sup> patients in pilot practices</b>	<b>All OoA registered patients</b>	<b>All day patients</b>
	%	%	%
<b>Gender</b>			
Men	52.4	47.0	35.5
Women	47.6	53.0	64.5
<b>Age</b>			
18-34	33.3	64.1	67.3
35-54	40.8	26.6	30.8
55+	25.9	9.2	1.9
<b>Economic activity</b>			
Full-time work	46.9	65.8	65.6
Part-time work	10.8	5.4	8.2
Full-time education	5.1	9.5	8.2
Unemployed	9.7	9.0	6.6
Permanently sick	6.7	1.4	-
Retired	13.3	3.1	8.2
Other activity	7.5	5.7	3.2
<b>Journey time to work (for those in work)</b>			
Up to 30 minutes	57.9	30.5	40.0
30 minutes or more	34.6	66.2	60.0
Live on site	7.5	3.3	-
<b>Is a parent (dependent children under 16 years)</b>	23.6	10.1	13.1
<b>Is an unpaid carer</b>	15.1	3.8	8.3
<b>Has long-standing health condition</b>	42.6	32.2	33.3
<b>None of the listed medical conditions</b>	5.1	67.9	57.7

<sup>1</sup> GPPS uses year 7 data, July to September 2012.

**Table 2: Patient experience of the most recent GP appointment in the last 6 months and registered practice: views of registered and day patients compared with all GPPS patients in pilot practices.**

<i>GPPS<sup>1</sup> and OoA registered patients aged 18+, who saw/spoke<sup>2</sup> to GP/nurse in last 6 months, DPs registered with a GP practice</i>	<b>GPPS patients in pilot practices</b>	<b>OoA registered patients</b>	<b>DPs</b>
	%	%	%
<b>Overall experience of making an appointment</b>			
Very good	37.4	47.1	59.6
Fairly good	39.4	37.2	27.7
Neither	13.6	8.0	8.5
Fairly poor	6.5	5.5	4.3
Very poor	3.1	2.2	-
<b>How good was the GP at...</b>			
<b>Giving you enough time</b>			
Very good	53.1	56.0	63.6
Good	33.0	33.3	30.3
Neither	9.1	5.4	3.0
Poor	2.7	2.3	3.0
Very poor	1.9	1.8	-
NA	0.2	1.2	-
<b>Treating you with care/ concern</b>			
Very good	51.6	59.3	60.6
Good	32.2	29.4	27.3
Neither	9.7	5.6	12.1
Poor	3.4	3.1	-
Very poor	2.3	1.9	-
NA	0.7	0.8	-
<b>Have confidence/trust in GP</b>			
Definitely	64.7	71.1	63.6
To some extent	28.2	22.2	30.3
Not at all	5.4	3.7	3.0
Don't know	1.8	3.1	3.0
<b>Overall experience of practice</b>			
Very good	47.1	57.3	n.a.
Fairly good	41.6	36.0	n.a.
Neither	7.0	3.2	n.a.
Fairly poor	3.3	1.0	n.a.
Very poor	1.0	2.6	n.a.

<sup>1</sup> GPPS year 7, wave 1, July to September 2012.

<sup>2</sup> DPs were only asked if they saw a GP or nurse.

## Reporting checklist

**Good Reporting of A Mixed Methods Study (GRAMMS)**

From O’Cathain, Murphy and Nicholl, 2008. The quality of mixed-methods studies in health services research. *J Health Serv Res Policy*. 13:2 (92-98).

	Guidelines for Good Reporting of A Mixed Methods Study (GRAMMS)	Found on page(s):
1.	Describe the justification for using a mixed methods approach to the research question	6
2.	Describe the design in terms of the purpose, priority and sequence of methods	6-7
3.	Describe each method in terms of sampling, data collection and analysis	6-7
4.	Describe where integration has occurred, how it has occurred and who has participated in it	7-11
5.	Describe any limitation of one method associated with the present of the other method	12
6.	Describe any insights gained from mixing or integrating methods	12

# BMJ Open

## Patients' experiences of the choice of GP practice pilot, 2012/13: a mixed methods evaluation

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14 **Patients' experiences of the choice of GP practice pilot, 2012/13: a**  
15 **mixed methods evaluation**  
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19 **Stefanie Tan\*, Bob Erens, Michael Wright, Nicholas Mays**  
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50 **Abstract 298 words**

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52 **Main text 3789 words**

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54 **Strengths and limitations 232 words**  
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## Abstract

### *Objectives*

To investigate patients' experiences of the choice of general practitioner (GP) practice pilot.

### *Design*

Mixed-method, cross-sectional study.

