LIST SIZE, STANDARDS AND PERFORMANCE IN GENERAL PRACTICE

A pilot study in the South East Thames Region

by

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CONTENTS

PREFACE

We are extremely grateful to the general practitioner trainers in the South East Thames region without whose generous co-operation this study could not have taken place. We also wish to record our gratitude to our advisers, Dr. K.S. Dawes, Dr. J.P. Horder, Professor D.H. Metcalfe and Dr. G. Singer. They bear no responsibility for any imperfections in the study or in this report.

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Readers who wish to have a brief summary only of the report are advised to consult sections 1, 2, 3 and 12. Readers who wish to have a fuller summary are advised in addition to consult the summaries in sections 4-10 inclusive.

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1. INTRODUCTION

1.1 This is the report of a pilot study carried out among 155 general practitioner trainers in the South East Thames region. Similar pilot studies have been carried out among trainers in four other regions of England. Separate reports have been prepared for each of the five regions, together with a summary report comparing the findings among the regions. The pilot studies were funded by the DHSS and carried out by staff of the Health Services Research Unit at the University of Kent at Canterbury.

1.2 The central theme of the investigation is the relationship between list sizes and standards of care in general medical practice. In particular, the project examines the proposition that doctors with larger lists are less likely to attain a given standard of care than those with smaller lists. To this end, the pilot study reported here took the form of a survey in which the trainers in the South East Thames region were first asked their opinions about good standards in different aspects of their work, and were then asked to provide information about their actual performance in those aspects. The replies were analysed to show the relationship between the standards set by the trainers and the performance they reportedly achieved, and the influence upon this relationship of the number of patients on their lists.

1.3 The pilot studies in the five regions had three aims: to test the feasibility of collecting the information needed to fulfill the objectives of the project; to produce data of use to the general practice training and educational programmes within the participating regions; and to provide tentative answers to the substantive research questions in the event of the main phase not taking place. The next phase of the project, which has now been funded, will consist mainly of a full survey among a larger, randomly selected sample of GPs nationally, using research instruments developed out of the experiences gained in the five pilot regions.

1.4 A total of 721 trainers were approached in the pilot studies, of whom 630 (87%) provided at least part of the information requested. There are obvious deficiencies in confining the pilot studies to GP trainers, since they are unlikely to be representative of the profession as a whole. Nevertheless, the oportunity of testing out the research methods among a large number of doctors at low cost was too valuable to miss, and when the main survey has been completed the data from the pilot surveys will enable some interesting comparisons to be made between GP trainers and the profession as a whole.

2. THE BACKGROUND AND AIMS OF THE PROJECT

2.1 The project, which is part of a wider programme of work on various aspects of the supply, distribution and use of general medical practitioners, originated with the question: what is a reasonable number of patients for GPs to have on their lists? It is an important question, carrying implications in many areas of health care policy, but there is no 'correct' or generally agreed answer. Published opinions have varied widely (from under 1,700 to over 3,000) according to the motives of those expressing them and the factors they have taken into consideration. Faced with such a wide range of opinion about a reasonable list size, the Royal Commission on the National Health Service recommended in 1979 that, before a maximum or minimum list size is adopted as national policy, considerable research should be carried out on what the Commission described as 'this important question'.

2.2 It is evident from the literature that there is a diversity of opinion not only about the actual size of a reasonable list, but also about the concept of 'reasonableness' itself. For example, as list sizes increase, the behaviour of GPs is bound to change: they may work longer hours, have lower consultation rates, spend less time on each consultation, make fewer home visits, do less work outside the practice, offer fewer services within the practice, or any combination of these. But how is it to be decided whether, and if so in what ways, these behavioural changes are relevant to the judgement about a reasonable list size? And are these appropriate criteria to be using at all?

2.3 These questions were tackled in the early part of the project by searching for criteria that have been used by the profession itself in medico-political debates about list sizes. A recurring criterion has been that of standards of care, the argument being that lists are unreasonably large when they constrain doctors to behave in ways that fall short of an acceptable standard. The concept of standards has usually been poorly articulated, but there are common-sense grounds for taking it seriously.

2.4 First, it is an acceptable criterion within the profession. To locate the question of a reasonable list size within the context of standards of care is to adopt an approach that is consistent with professional thinking and attitudes. Second, it is a tenable criterion. It is a plausible proposition that GPs with larger lists are less able to attain particular standards of care than those with smaller lists. Third, by using the concept of standards as the defining criterion of reasonableness, the beneficiaries of a reasonable list size are the patients (through the better care they receive) as well as the doctors (through the enhanced professional satisfaction they derive from their work).

2.5 Yet however sensible this approach may be in principle, in practice it raises difficult questions of conceptualisation, measurement and application. How are acceptable standards of care to be defined and measured? Who is to decide what constitutes an acceptable standard? For what particular aspects of practice are standards to be set? Answers to these questions gradually emerged through a review of the American and British literature on audit and through discussions with interested practitioners and other researchers in the field.

2.6 An initial distinction was made between 'standards' and 'performance'. Standards are subjective opinions about the way things <u>should</u> be done. They are ideals to be aimed at, belonging to the normative world of 'how things ought to be'. Performance, by contrast, describes the way things actually <u>are</u> done. Measures of performance belong to the empirical world of 'how things really are'. This distinction offered a means of relating list sizes and standards of care in general practice. If standards could be set for specific aspects of the GP's work (if, that is, opinions could be elicited about the ways in which those aspects of the GP's work <u>should</u> be conducted), and if his or her actual performance in those aspects of work could be measured, it would be possible to see whether, with increasing list sizes, practitioners became increasingly unlikely to attain the specified standards in different aspects of their work.

2.7 Before this package of ideas could be tried out in the real world of general practice, two further questions of principle had to be resolved. First, who should set the standards? Several kinds of people could be involved in setting standards in general practice, including individual GPs, groups of GPs acting in consensus, other members of the primary health care team, 'experts' in the field (such as senior GPs or specialists), 'outside' academics, or patients. In this project it was decided to restrict the task of standard-setting to individual GPs. General practitioners themselves were chosen partly to ensure that the investigation would be taken seriously by the profession and partly because the argument about standards is usually couched in terms of the difficulty that GPs with large lists experience in attaining the standards that they themselves would wish to do. Practitioners were involved individually in setting their own personal standards (rather than collectively in setting consensus standards) partly because of the sheer difficulty of getting GPs together in groups, but mainly because of the focus of the investigation on the relationship between standards and performance for individual GPs with different list sizes.

2.8 The second question to be resolved was: for what particular aspects of their work should GPs be invited to set standards and have their performance measured? The literature on standard-setting in medical practice commonly identifies three components of practice that can be the focus of study: structure, process and outcome. In this project the choice was based not on theoretical considerations of the relative advantages of structure, process or outcome, but on a pragmatic consideration of those aspects of practice where performance is believed to be at greatest risk of falling below an acceptable standard as lists increase in size. The shopping list was compiled in different ways. Some aspects were culled from medico-political debates about list sizes; some were identified from an earlier literature review; some were included at the specific request of the DHSS; and some emerged from exploratory interviews conducted at an early stage in the investigation with a number of local GPs.

2.9 Eventually, seven major aspects of practice were selected for inclusion

in the pilot studies, dealing partly with the structure and partly with the processes of general practice. They are: accessibility; consultation length; the range of services offered through the practice; special care of the housebound chronically ill; special care of the elderly; repeat prescribing; and the prevention of disease and the promotion of health. Each aspect was further disaggregated into more specific component parts. For example, the first aspect (accessibility) was sub-divided into the following components: hours of opening of practice premises; hours of availability of a doctor on practice premises; the provision of normal surgeries in evenings and at weekends; the time taken by patients to obtain appointments for urgent and non-urgent matters; the arrangements for handling requests for home visits; and the provision of 'out-of-hours' care. In all, 36 specific features were identified about which information on standards and performance was sought.

2.10 In sum, the project seeks to contribute to policy decisions about a reasonable number of patients for GPs to have on their lists by examining the nature of the relationship between list sizes and standards of care. In particular, it deals with the claim that, as list sizes increase, practitioners are increasingly less likely to achieve the standards they set for themselves in different aspects of their work. The principal aim of the pilot study has been to test out ways of collecting the requisite information, but it is hoped also that data will have been generated that is of use to training programmes within the participating regions.

3. METHODS

3.1 Once the aims and theoretical grounding of the project had been worked out, their application to the real world of general practice had to be tested. The first step involved the informal discussion of ideas and possible methods among friendly practitioners. Typically, an initial visit was made to the practice by one member of the research team to carry out a semi-structured tape-recoreded interview exploring the doctor's perceptions of standards, followed by a further visit from another member of the team to discuss different ways of collecting information about performance.

3.2 After working in this way with a dozen GPs over a period of several months, the research instruments had evolved to the point where they could be piloted more formally under the conditions of a postal survey. Although a postal survey has a number of inadequacies, particularly for a sensitive topic such as this, it is the only feasible way of collecting the amount of information required from a large number of GPs across the country. At this stage the opportunity arose of conducting pilot surveys among GP trainers in five regions of England, and although the number of prospective respondents (721) was much larger than necessary, it seemed sensible to take advantage of the opportunity.

3.3 The research instruments that were piloted were altered somewhat from region to region as their inadequacies became apparent. In the South East Thames region, which was the second to be studied, the survey involved two separate mailings. The first consisted of a questionnaire designed to elicit the views of the trainers about their standards in each of the selected aspects of practice (see para. 2.9). Some background information was also collected about their practices and workloads. The wording of the questions about standards created some difficulty. It had been found in the initial phase of the research (see para. 3.1) that GPs gave different responses to questions about minimum standards, ideal standards, and the standards that they were trying to achieve in their own practices. After much deliberation, the wording on the questionnaire invited each trainer to identify 'what you personally regard as the standards that general practitioners should be aiming to achieve in different aspects of their work', and in

doing so they were asked to answer 'from the point of view of a similar practice to your own, in a similar location to yours, and with a similar type of practice population'.

3.4 The second mailing was sent about six weeks after receipt of the first questionnaire, and consisted of three separate instruments designed to elicit the required information about the trainers' performance in each of of the selected aspects of practice. The gap of six weeks was chosen to minimise the risk of the trainers' responses to the 'performance' questions being influenced by their earlier responses to the 'standards' questions. The first instrument was a set of 22 questions completed by the trainers themselves; the second was a set of 17 questions completed by their secretaries/receptionists; and the third was a simple workload recording form covering two weeks' activities in their practices. There were, however, problems associated with the completion of the workload recording forms,and none of the information from that source has been used in this report.

3.5 The first mailing in the South East Thames region was sent in June 1982 to 166 trainers identified by the Regional Associate Adviser in General Practice, and was accompanied by a letter from the Senior Research Fellow working on the project and a letter of commendation from the Associate Adviser. One follow-up reminder was sent to non-respondents. Useable replies were received from 155 trainers, giving a response rate to the first mailing of 93%.

3.6 The second mailing was sent some six weeks after receipt of the first questionnaire, and again one follow-up reminder was sent to non-respondents. Of the 155 trainers to whom the second mailing was sent, 110(71%) responded, although three gave insufficient replies to be useful, and have been excluded from the analyses of the information gained through the second mailing. Expressing these responses as percentages of the 166 eligible trainers in the region, 107 trainers (64%) provided the full range of information requested, 48 (29%)

provided partial information, and 11 (7%) provided no information at all. This is regarded as a satisfactory response rate, and one that is similar to the rates achieved in the four other regions.

3.7 The 155 trainers who replied to the first mailing were reasonably representative of the 166 eligible trainers to whom it was sent. Trainers who qualified in the UK, and who were members of the RCGP, were slightly over-represented among the respondents. The 107 trainers who replied to the second mailing were highly representative of the 155 to whom it was sent in terms of sex, years since qualification, area of residence within the region, practice size, and composition of the primary health care team. They were also reasonably representative in their geographical distribution amongst Family Practitioner Committees (FPCs) of all GPs in the region. The proportion was only marginally higher for Kent and marginally lower for Lambeth, Southwark and Lewisham (table 3.1). As will be seen, however, respondents differed appreciably in many other respects from all GPs at regional or national level, and the results cannot be regarded as typical of general practice as a whole.

3.8 There are many deficiencies in the data, some stemming from inherent limitations in the aims and methods of the project itself, others from the particular circumstances of the pilot. The following observations are important in setting this report in an appropriate perspective.

3.9 First, the project is confined to those aspects of practice for which measures of standards and performance can feasibly be obtained through the medium of a postal survey. Important though these aspects are, they fail to take account of a whole range of less tangible qualities of sensitivity, professional acumen, skill in communication, and so on, that are equally important components of the quality of care. The project makes no claim whatsoever to comment on the overall performance of general practitioners; it confines itself explicitly to a small number of measurable aspects of practice.