### *Setting*

Patients in the UK National Health Service (NHS) register with a general practice responsible for their primary medical care and practices set geographic boundaries. In 2012/13, 43 volunteer general practices in four English NHS primary care trusts (PCTs) piloted a scheme allowing patients living outside practice boundaries to register as an out of area patient or be seen as a day patient.

### *Participants*

Analysis of routine data for 1108 out of area registered patients and 250 day patients; postal survey of out of area registered (315/886, 36%) and day (64/188, 34%) patients over 18 years of age, with a UK mailing address; comparison with general practice patient survey (GPPS); semi-structured interviews with 24 pilot patients.

### *Results*

Pilot patients were younger and more likely to be working than non-pilot patients at the same practices and reported generally more or at least as positive experiences than patients registered at the same practices, practices in the same PCT and nationally, despite belonging to sub-groups of the population who typically report poorer than average experiences. Out of area patients who joined a pilot practice did so: after moving house and not wanting to change practice (26.2%); for convenience (32.6%); as newcomers to an area who selected a practice although they lived outside its boundary (23.6%); because of dissatisfaction with their previous practice (13.9%). Day patients attended primarily on grounds of convenience (68.8%). 51.6% of the day patient visits were for acute infections, most commonly upper respiratory infections (20.4%). 66.0% of day patients received a prescription during their visit

### *Conclusion*

Though the 12-month pilot was too brief to identify all costs and benefits, the scheme provided a positive experience for participating patients and practices.

*Keywords:* primary health care, general practice, access, choice, practice boundaries

Abstract: 298 words

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3 Strengths and limitations of this study

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- A strength of this study is that it adds to the very slender evidence either from the NHS or other systems on the effects of widening patient choice of general practice, and specifically the effects of removing geographic boundaries. It reveals that patients reported high satisfaction with their experience in a short-term pilot of practice boundary removal and that most patients joined the pilot on grounds that the pilot practice was more convenient than their previous source of primary medical care.
  - The main strength of the study is that it compares pilot patients' characteristics and experiences with those of all patients in the GP Patient Survey registered in the same practices and nationally. Survey response rates were similar to those for GPPS in the same PCTs. Semi-structured interviews assisted in the development pilot-specific survey questions and interpretation of the results.
  - The study is limited by the structure of the pilot itself, which took place in relatively few, self-selected practices and could not be widely promoted, so it is not possible to estimate the likely patient participation rate were the scheme to be rolled out nationwide.
  - In the 12-month pilot, it was not possible to identify the impact of removing practice boundaries on, for instance, referrals, overall use of primary and secondary care, costs to commissioners, equity of access, or practice patient mix.

## Introduction

Giving patients more choice over where they access care has been central to reforms in England's National Health Service (NHS) since the late 1990s<sup>1-3</sup>. In normal circumstances, NHS patients are expected to seek their primary medical care from the practice with which they are registered and practices generally only accept patients who live within their geographic boundaries. Geographical boundaries in primary care were developed in the 1980s in response to the scattering of practices' patients which hampered home visits and linkages to community nursing organized on a patch basis.

A 2009 public consultation on increasing choice of GP practice found that 18% of respondents were likely to register with a different practice within their local area (i.e. register with a practice outside their current practice's boundary) if the option to do so was available<sup>4</sup>. From 2012, general practices have been able to register patients that live beyond their 'normal' practice boundary as 'outer boundary' or 'fringe' list patients. However, practices are required to provide all care, including home visits, to these patients<sup>5</sup>. In other circumstances outside the pilot, practices have the discretion to allow any patient to register, but may choose not to offer services such as home visits to distant patients.

As part of the Coalition government's pledge to increase patient choice and improve access, a 12-month choice of GP practice pilot was implemented in four primary care trusts (PCTs) from April 2012-March 2013. The pilot allowed patients to either register at a volunteer practice as an out of area patient, with access to all primary medical services, except home visits, or to see a GP or nurse as a day patient at a volunteer practice, for routine or non-urgent care, while remaining registered with their current GP practice<sup>6</sup>. Unlike the 'outer boundary policy', home visits for out of area registered patients were to be provided by the home PCT. The pilot did not alter the existing arrangements for providing GP care to Temporary Residents or those requiring 'Immediate and Necessary' care. However, access was intended to differ in the pilot in that day patients were not required to show that they were living temporarily in the area and did not necessarily need to present with 'immediate and necessary' needs for care. In the case of out of area patients, the practice had access to patients' usual electronic records, but this was not so for day patients (information on whose visits were expected to be shared with the patients' registered practice).