3.10 Second, the study is confined entirely to aspects of the structure and process of general practice, and has nothing to say about the outcome

of care. In one sense this is an important omission, for there may be little virtue in GPs carrying out the processes of care in ways that match up to their standards if there is little resulting benefit to patients. However, the measurement of outcome, and the identification of causal links between processes and outcome, has proved to be so difficult that attention must be limited for the time being upon standards of structures and processes that are believed to be related to a favourable outcome.

3.11 Third, the repeatability and validity of some of the questions used in the study may be suspect. A question is repeatable if it yields consistent answers whenever it is asked of the same subject. In the case of the 'standards' questions used in this study, there are grounds for doubting whether all the responses of the trainers were consistently held opinions or whether they were (at least to some extent) off-the-cuff replies that would differ if the questions were repeated. No repeatability checks were carried out in the pilot studies. A question is valid if it elicits a 'true' or 'real' account of whatever it intends to measure. No systematic validation checks were made but some of the questions were repeated in different contexts. For example, in the first mailing trainers were asked to estimate the average number of surgery consultations and home visits they made each week, and in the second mailing receptionists were asked to record the actual number of surgery consultations and home visits in the appointment book for the most recent week when the trainer was not on leave. In addition, the trainers were asked in the workload recording forms to note all consultations and home visits over a two-week period. The first question was expected to be no more than an informed guess or impression of the 'average' number of patient contacts in a 'typical' week. The second question was more specific, yielding information from booking diaries and records. The information from the workload recording forms was prospective, and it related to unselected weeks which may or may not have been typical. The data from these three sources cannot be compared directly, but they nevertheless showed a reasonable degree of association, albeit with the trainers' estimates of the weekly numbers of surgery consultations and home visits frequently exceeding those recorded in the booking diaries and records.

3.12 Fourth, many of the questions about standards required an unconditional response, making no allowance for those who wished to qualify their answers in any way. There is an obvious element of distortion here in which the subtlety of a conditional or qualified answer is sacrificed for the sake of one that can be categorised with those of other respondents.

3.13 The main deficiencies in the data resulting from the particular circumstances of the pilot studies are two-fold. First, the number of respondents in each region was quite small, limiting the analyses to simple forms. Moreover, different numbers of trainers replied to the two mailings, reducing the numbers still further. Second, the analyses have revealed ambiguities of wording in certain questions (and therefore in the replies to those questions) that could not entirely have been foreseen during the compilation of the questionnaires. It is, of course, a primary purpose of the pilot studies to detect such flaws and correct them before beginning the main survey; but the reader will doubtless be irritated by a number of annoying inadequacies that will be encountered in the remainder of the report.

TABLE 3.1 FAMILY PRACTITIONER COMMITTEE (FPC) OF ALL SE THAMES UNRESTRICTED PRINCIPALS (OCTOBER 1981) AND OF TRAINERS, BY TYPE OF RESPONSE

FPC	ALL UNRESTRICTED PRINCIPALS SE THAMES	TRAINERS			
		forms mailed	response first mailing	complete returns both mailings	non-response or refusals
Kent	684 (39%)	71 (43%)	66 (43%)	48 (45%)	5
East Sussex	331 (19%)	35 (21%)	32 (21%)	22 (21%)	3
Bromley	142 (8%)	15 (8%)	13 (8%)	7 (7%)	2
Greenwich and Bexley	194 (11%)	17 (10%)	17 (11%)	12 (11%)	0
Lambeth, Southwark and Lewisham	389 (22%)	28 (17%)	27 (17%)	18 (17%)	1
TOTAL SE THAMES	1740 (100%)	166 (100%)	155 (100%)	107 (100%)	11

4. BACKGROUND CHARACTERISTICS OF THE TRAINERS AND THEIR PRACTICES

4.1 Sex, age and College affiliation

4.1.1 The 155 trainers who replied to the first mailing were atypical of GPs nationally, being older, more oriented towards the Royal College of General Practitioners, and containing proportionally fewer women than the profession as a whole (table 4.1).

4.2 List size

4.2.1 The definition of each trainer's list size was problematic in the case of partnerships. In published DHSS statistics, the list size of a doctor in a partnership is taken as the total number of patients registered with the partnership divided by the number of unrestricted principals. In this study, however, it was important to obtain a reasonable estimate of each trainer's personal list size, and a distinction was therefore made between practices in which each doctor attended mainly to the patients on his own list (as recorded by the Family Practitioner Committee) and those in which patients were free to consult any of the partners. In the former practices the trainers' personal lists were taken as the numbers of patients registered with them. In the latter practices, in order to take account of the uneven distribution of work that sometimes results from a free-flow system, the equivalent of a personal list size was estimated by the trainers in response to the question: 'what size would a personal list have to be to give you the same workload as you now have?' Some trainers answered the question by giving the practice average, implying that the workload was evenly shared, but others gave alternative estimates either higher or lower than the practice average.

4.2.2 The mean personal list size, calculated in the manner described above, was 2,537 (table 4.2). Because of the particular manner of its calculation, no direct comparison can be made with the list sizes of all GPs in the South East Thames region, but a rough comparison can be made by dividing the practice list by the whole-time equivalent number of doctors in the practice, counting two part-time doctors as the equivalent of one whole-time doctor. The results show that the lists of the trainers were appreciably higher than those of all unrestricted principals in the region (table 4.3). The mean list size was 2,404 among the trainers compared with 2,197 among all principals, and only 5% of trainers had an average list per whole-time quivalent doctor of less than 1,750 compared with 21% of all principals.

4.2.3 The trainers were asked in the first mailing what their ideal list size would be, assuming there were no adverse financial consequences. Twenty-eight per cent would have liked a personal list of less than 1,750, and 58% specified a list of 1,750-2,249 as their ideal (table 4.2). The mean ideal list was 1,908 - a quarter lower than the mean actual personal list size of 2,537. A comparison of the trainers' actual and ideal list sizes shows that 18 (12%) selected an ideal list that was the same as their actual lists; 129 (85%) selected an ideal list that was smaller than their actual lists; and 4 (3%) selected an ideal that was larger. The ideal lists were closer to the actual lists among trainers with smaller than with larger lists (table 4.4).

4.2.4 Trainers were also asked in what ways they would expect the nature or content of their work to change if they acquired their ideal list size. The main activities on which the trainers would have expected to spend more time were consultations, self-education, leisure, and teaching (table 4.5). Trainers with lists of 2,750 and above were rather more likely than the others to emphasise the extra time they would expect to spend on teaching activities.

4.3 Practice size

4.3.1 The trainers who replied to the first mailing were working in partnerships or group practices of widely varying sizes. (No distinction was made between partnerships and group practices, and no account was taken of trainees). At one extreme, nine trainers were in single-handed practices; at the other extreme, three were in practices with 12 full-time doctors. In addition, 45 trainers reported one part-time partner in their practices, and 12 reported two or more part-time partners. The mean number of full-time doctors was 4.2 (table 4.6). Practice size was positively associated with list size, the mean number of full-time doctors increasing from 3.8 among those with lists of less than 2,250 to 4.6 among those with lists of 2,750 and above (table 4.6). The sizes of the trainers' practices were larger than those of all unrestricted principals in the region. For example, whereas only 6% of the trainers were single-handed and 21% were working in groups of six or more, the corresponding proportions for all unrestricted principals in the region were 19% and 12% respectively.

4.4 Primary health care teams (PHCTs)

4.4.1 Trainers were asked in the first mailing to specify the whole-time equivalent number of PHCT members employed in or attached to their practices. Some trainers merely indicated that a particular category of staff was employed without specifying the actual numbers, and these have been excluded from the analysis. The 'average' team, excluding the doctors, contained just over 11 members, of whom the secretaries/receptionists were the most numerous, followed by the district nurses and health visitors (table 4.7). The number of nurses employed in the practice varied widely. Twenty-seven per cent of the trainers had no practice nurse; 14% had only a part-time practice nurse; and the remaining 59% had from one to seven full-time practice nurses. Taking all the nurse members together, nearly all of the trainers had at least one part-time nurse, the numbers ranging up to 23 full-time equivalent nurse members. The mean number of all members and of nurse members of the PHCT is shown by list size in table 4.8. The mean size of the team increased with rising list size, although the effect was less marked (particularly among the nurse members) when practice size is taken into account (table 4.8).

4.5 The use of time

4.5.1 Trainers were asked in the first mailing to estimate the number of hours they spent each week, on average throughout the year, on different activities within their practices. The total estimated time (excluding time 'on call') ranged from under 30 hours per week to over 70. The mean number of hours spent per week on all practice activities was 47.2 (table 4.9). This is higher than that usually found in surveys of randomly selected general practitioners, but consistent with that reported by the trainers in the other regional pilot surveys. Of this total, 20.9 hours (44%) were spent on surgery consultations, 9.1 hours (19%) on home visits, and 3.8 hours (8%) on vocational training. Trainers with lists of less than 2,500 had lower estimates of the total amount of time spent within the practice, particularly of the time spent on surgery consultations and home visits, than those with larger lists.

4.5.2 An indication of the reliability of the trainers' estimates of the time they spent on different activities can be obtained by comparing their estimated time spent on surgery consultations with the information pro-

vided by the receptionists in the second mailing about the trainers' nominal consulting hours and weekly numbers of sessions (including clinics and branch surgeries). Whereas the trainers had estimated spending an average of 20.9 hours per week on surgery consultations (with an individual range from 11 to 54 hours), the receptionists' information indicated an average of 16.4 consulting hours per week (with an individual range from 8½ to 34 hours) (table 4.10). The difference between the two figures can be explained partly by the discrepancy between the actual and the nominal times of surgeries and also the exclusion from the receptionists' information of Saturday surgeries. But these differences of definition do not fully explain the variation, and it is likely that at least some of the trainers chose peak working times rather than average working times.

4.5.3 The estimated time spent on professional activities outside the practice ranged from zero to 27 hours, with a mean of 4.7 hours (table 4.11). The most common outside activities were insurance work, hospital work, industrial work and well-baby clinics. The estimated mean number of hours spent each week outside the practice varied widely among the trainers, but was not systematically related to their personal list sizes.

4.5.4 Two separate estimates were derived of the number of hours 'on call' each week outside normal working hours. In the first mailing trainers were asked to estimate the average weekly number of 'on call' hours throughout the year, and in the second mailing they were asked to specify, for the previous four weeks, the number of out-of-hours duty spells they had had and the number of hours spent on each spell. A distinction was made between weekdays, Saturdays and Sundays, and an adjustment was made to allow for unusual patterns of out-of-hours duties, for example due to absences by partners. The replies in the first mailing covered a wide range, from zero to 60 hours 'on call' per week, with a mean of 27.3 (table 4.12). The variations among trainers with differing list sizes were not large, although those with lists of 2,750 and above spent fewer hours on call than those with lists of less than 2,500. This reflects the fact that they were working in larger practices (table 4.6). The information provided in the second mailing showed that, in the previous four weeks, the trainers had spent an average of 61 hours 'on call' during

weekdays, 22 hours during Saturdays, and 22 hours during Sundays (table 4.13). Adding these together, the result is an overall average of 26.3 hours per week - very close indeed to the rough estimate provided by the trainers in response to the first mailing (table 4.12). Again, trainers with lists of 2,750 and above spent fewer hours on call than those with smaller lists.

4.6 Workload

4.6.1 Two separate estimates were derived of the average weekly number of surgery consultations and home visits carried out by the trainers. In the first mailing they were asked to estimate the average number of surgery consultations and home visits they did each week throughout the year, and in the second mailing the receptionists were asked to give the number of consultations and visits actually recorded in the practice appointment book for the trainer in the previous week. Both estimates showed a wide range in surgery workload, from about 50 to 250 consultations per week. The mean number of consultations per week estimated by the trainers (157) was 10% higher than the number (143) recorded in the appointment book (table 4.14).

4.6.2 Whichever estimate of surgery consultations was used, the number of consultations each week tended to increase with rising list size (table 4.15). However, this tendency disappeared, and was to some extent even reversed, when the number of surgery consultations was expressed as a rate per 100 patients on the list (table 4.15).

4.6.3 Similar patterns were evident in the data on home visits. The range of visits was wide in both estimates, from 3 to 80 per week, and the trainers' own estimates were slightly higher than the numbers recorded in the practice appointment book (table 4.16). Trainers with lists of less than 2,250 made rather fewer visits per week than those with larger lists, but the effect disappeared when the home visits were expressed as a rate per 100 patients on the list (table 4.17).