Participating practices were paid a £12.93 fee for each day patient visit. When an out of



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3 area patient registered with a pilot practice, the global sum funding for that patient was  
4 transferred to the pilot practice for the following year or the next payment period.  
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8 The pilot was intended to improve access for people such as workers finding it difficult to  
9 visit their regular practice during working hours, long-haul commuters or those wishing to  
10 register at another location (e.g. near a family member). Very little is known of the  
11 consequences of removing or flexing practice boundaries. This paper describes patients' self-  
12 reported experiences of being an out of area patient or a day patient, drawn from the wider  
13 evaluation of the choice of GP practice pilot <sup>7</sup>.  
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## 18 **Methods**

### 19 *Routine data*

20 Basic quantitative profile data were collected for all 1358 (1108 out of area registered  
21 patients and 250 day patients) patients who used the pilot between April 2012 and March  
22 2013. For out of area patients, limited administrative information was available through the  
23 National Health Authority Information System (NHAIS, now Connecting for Health) on age,  
24 gender, new practice code and the first 3-4 digits of the patient's home address post code.  
25 It was not feasible given the short duration of the pilot to negotiate permission to extract  
26 clinical data on out of area patients' use of their new practices from practice computer  
27 systems. For day patients, clinical data were available on the number of visits, along with  
28 the reason and consequence of each since all day patient visits were separately recorded  
29 and transmitted to the PCT for payment purposes. The local area team removed all  
30 identifiable information from the day patient visit forms before sharing it with the research  
31 team.  
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### 42 *Interviews with patients*

43 Semi-structured telephone interviews were undertaken with 18 out of area registered  
44 patients and 6 day patients chosen, as far as possible, for maximum variation in terms of age  
45 and occupation, in order to explore why patients used the pilot scheme, their experiences,  
46 and the perceived benefits and drawbacks of the scheme. Written informed consent was  
47 obtained based on a project evaluation information sheet for all patients interviewed. All  
48 interviews were recorded and transcribed. Transcripts were analysed thematically and  
49 coded in NVivo 10.  
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### 56 *Patient survey*

We conducted a postal survey of all day (64/188, 34% response rate) and out of area registered (315/886, 36%) patients aged 18 years and over and with a permanent address in the UK. Out of 1358 pilot patients, 284 pilot patients were not included in the survey, of these, 260 were aged under 18 (n=222 for out of area registered patients and n=38 for day patients), and 24 day patients did not have an available UK address. Pilot patients under 18 years were excluded because the GP Patient Survey is only administered to adults aged 18 years and over. The patient survey questionnaire was modelled on that used for the national GP Patient Survey (GPPS) (<http://www.gp-patient.co.uk/questionnaires/>), and results were compared with GPPS results for year 7 wave 1 (July to September 2012) for the same PCTs and practices. In order to account for varying probabilities of selection and differential non-response (e.g. by age and sex), the GPPS results were weighted (by Ipsos MORI, the organisation that carries out the GPPS) to be representative of all registered patients (aged 18+ years) within a practice, a PCT and nationally ([http://www.gp-patient.co.uk/results/download/\\_y6q2/y6w2\\_AnnualTechnical.pdf](http://www.gp-patient.co.uk/results/download/_y6q2/y6w2_AnnualTechnical.pdf)). The data for the out of area registered patients were corrected for non-response and weighted so that the achieved sample matched the age distribution for all out of area patients aged 18+ years. Due to small numbers, the day patient survey data were not weighted for non-response. Further details of the pilot patient survey methodology can be found in [<http://www.piru.ac.uk/assets/files/General%20Practice%20Choice%20Pilot%20Evaluation.pdf>].

The survey data were analysed using SPSS 20. Descriptive statistics are presented in Table 1. All differences between the pilot patients and GPPS highlighted in the Results are statistically significant at the 95% level.

#### *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.

## **Results**

### *Pilot practice characteristics*

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3 In the four PCTs, 43 general practices out of 269 eligible practices volunteered for the pilot  
4 (with 20/53 (38%) of practices in Westminster, 7/63 (11%) in Nottingham, 8/102 (8%) in  
5 Manchester, and 8/51 (16%) in Salford). All participating practices were in urban areas. Pilot  
6 and non-pilot practices were similar in terms of list size, Quality and Outcome Framework  
7 (QOF) scores, and patient experiences and views in the GPPS (see the full report of the  
8 evaluation <sup>7,8</sup> for further details about practice characteristics, list size and QOF score).  
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13 There was no evidence that pilot practices were obviously 'better' practices.