4.6.4 Information was collected about the trainers' workload when on out-of-hours duty (see para. 4.5.4). They were asked to specify, for the most recent duty spells on a weekday, a Saturday and a Sunday, the number of telephone calls received, the number of home visits made, and the number of night visits made after 11.00 p.m. Excluding those who could

not remember or had not kept records, the mean number of telephone calls was 4.1 on weekdays, 9.8 on Saturdays and 9.5 on Sundays. The mean number of home visits was 2.3 on weekdays, 6.2 on Saturdays and 6.5 on Sundays. Overall, one-tenth of the home visits were made at night (table 4.18).

4.6.5 Trainers were asked in the first mailing to rate their feelings about their workload on a simple three-point scale. Eleven per cent felt that they were very overworked, 47% that they were moderately overworked, and 39% that they were not overworked (table 4.19). Trainers with lists of less than 2,250 were markedly less likely than the remainder to regard themselves as very or moderately overworked, and correspondingly more likely to regard themselves as not overworked.

4.7 Summary

4.7.1 The GP trainers in the South East Thames region were, as a group, atypical of GP principals nationally: compared with the profession as a whole they were older (measured in terms of the number of years since qualification), were more oriented towards the Royal College of General Practitioners, contained fewer women, had larger list sizes, worked in larger practices with larger primary health care teams, and probably spent more time working in their practices.

4.7.2 The group was, however, by no means homogeneous. In spite of their common status as trainers, they displayed a large degree of diversity on many of the background variables reported in this section. In some cases this diversity is unexceptionable, but in other instances (such as their use of time or their pattern of patient contacts) the diversity of the responses is less to be expected.

4.7.3 The mean personal list size of the trainers in the study was 2,537, which is rather higher than that of all unrestricted principals in the region. The mean ideal list size was 1,908 - 25% lower than the mean actual list. The main benefit of a smaller list size was felt to be the longer consultations that could ensue. Trainers with lists of less than 2,250 differed from the others in a number of ways: they were younger; they worked in smaller partnerships with smaller primary health care teams; they spent less time on surgery consultations and home visits and saw fewer patients; and they were less likely to regard themselves as overworked.

4.7.4 The mean practice size consisted of 4.2 full-time doctors and the typical primary health care team was made up of just over 11 members (excluding the doctors), of whom secretaries/receptionists and district nurses comprised almost two-thirds.

4.7.5 The trainers estimated that they spent, on average, 47.2 hours per week on practice work and 4.7 hours on work outside the practice. These estimates are somewhat higher than those reported in other studies, and they may be over-estimates of the real amount of time spent. During these hours, the trainers saw, on average, about 150 patients each week in surgery consultations and made about 20 home visits. They spent, on average, a little over 26 hours a week 'on call', receiving about 4 telephone calls during the week and about 10 at weekends during each spell 'on call'. Almost half of the trainers thought they were moderately overworked and a further tenth that they were very overworked.

4.7.6 Against this background, the remainder of the report examines the standards that the trainers held in different aspects of their work, and the levels of performance they achieved.

TABLE 4.1 SEX, YEARS SINCE QUALIFICATION, AND AFFILIATION TO THE RCGP

SEX		
male	92%	N (= 100%) 155
female	8%	
YEARS SINCE QUALIFICATION		
less than 15	17%	
15-24	37%	N (= 100%) 155
25 or more	46%	
AFFILIATION TO THE RCGP		
Member or Fellow	57%	N (= 100%) 155
no affiliation	43%	

TABLE 4.2 ACTUAL PERSONAL LIST SIZE AND IDEAL LIST SIZE

LIST SIZE	ACTUAL PERSONAL LIST SIZE	IDEAL LIST SIZE
Less than 1,750	4 (3%)	43 (28%)
1,750-2,249	40 (26%)	90 (58%)
2,250-2,499	18 (12%)	2 (1%)
2,500-2,749	45 (29%)	13 (8%)
2,750 and above	48 (31%)	3 (2%)
Other replies	0	4 (3%)
TOTAL	155 (100%)	155 (100%)
MEAN	2,537	1,908

TABLE 4.3 LIST SIZE PER PARTNER: TRAINERS AND ALL UNRESTRICTED PRINCIPALS IN THE REGION

LIST SIZE PER PARTNER	TRAINERS	ALL UNRESTRICTED PRINCIPALS
Less than 1,750	5%	21%
1,750-1,999	10%	16%
2,000-2,249	18%	16%
2,250-2,499	22%	17%
2,500-2,749	26%	16%
2,750-2,999	12%	9%
3,000 and above	7%	6%
N (= 100%)	155	1,740
MEAN	2,404	2,197

NOTE: for the purposes of this table, the list size of a partnership was divided by the whole-time equivalent number of doctors in the practice, counting two part-time doctors as the equivalent of one whole-time doctor.

TABLE 4.4 IDEAL LIST SIZE AS PERCENTAGE OF ACTUAL PERSONAL LIST SIZE

IDEAL AS PERCENTAGE OF ACTUAL	PERSONAL LIST SIZE less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Mean percentage	86%	80%	79%	67%	77%
(number of cases)	(42)	(18)	(44)	(47)	(151)

TABLE 4.5 EXPECTED CHANGES IN WORK PATTERN IF IDEAL LIST ACQUIRED

WOULD EXPECT MORE TIME TO BE SPENT ON:	PERSONAL LIST SIZE less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
consultations	80%	78%	87%	87%	83%
self-education	66%	72%	67%	61%	64%
leisure	52%	61%	62%	56%	57%
teaching	57%	61%	56%	80%	63%
other clinical work in the practice	39%	22%	33%	46%	37%
other work outside the practice	25%	28%	33%	35%	31%
list size is ideal now	27%	6%	9%	2%	12%
N (= 100%)	44	18	45	48	155

NOTE: most respondents gave more than one answer; the cumulative percentages therefore exceed 100.