#### 14 15 16 *Pilot patient characteristics*

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18 1108 patients registered at a pilot practice away from the area where they lived, while 250  
19 patients saw a GP or nurse as a day patient. The vast majority of patients registered with, or  
20 attended, a pilot practice in Westminster, which accounted for 789/1108 (71%) of out of  
21 area registered patients and 196/250 (78%) of day patients, with the remaining 121/1108  
22 (11%) and 52/250 (21%), respectively, in Nottingham, 114/1108 (10%) and 0/250 (0%),  
23 respectively, in Manchester, and 84/1108 (8%) and 2/250 (1%), respectively, in Salford.

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29 When compared to GPPS patients from the same practices, Table 1 shows that out of area  
30 registered and day patients were much younger than other patients in the pilot practices  
31 (64.1% of out of area registered and 67.3% of day patients were aged 18-34 compared with  
32 33.3% of GPPS patients in pilot practices). They were also more likely to be in full-time work  
33 (65.8% for out of area registered patients and 65.6% for day patients compared with 46.9%  
34 of GPPS patients in pilot practices). Among those in work, out of area registered and day  
35 patients tended to have a longer commute (66.2% and 60.0% respectively had a journey to  
36 work time of half an hour or more compared with 34.6% of GPPS patients in pilot practices).

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Out of area registered patients were more likely to be in education (9.5% for out of area registered patients compared with 5.1% of GPPS patients in pilot practices) and less likely to be retired (3.1% out of area registered compared with 13.3% GPPS patients in pilot practices). Out of area registered patients were much less likely to have dependent children under 16 (10.1% compared with 23.6% of GPPS patients in pilot practices) or to be unpaid carers (3.8% compared with 15.1% of GPPS patients in pilot practices).

#### 55 *Patients' reasons for taking part in the pilot*

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3 We identified four types of out of area registered patients based on two survey questions  
4 that asked their reasons for participating in the pilot and for choosing the particular practice  
5 they were now registered with (see <sup>8</sup> for details of questions). About a quarter (26.2%) had  
6 moved house and wished to stay with the same practice. About a quarter (23.6%) had  
7 recently moved into the area and had registered with a local practice despite being outside  
8 its catchment. Around a third (32.6%) chose their practice for convenience (e.g. near their  
9 workplace); one such patient said the scheme was suitable “because this way, I don’t have  
10 to take time off work to see my GP... now I can walk to the surgery within ten minutes, it’s  
11 extremely convenient” and “I can go and see my GP and be back at the office within half an  
12 hour, maybe 45 minutes...it is great for me, it is great for my employer “(patient interview,  
13 London). Some (13.9%) chose their practice because they were dissatisfied with their  
14 previous GP or sought services that their previous practice could not provide. (A small  
15 proportion of out of area registered patients could not be classified, mostly because of  
16 missing data (3.7%).) Box 1 presents two different patient profiles from the qualitative  
17 interviews.  
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29 We identified three types of day patients based on survey questions about the main reason  
30 they had visited as a day patient instead of visiting their registered practice, whether they  
31 had tried to make an appointment at their registered practice, and how the practice they  
32 had visited compared with their registered practice (see <sup>8</sup> for the questions). Day patients  
33 generally attended pilot practices because they were convenient (68.8%). The second type  
34 would have been more appropriately categorised as Temporary Residents or requiring  
35 ‘Immediate and Necessary’ care. Nearly one in five (18.8%) day patients fell into this type.  
36 This is consistent with qualitative interview findings that revealed some confusion among  
37 practices between the day patient option and existing provisions for urgent appointments in  
38 primary care. A small proportion of patients preferred a specific practice or a specific doctor  
39 (e.g., if they had been registered at one practice before moving house and wanted to see  
40 their former GP while remaining registered with a local practice), received specialist care  
41 that their registered practice did not offer, or were not satisfied with the quality of care  
42 received at their registered practice (7.8%). One such day patient said the day patient  
43 option made seeing a GP easier as “the opening hours are good and the first time I went  
44 before work which was really useful – 8 o’clock, I think, and the second time I went in,  
45 somebody saw me right away” (patient interview, Nottingham). A small percentage of day  
46 patients could not be classified due to missing data (4.7%). Most day patients (77%) had not  
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3 tried to make an appointment at their registered practice before their visit. Box 2 provides a  
4 vignette from a day patient interview.  
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8 *Conditions for which day patients consulted a pilot practice*

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10 Half (51.6%) of the visits were for acute infections, most commonly upper respiratory  
11 infections (20.4%). Other acute conditions accounted for a further one in five (21.2%) day  
12 patient visits, followed by medication issues (7.6%) and chronic conditions (5.2%). A  
13 relatively small percentage of visits did not require any treatment, or were to obtain  
14 reassurance or a second opinion (8.4%). This pattern of use contrasts markedly with the  
15 overall pattern in general practice where around 80% of GP consultations are for ongoing or  
16 chronic conditions<sup>9</sup>.  
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22 Two-thirds (66.0%) of day patients received a prescription during their visit. Referrals were  
23 less common, with only one in ten (10.1%) day patients referred by the GP for tests or other  
24 services. Some referrals were for routine blood tests. Most referrals were for MRIs (for knee  
25 or back injuries) or physiotherapy; several day patients, many of whom presented in  
26 Westminister, used their private health insurance following a NHS GP referral.  
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32 *Out of area registered patient experiences compared with all GPPS patients in the same*  
33 *practices*

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35 Out of area registered patients were more likely than all GPPS patients in the same pilot  
36 practices to describe the overall experience of making an appointment and their most  
37 recent visit to their practice as 'very good' (47.1% and 57.3%, respectively, of out of area  
38 registered compared with 37.4% and 47.1%, respectively, of GPPS patients in pilot practices)  
39 (see Table 2). In general, out of area registered patients reported better experiences than  
40 non-pilot GPPS patients. This is notable given the much younger age profile of pilot patients  
41 and the well-supported finding that younger patients tend to be more critical of their GP  
42 practice<sup>10</sup>. They valued the quality of the service at their new practice and were happy with,  
43 and trusted, the care they received from GPs and nurses.  
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52 Patients who did not change practice held positive views of their GP practice and said the  
53 scheme had enabled them to stay with a practice that they trusted and which was sensitive  
54 to their health needs. Continuity of care was also important to those out of area patients  
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3 who did not change practice and who had had a serious health incident, chronic condition,  
4 bereavement, or major life transition.  
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8 Among those who had changed practice, three in five said their new practice was much  
9 (46.5%) or somewhat (14.5%) better than their previous one and one in four (23.8%) that it  
10 was about the same. Only a small minority said it was somewhat (3.0%) or much (2.6%)  
11 worse than their previous practice. One interviewee who was dissatisfied with her previous  
12 practice and who had a positive reason for choosing an out of area practice said the pilot  
13 gave “access to a good quality practice which I wouldn’t have if I could only register with the  
14 practice near where I live” (patient interview, Nottingham).  
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### 19 20 21 *Day patient experiences*

22 Day patients were more likely than all GPPS patients in the same pilot practices to describe  
23 their overall experience of making an appointment as ‘very good’ (59.6% of day patients  
24 compared with 37.4% of GPPS patients in pilot practices). The majority of day patients  
25 viewed the practice they visited as a day patient to be comparable to (40%), or better than  
26 (34.6%), their registered practice. Only 9.1% thought it was worse than their registered  
27 practice. In the interviews, day patients explained that their decision to visit a practice as a  
28 day patient was not a reflection of dissatisfaction with the type or quality of service at their  
29 registered practice, or even the superiority of the practice they visited as a day patient (they  
30 had very limited knowledge of the practice they had visited as a day patient) as much as the  
31 fact that the practice they visited as a day patient had been more convenient.  
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## 41 **Discussion**

### 42 *Statement of the principal findings*

43 The pilot attracted a relatively small proportion of practices in the four pilot PCTs. There was  
44 no evidence that these were better performing practices. About half of out of area  
45 registered patients had made a positive decision to change practice, with 32.6% choosing a  
46 practice for convenience and 13.9% moving because they were dissatisfied with their  
47 previous practice or attracted to some feature of the new practice. Of the rest, about a  
48 quarter joined the scheme because they chose to stay with a GP practice after moving out of  
49 the catchment area (26.2%), while another quarter had moved to the area but had selected  
50 a practice which they would not normally have been able to register with (23.6%). A few  
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3 could not be classified due to missing data (3.7%). Over two-thirds of day patients joined the  
4 scheme for reasons of convenience (68.8%).  
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8 Participating patients were younger, more likely to be in work and had better self-reported  
9 health than other patients registered at the same practices. Despite these characteristics,  
10 out of area registered and day patients' assessments of their new practice and care were  
11 better than those reported nationally and in the same practices, and they generally  
12 expressed positive views of the scheme. These positive views are not surprising given the  
13 high proportion of pilot patients who had either stayed with an existing GP after moving  
14 house (presumably because they were satisfied with the practice), or had left a practice they  
15 were dissatisfied with, or had chosen their new practice for a particular reason. These  
16 findings suggest that the pilot of removing practice boundaries was successful in improving  
17 patient experience, at least in the short term. It is unclear whether these positive  
18 experiences could be maintained in the longer term  
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### 27 *Strengths and limitations*