TABLE 4.6 PRACTICE SIZE (NUMBER OF FULL-TIME DOCTORS)

NUMBER OF FULL-TIME DOCTORS	PERSONAL LIST SIZE less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
1, 2	5 (11%)	3 (17%)	7 (16%)	5 (10%)	20 (13%)
3	15 (34%)	4 (22%)	9 (20%)	11 (23%)	39 (25%)
4	12 (27%)	4 (22%)	11 (24%)	11 (23%)	38 (24%)
5	9 (20%)	5 (28%)	6 (13%)	6 (13%)	26 (17%)
6 or more	3 (7%)	2 (11%)	12 (27%)	15 (31%)	32 (21%)
TOTAL	44 (100%)	18 (100%)	45 (100%)	48 (100%)	155 (100%)
MEAN	3.8	4.0	4.3	4.6	4.2

TABLE 4.7 MEAN NUMBER OF MEMBERS OF THE PRIMARY HEALTH CARE TEAM EMPLOYED IN, OR ATTACHED TO, THE PRACTICE (WHOLE-TIME EQUIVALENTS)

TEAM MEMBER	MEAN NUMBER	NUMBER OF CASES
Nurse in the practice	1.0	144
Nurse in the district	2.3	141
Health visitor	1.9	140
Midwife	0.9	140
Secretary/receptionist	4.9	138
Manager/administrator	0.2	154

NOTE: the number of cases excludes responses where the actual numbers of staff were not specified.

TABLE 4.8 MEAN NUMBER OF MEMBERS OF THE PRIMARY HEALTH CARE TEAM (WHOLE-TIME EQUIVALENTS) AND NUMBER PER FULL-TIME DOCTOR

	PERSONAL LIST SIZE				
TEAM MEMBER	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
All members:					
mean number	9.5	12.2	11.4	13.5	11.5
per full-time doctor	2.4	3.2	2.7	3.0	2.8
Nurse members:					
mean number	5.5	6.4	6.2	7.3	6.3
per full-time doctor	1.4	1.7	1.4	1.6	1.5
NUMBER OF CASES	40	16	38	41	135

NOTE: the number of cases excludes responses where the actual numbers of staff were not specified

TABLE 4.9 ESTIMATED MEAN NUMBER OF HOURS SPENT PER WEEK ON ACTIVITIES WITHIN THE PRACTICE

ACTIVITY	PERSONAL LIST SIZE less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
NHS surgery consultations	19.3	17.1	22.0	22.7	20.9
NHS home visits	7.8	7.0	11.1	9.4	9.1
Private practice	0.4	0.7	0.8	0.7	0.6
Other clinical work	2.6	2.2	2.3	2.2	2.3
Travelling	2.2	2.6	2.5	2.4	2.4
Reading	2.9	2.1	3.4	3.4	3.1
Administration	2.3	3.1	3.1	2.3	2.7
Practice meetings	1.9	1.5	1.5	1.5	1.6
Vocational training	3.8	4.0	3.7	4.0	3.8
Other	0.7	0.3	0.7	1.0	0.7
TOTAL	43.9	40.6	51.1	49.6	47.2
NUMBER OF CASES	44	18	45	48	155

NOTE: the time spent on travelling to home visits is included in the category of 'home visits', not 'travelling'.

TABLE 4.10 SURGERY CONSULTATION HOURS PER WEEK: TRAINERS' ESTIMATES AND NOMINAL CONSULTING HOURS

HOURS PER WEEK	TRAINERS' ESTIMATES	NOMINAL CONSULTING HOURS
Less than 16	23 (15%)	48 (45%)
16-18	30 (19%)	32 (30%)
19-21	37 (24%)	13 (12%)
22-24	34 (22%)	9 (8%)
25 and above	29 (19%)	5 (5%)
No answer	2 (1%)	0
TOTAL	155 (100%)	107 (100%)
MEAN	20.9	16.4

TABLE 4.11 ESTIMATED NUMBER OF HOURS SPENT PER WEEK ON ALL PROFESSIONAL ACTIVITIES OUTSIDE THE PRACTICE

	PERSONAL LIST SIZE				
ESTIMATED NUMBER OF HOURS	less than 2,250	2,250-2,449	2,500-2,749	2,750 and above	TOTAL
None	5 (11%)	0	3 (7%)	4 (8%)	12 (8%)
Less than 2	7 (16%)	5 (28%)	12 (27%)	5 (10%)	29 (19%)
2-3	8 (18%)	1 (5%)	10 (22%)	12 (25%)	31 (20%)
4-5	6 (14%)	2 (11%)	7 (16%)	9 (19%)	24 (15%)
6 or more	13 (30%)	8 (44%)	11 (25%)	13 (27%)	45 (29%)
Hours not specified	5 (11%)	2 (11%)	2 (4%)	5 (10%)	14 (9%)
TOTAL	44 (100%)	18 (100%)	45 (100%)	48 (100%)	155 (100%)
MEAN	4.7	7.0	3.8	4.8	4.7

TABLE 4.12 MEAN NUMBER OF HOURS 'ON CALL' PER WEEK: TRAINERS' ESTIMATES AND ACTUAL HOURS IN FOUR-WEEK PERIOD

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
TRAINERS' ESTIMATES					
average weekly hours	27.0	27.6	29.6	25.4	27.3
(number of cases)	(44)	(18)	(45)	(48)	(155)
ACTUAL HOURS IN FOUR-WEEK PERIOD					
average weekly hours	27.1	28.6	27.3	23.8	26.3
(number of cases)	(31)	(13)	(28)	(35)	((107)

TABLE 4.13 OUT-OF-HOURS DUTY SPELLS AND HOURS 'ON CALL' IN FOUR-WEEK PERIOD

	WEEKDAYS	SATURDAYS	SUNDAYS
Mean number of duty spells in previous 4 weeks	4.6	1.2	1.1
Mean number of hours in each duty spell	13.2	18.2	19.6
Mean number of duty hours in previous 4 weeks	61	22	22
NUMBER OF CASES	107	107	107

TABLE 4.14 AVERAGE NUMBER OF SURGERY CONSULTATIONS PER WEEK: TRAINERS' ESTIMATES AND APPOINTMENT RECORDS

AVERAGE NUMBER OF SURGERY CONSULTATIONS	TRAINERS' ESTIMATES	APPOINTMENT RECORDS
Less than 100	2 (1%)	10 (9%)
100-119	20 (13%)	21 (20%)
120-139	30 (19%)	23 (21%)
140-159	30 (19%)	21 (20%)
160-179	27 (17%)	16 (15%)
180 or more	45 (29%)	13 (12%)
No answer	1 (1%)	3 (3%)
TOTAL	155 (100%)	107 (100%)
MEAN	157	143

TABLE 4.15 AVERAGE NUMBER OF SURGERY CONSULTATIONS PER WEEK, AND RATE PER 100 PATIENTS ON LIST: TRAINERS' ESTIMATES AND APPOINTMENT RECORDS