28 The main strength of this study is the ability to compare pilot patients' characteristics and  
29 experiences with those of all patients in the GPPS registered in the same practices and  
30 nationally. Survey response rates were equivalent to those for GPPS in the same PCTs.  
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32 Another strength is that the semi-structured interviews helped identify additional questions  
33 to include in the survey and, afterwards, helped with the interpretation of the survey results.  
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38 However, there are several limitations to the study, primarily due to the form of the pilot.  
39 Firstly, the practices and patients were relatively few, self-selected and predominantly  
40 within Westminster PCT. Secondly, the pilot was not able to be widely promoted so patients  
41 often first learned about the scheme when they approached a new practice or notified their  
42 registered practice that they had moved house. As a result, it is impossible to estimate the  
43 likely patient participation rate were it rolled out nationwide and advertised. Thirdly, in the  
44 limited time of the Pilot, it was not possible to analyse the practices from which the pilot  
45 participants came. With a small number of patients coming from a large number of  
46 practices, it was not feasible to collect data about patient experience from the 'losing'  
47 practices. Fourthly, we are unable to interview staff at non-participating practices to  
48 ascertain why many practices had chosen not to participate.  
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3 Finally, although patient experiences were largely positive, a 12-month pilot was insufficient  
4 to reveal the full range of possible adverse consequences of this programme. For example,  
5 it was not possible to identify the impact of removing practice boundaries on factors such as  
6 referrals, overall use of primary and secondary care, costs of information transfer or  
7 increased care coordination, equity of access, or practice patient mix. For instance, only two  
8 interviewed patients left the scheme during the pilot, one because she moved house (over  
9 50 miles from the practice) and the other because the pilot practice did not meet his health  
10 care needs.  
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### 16 17 18 *Comparisons with existing literature*

19 This is the first study on the removal of practice boundaries in the English NHS. Previous  
20 efforts to provide first contact care more conveniently, such as at NHS walk in centres, have  
21 tended to have high unit costs due to low take up and have tended to become additions  
22 rather than substitutes for previous sources of care<sup>3 11-13</sup>. The current pilot did not appear  
23 to incur significant additional costs<sup>7</sup>, primarily because it used existing practices, but  
24 demand was modest (at least in the short period of the pilot) and it was run for too short a  
25 period to identify any substitution effects.  
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32 The findings resonate with what is known about patient behaviour in the UK where patients  
33 appear to value continuity of care highly, particularly those with long term conditions, and in  
34 discrete choice experiments, prioritise continuity of care over reduced waiting times or more  
35 convenient appointments<sup>14</sup>. This is consistent with our findings that one quarter of out of  
36 area registered patients entered the pilot to avoid changing practice. On the other hand,  
37 convenience does matter when waiting times lengthen<sup>15</sup> and this appeared to be the main  
38 motivation for a third of out of area registered patients and two-thirds of day patients  
39 joining the scheme.  
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46 Nearly one in seven pilot patients chose out of area registration because they were  
47 dissatisfied with their previous practice. This is consistent with the limited UK evidence on  
48 voluntary disenrollment from general practices which suggests that the small minority of  
49 patients who leave their current GP practice without moving house are leaving practices  
50 with relatively low levels of patient satisfaction, especially in terms of the quality of doctor-  
51 patient communication<sup>16</sup>.  
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### *Implications for research and practice*

Since the pilot and its evaluation, NHS Employers, on behalf of NHS England, reached agreement with the British Medical Association (BMA), that all GP practices will be able to register patients outside their practice boundary on a voluntary basis in 2015. Practices are not obliged to provide home visiting for such patients and NHS England will be responsible for arranging in-hours urgent medical care for participating patients. The day patient option will not be provided<sup>17</sup>. Given the small scale and limited duration of the pilot, the roll out should be accompanied by a longer term, fuller evaluation. It is possible that a range of drawbacks of the scheme will only emerge over a longer period (see<sup>18</sup> for a policy analysis on the impact of removing practice boundaries as one among a number of ways of improving access to urgent care in the English NHS). For example, when an out of area registered patient's circumstances change, how easily will they be able to find a practice near where they live? How easily will they be able to access urgent care near where they live while registered with a practice elsewhere? Could practices in commuter belts lose so many patients as to threaten their viability?

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5 Authors' contributions

6 ST and NM drafted the manuscript. ST was responsible for qualitative data collection. BE  
7 and ST were responsible for survey design and data analysis. Each of the authors was  
8 involved in data interpretation, and critical review and refinement of the manuscript.  
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11 Data sharing

12 No additional data available

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14 Competing interests

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## References

1. Mays N, Dixon A, Jones L. Understanding New Labour's Market Reforms of the English NHS. London: King's Fund 2011.
2. Darzi A, Britain G. *NHS next stage review: interim report*: COI for the Department of Health, London: Department of Health, 2007.
3. Tan S, Mays N. Impact of initiatives to improve access to, and choice of, primary and urgent care in the England: A systematic review. *Health Policy* 2014(0).
4. Department of Health. Your choice of GP practice: A consultation on how to enable people to register with the GP practice of their choice. London: Department of Health, 2010.
5. Department of Health. Choice of GP practice: guidance for all PCTs – covering outer boundaries, open and closed lists and aspects of the patient choice scheme. London: Department of Health, 2012.
6. Department of Health. Choice of GP Practice: the patient choice scheme. Secondary Choice of GP Practice: the patient choice scheme. London: Department of Health, 2012.
7. Mays N, Eastmure E, Erens B, et al. Evaluation of the choice of GP practice pilot, 2012-13: final report. Secondary Evaluation of the choice of GP practice pilot, 2012-13: final report. London: Policy Innovation Research Unit, 2014. [www.piru.ac.uk/assets/files/General%20Practice%20Choice%20Pilot%20Evaluation.pdf](http://www.piru.ac.uk/assets/files/General%20Practice%20Choice%20Pilot%20Evaluation.pdf).
8. Mays N, Eastmure E, Erens B, et al. Evaluation of the choice of GP practice pilot, 2012-13: final report, appendices. Secondary Evaluation of the choice of GP practice pilot, 2012-13: final report, appendices. London: Policy Innovation Research Unit, 2014. [www.piru.ac.uk/assets/files/GP%20Choice%20Pilot%20Evaluation-Appendices.pdf](http://www.piru.ac.uk/assets/files/GP%20Choice%20Pilot%20Evaluation-Appendices.pdf).
9. Wilson T, Buck D, Ham C. Rising to the challenge: will the NHS support people with long term conditions? *BMJ* 2005;**330**(7492):657-61.
10. Kontopantelis E, Roland M, Reeves D. Patient experience of access to primary care: identification of predictors in a national patient survey. *BMC family practice* 2010;**11**(1):61.
11. Coleman A, Checkland K, McDermott I, et al. The limits of market-based reforms in the NHS: the case of alternative providers in primary care. *BMC health services research* 2013;**13**(Suppl 1):S3.
12. O'Cathain A, Coster J, Salisbury C, et al. Do walk-in centres for commuters work? A mixed methods evaluation. *The British Journal of General Practice* 2009;**59**(569):e383.
13. Coster J, O'Cathain A, Nicholl J, et al. User satisfaction with commuter walk-in centres. *The British Journal of General Practice* 2009;**59**(569):e390.
14. Cheraghi-Sohi S, Hole AR, Mead N, et al. What patients want from primary care consultations: a discrete choice experiment to identify patients' priorities. *The Annals of Family Medicine* 2008;**6**(2):107-15.
15. Lagarde M, Erens B, Mays N. Determinants of the Choice of GP Practice Registration in England: Evidence from a Discrete Choice Experiment. *Health Policy* 2014.
16. Nagraj S, Abel G, Paddison C, et al. Changing practice as a quality indicator for primary care: analysis of data on voluntary disenrollment from the English GP Patient Survey. *BMC family practice* 2013;**14**(1):89.
17. NHS Employers. Summary of 2014/15 GMS Contract negotiations. Secondary Summary of 2014/15 GMS Contract negotiations. 14 November 2013. <http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/GMSContractChanges/Pages/Contractchanges201415.aspx#8>.

18. Mays N, Tan S, Eastmure E, et al. Potential impact of removing general practice boundaries in England: A policy analysis. Health Policy 2014.

### Tables and boxes

#### Box 1. Two out of area registered patient vignettes

Male, age 28 years, in full-time employment, with chronic depression.

He has been registered with the same practice for 6 years. He was invited to enter the pilot after revealing that he had moved out of the catchment area. He 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.” He wished to stay with this practice 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.”

Female, age 40 years, in full-time employment, with multiple chronic conditions. She joined the pilot after enquiring at a practice near her office. She felt “the doctors where I live [are] absolutely horrendous and it would take me days or weeks to get an appointment.” She reported health complications related to multiple chronic conditions “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.” She felt her new practice was much better because “the nurses are fantastic. The GP, she sorted me out right away... they really take their time with you as well. Nothing’s rushed...”

#### Box 2. Day patient vignette

Male, age 33 years, in full time employment, no chronic conditions.

He learned about the pilot through his work and visited as a day patient for an acute infection. He found the service convenient because he could see a GP before, during or after work, in contrast to his registered GP, where he would need to take time off work or arrange to work at home because his train to work only ran during peak hours and it would be “a bit of a nightmare having to get back into work after doing something out of the ordinary.” He felt the quality of service was comparable to his registered practice, but voiced concerns over data-sharing between the two practices, specifically “how are these GPs accessing my medical data to understand perhaps historic things that might aid in the resolution of a particular case diagnosis?”