SURGERY CONSULTATIONS	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
TRAINERS' ESTIMATES:					
average number	138	139	159	179	157
rate per 100 patients	7.0	6.0	6.2	5.8	6.3
NUMBER OF CASES	44	17	45	48	154
APPOINTMENT RECORDS:					
average number	127	152	141	157	143
rate per 100 patients	6.5	6.5	5.5	5.1	5.7
NUMBER OF CASES	30	13	27	34	104

TABLE 4.16 AVERAGE NUMBER OF HOME VISITS PER WEEK: TRAINERS' ESTIMATES AND APPOINTMENT RECORDS

AVERAGE NUMBER OF HOME VISITS	TRAINERS' ESTIMATES	APPOINTMENT RECORDS
None	2 (1%)	1 (1%)
Less than 10	17 (11%)	15 (14%)
10-19	48 (31%)	33 (30%)
20-29	40 (26%)	16 (15%)
30 or more	48 (31%)	12 (11%)
No answer	0	30 (28%)
TOTAL	155 (100%)	107 (100%)
MEAN	22	20

TABLE 4.17 AVERAGE NUMBER OF HOME VISITS PER WEEK, AND RATE PER 100 PATIENTS ON LIST: TRAINERS' ESTIMATES AND APPOINTMENT RECORDS

HOME VISITS	PERSONAL LIST SIZE less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
TRAINERS' ESTIMATES					
average number	18	20	26	23	22
rate per 100 patients	0.9	0.9	1.0	0.7	0.9
NUMBER OF CASES	44	18	45	48	155
APPOINTMENT RECORDS					
average number	14	18	26	20	20
rate per 100 patients	0.7	0.8	1.0	0.6	0.8
NUMBER OF CASES	23	12	21	21	77

TABLE 4.18 MEAN NUMBER OF TELEPHONE CALLS, HOME VISITS AND NIGHT VISITS DURING MOST RECENT OUT-OF-HOURS DUTY SPELL

	WEEKDAYS	SATURDAYS	SUNDAYS
Number of telephone calls	4.1	9.8	9.5
Number of home visits	2.3	6.2	6.5
Number of night visits	0.6	0.6	0.4
NUMBER OF CASES	95	91	86

TABLE 4.19 SUBJECTIVE FEELINGS ABOUT WORKLOAD

FEELINGS ABOUT WORKLOAD	PERSONAL LIST SIZE				TOTAL
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	
Very overworked	5 (11%)	2 (11%)	3 (7%)	7 (15%)	17 (11%)
Moderately overworked	10 (23%)	11 (61%)	21 (47%)	31 (65%)	73 (47%)
Not overworked	27 (61%)	5 (28%)	19 (42%)	9 (19%)	60 (39%)
No answer	2 (5%)	0	2 (4%)	1 (2%)	5 (3%)
TOTAL	44 (100%)	18 (100%)	45 (100%)	48 (100%)	155 (100%)

5. ACCESSIBILITY

5.1 Introduction

5.1.1 The first aspect of practice with which the project is concerned is accessibility (see para. 2.9). The concept of accessibility was broken down into eight constituent parts, and information was sought about the trainers' standards and performance in each part. However, deficiencies in some of the questions have prevented an exact comparison between standards and performance in some cases.

5.2 Hours of opening of practice premises

5.2.1 Trainers were asked in the first mailing for how long they thought main practice premises should be open each day to patients who called or telephoned for any reason. In the second mailing the receptionists were asked the actual times of opening. Table 5.1 shows the replies of those who answered each question. There was a wide variation among the trainers in both their standards (from 3½ to 12 hours) and their performance (from 4 to 12½ hours), but these variations were not systematically associated with list size. The actual opening hours did, however, vary with the size of practice.

5.2.2 The 107 trainers who replied to both mailings (that is, who provided information about both standards and performance) were divided into three categories: those whose premises were open for the exact number of hours that they thought they should be open (performance same as standard); those whose premises were open for more hours than they thought they should be (performance better than standard); and those whose premises were open for fewer hours than they thought they should be (performance worse than standard). The distribution is shown in table 5.2 Overall, 48% of the trainers had the same performance as the standard they had set; 15% had a better performance; and 36% had a worse performance. By virtue of the smaller average number of hours that their premises were actually open each day, trainers with lists of less than 2,250 were rather more likely than the rest to have a worse performance than the standard they had set.

5.3 Hours of availability of a doctor on practice premises

5.3.1 Trainers were asked in the first mailing for how long each day they thought a doctor should always be available on main practice premises. In the second mailing the receptionists were asked the actual times of availability. Table 5.3 shows the replies of those who answered each question. There was a wide variation among the trainers in both their standards (from 3 hours to 12 hours)and their performance (from 4 hours to 12 hours). Those with lists of less than 2,500 had somewhat lower mean scores on both the 'standards' and the 'performance' questions than those with larger lists, this being associated in part with practice size.

5.3.2 The relationship between the standards and the performance of the 107 trainers who replied to both mailings is shown in table 5.4. The picture is clouded by the large proportion of trainers (28%) who failed to provide useable answers to either or both of the questions. Overall, 32% of the trainers had the same performance as the standard they had set; 13% had a better performance; and 27% had a worse performance. There were no consistent variations among trainers with differing list sizes.

5.4 Evening surgeries

5.4.1 In the first mailing trainers were asked whether they thought normal surgeries should be held in the evenings. In the second mailing receptionists were asked when the normal consulting hours ended, and practices with a finishing time of 6 p.m. or later were deemed to hold evening surgeries. The two sets of replies are shown in table 5.5. Seventy-seven per cent of the trainers in the first mailing thought that normal surgeries should be held in the evenings, and 79% of the receptionists in the second mailing said they were actually held. There were no significant variations among trainers with differing list sizes.

5.4.2 The trainers' views about evening surgeries corresponded fairly well with their actual consulting hours (table 5.6). Overall, 63% of the 107 trainers who replied to both mailings were in favour of evening surgeries and also held them, and a further 11% were not in favour and closed their surgeries before 6.00 p.m. In all, therefore, 74% had the same performance as the standard they had set, 15% had a better performance, and 9% had a worse performance. There were no consistent variations among trainers with differing list sizes in the relationship between their standards and their performance (table 5.7).