**Table 1. Demographic and health characteristics of out of area registered and day patient survey respondents compared with all GPPS patients in pilot practices.**

<i>Base: aged 18+</i>	<b>All GPPS<sup>1</sup> patients in pilot practices</b>	<b>All OoA registered patients</b>	<b>All day patients</b>
	%	%	%
<b>Gender</b>			
Men	52.4	47.0	35.5
Women	47.6	53.0	64.5
<b>Age</b>			
18-34	33.3	64.1	67.3
35-54	40.8	26.6	30.8
55+	25.9	9.2	1.9
<b>Economic activity</b>			
Full-time work	46.9	65.8	65.6
Part-time work	10.8	5.4	8.2
Full-time education	5.1	9.5	8.2
Unemployed	9.7	9.0	6.6
Permanently sick	6.7	1.4	-
Retired	13.3	3.1	8.2
Other activity	7.5	5.7	3.2
<b>Journey time to work (for those in work)</b>			
Up to 30 minutes	57.9	30.5	40.0
30 minutes or more	34.6	66.2	60.0
Live on site	7.5	3.3	-
<b>Is a parent (dependent children under 16 years)</b>	23.6	10.1	13.1
<b>Is an unpaid carer</b>	15.1	3.8	8.3
<b>Has long-standing health condition</b>	42.6	32.2	33.3
<b>None of the listed medical conditions</b>	5.1	67.9	57.7

<b>Bases<sup>2</sup></b>	4624	311	64
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<sup>1</sup> GPPS uses year 7 data, July to September 2012.

<sup>2</sup> Bases vary, bases shown are for gender.

**Table 2: Patient experience of the most recent GP appointment in the last 6 months and registered practice: views of registered and day patients compared with all GPPS patients in pilot practices.**

<i>GPPS<sup>1</sup> and OoA registered patients aged 18+, who saw/spoke<sup>2</sup> to GP/nurse in last 6 months, DPs registered with a GP practice</i>	<b>GPPS patients in pilot practices</b>	<b>OoA registered patients</b>	<b>DPs</b>
	%	%	%
<b>Overall experience of making an appointment</b>			
Very good	37.4	47.1	59.6
Fairly good	39.4	37.2	27.7
Neither	13.6	8.0	8.5
Fairly poor	6.5	5.5	4.3
Very poor	3.1	2.2	-
<b>How good was the GP at...</b>			
<b>Giving you enough time</b>			
Very good	53.1	56.0	63.6
Good	33.0	33.3	30.3
Neither	9.1	5.4	3.0
Poor	2.7	2.3	3.0
Very poor	1.9	1.8	-
NA	0.2	1.2	-
<b>Treating you with care/ concern</b>			
Very good	51.6	59.3	60.6
Good	32.2	29.4	27.3
Neither	9.7	5.6	12.1
Poor	3.4	3.1	-
Very poor	2.3	1.9	-
NA	0.7	0.8	-
<b>Have confidence/trust in GP</b>			
Definitely	64.7	71.1	63.6
To some extent	28.2	22.2	30.3
Not at all	5.4	3.7	3.0
Don't know	1.8	3.1	3.0
<b>Overall experience of practice</b>			
Very good	47.1	57.3	n.a.
Fairly good	41.6	36.0	n.a.
Neither	7.0	3.2	n.a.
Fairly poor	3.3	1.0	n.a.
Very poor	1.0	2.6	n.a.

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Bases <sup>3</sup>	4624	307	47
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<sup>1</sup> GPPS year 7, wave 1, July to September 2012.

<sup>2</sup> DPs were only asked if they saw a GP or nurse.

<sup>3</sup> Bases vary, bases shown are for 'overall experience of making an appointment.'

For peer review only

## Reporting checklist

**Good Reporting of A Mixed Methods Study (GRAMMS)**

From O’Cathain, Murphy and Nicholl, 2008. The quality of mixed-methods studies in health services research. *J Health Serv Res Policy*. 13:2 (92-98).

	Guidelines for Good Reporting of A Mixed Methods Study (GRAMMS)	Found on page(s):
1.	Describe the justification for using a mixed methods approach to the research question	6
2.	Describe the design in terms of the purpose, priority and sequence of methods	6-7
3.	Describe each method in terms of sampling, data collection and analysis	6-7
4.	Describe where integration has occurred, how it has occurred and who has participated in it	7-11
5.	Describe any limitation of one method associated with the present of the other method	12
6.	Describe any insights gained from mixing or integrating methods	12