5.5 Weekend surgeries

5.5.1 In the first mailing trainers were asked whether they thought normal surgeries should be held at weekends. In the second mailing the receptionists were asked whether Saturday or Sunday surgeries were actually held in the practice. The two sets of replies are shown in table 5.8. Forty-one per cent of the trainers in the first mailing thought that weekend surgeries should be held (the majority of them specifying Saturday mornings only), and almost all (93%) of the receptionists in the second mailing said that weekend surgeries were actually held (all of them on Saturdays). There were no significant variations by list size in either set of replies.

5.5.2 The receptionists were also asked in the second mailing how often the trainers were on duty for Saturday surgeries. The most common pattern was a duty rota of one week in three or four Saturdays (table 5.9). As this table shows, there was an association between the frequency of the trainers' Saturday duty rotas and their opinions about weekend surgeries. Those who were opposed to weekend surgeries were on duty less frequently than those who were in favour of them.

5.5.3 The relationship between standards and performance is shown in table 5.10. Since virtually all of the practices were actually providing Saturday surgeries, it is no surprise that, overall, 48% of those who replied to both mailings had the same performance as the standard they had set, and 51% had a better performance. There were no consistent variations among trainers with differing list sizes.

5.6 Delay in obtaining an appointment

5.6.1 Trainers were presented in the first mailing with the hypothetical situation of a patient telephoning at mid-day on a Monday to request a surgery consultation with his usual doctor about an urgent and a non-urgent matter, and they were asked what they thought was the maximum time that such a patient should have to wait to see the doctor. In the second mailing the receptionists were asked when such a patient would actually have been booked in. As would be expected, the replies in tables 5.11 and 5.12 show that the trainers felt there should be a much shorter waiting time for an urgent than for a non-urgent matter: 49% thought that the maximum wait should be only

six hours for an urgent matter compared with 3% for a non-urgent matter There was no consistent variation among the replies of trainers with different list sizes. Almost all (94%) of the 107 receptionists who replied to the second mailing reported that an appointment would actually have been made on the same day for an urgent matter (table 5.12) compared with 14% for a non-urgent matter (table 5.11). There were no variations among trainers with differing list sizes in the booking of appointments for urgent matters, but those with lists of 2,250-2,499 were more likely, and those with lists of 2,500-2,749 were less likely, to report a booking on the same day for non-urgent matters.

5.6.2 The comparison between standards and performance is impaired by the different categories of response to the two questions. However, an approximate comparison can be made by assuming that the response categories to the 'standards'question (i.e. '6 hours', '24 hours', and '48 hours or more') are the equivalent of those to the'performance' question (i.e. 'same day', 'following day', and '2 or more days later'). On this assumption, the relationship between the standards and the performance of the 107 trainers who replied to both mailings is shown in table 5.13. Overall, the performance of the trainers was very good in relation to their standards: fewer than 5% had a worse performance than the standard they had set, and the proportions with a better performance than standard were 64% for non-urgent matters and 49% for urgent matters. There were no significant variations among trainers with differing list sizes in the case of urgent matters, but those with lists of 2,250-2,499 were a little less likely than the rest to have a better peformance than standard in the case of appointments for non-urgent matters.

5.7 Classification of patients' requests for a surgery consultation

5.7.1 Trainers were asked in the first mailing how it should normally be decided whether a patient's request for a surgery consultation is treated as urgent or non-urgent. In the second mailing the receptionists were asked how such decisions were actually made. Table 5.14 shows the replies. Seventy-five per cent of those who replied to the first mailing said that the patient's own assessment of the

urgency of his request should normally be accepted, and 15% that the receptionist should normally refer the request to the doctor. There were no consistent variations among trainers with differing list sizes. The pattern of performance was a little different to that of the standards: 59% of the receptionists who replied to the second mailing said that the patient's own assessment was normally accepted, the proportion being appreciably higher among trainers with lists of 2,500-2,749.

5.7.2 The relationship between the standards and the performance of the 107 trainers who replied to both mailings is shown in table 5.15. Because of the lack of any obvious grounds for judging whether any one method is better or worse than another, the classification is restricted to those trainers whose performance was the same as the standard they had set, and those whose performance was different. Overall, 64% of the trainers had the same performance as the standard they had set; 24% had a different performance; and 12% failed to provide replies from which a clear comparison could be made. Trainers with list sizes of 2,500-2,749 were a little more likely than the others to have the same performance as the standard they had set.

5.8 Classification of patients' requests for a home visit

5.8.1 Trainers were asked in the first mailing how it should normally be decided whether a patient's request for a home visit is met. In the second mailing the receptionists were asked how such decisions were actually made. The replies, which are shown in table 5.16, are not directly comparable because many receptionists gave more than one response to the 'performance' question. Overall, 55% of the 155 trainers who replied to the first mailing thought that the patient's own assessment of the need for a home visit should be accepted, and 30% felt that the receptionist should refer the request to the doctor for decision. Trainers with lists of less than 2,250 were more likely, and those with lists of 2,250-2,499 were less likely, to think that the patient's own assessment should normally be accepted. Of the 107 receptionists who replied to the second mailing, 53% reported that the patient's own assessment was usually accepted; 37% said that the receptionist sometimes took the decision; and 22% said that the request was sometimes referred to the doctor. These replies include those who chose more than one procedure.

5.8.2 Because of the multiple replies that were given by many receptionists to the 'performance' question, an exact comparison between standards and performance is not possible. However, a partial comparison can be made by taking each pair of replies separately. Of the 107 trainers who replied to both mailings, 67 thought that the patient's own assessment should normally be accepted, and of these 44 reported that in fact the patient's own assessment was accepted, at least in some degree. Eight of the 107 trainers thought that the receptionist should normally decide for herself, and of these, 6 indicated that this was what actually happened, at least to some extent. Twenty-nine of the 107 trainers felt that the receptionist should normally refer the request to the doctor to decide, and of these, 15 reported that the receptionist did usually do that, at least in part. Summing these replies, the data indicate that, of the 107 trainers who replied to both mailings, 65 (61%) were actually using methods which, at least in part, were the same as their identified standards. The distribution of these 65 trainers among list-size groups is shown in table 5.17. There was no consistent relationship with list size.

5.9 Arrangements for 'out-of-hours' care

5.9.1 Trainers were asked in the first mailing what arrangements they thought should be made for 'out-of-hours' care, and in the second mailing what arrangements actually existed in their practices. The replies are shown in table 5.18. Overall, 72% of the 155 trainers who replied to the first mailing thought that the arrangement for 'out-of-hours' care should take the form of a rota within the practice; 19% favoured a rota system with neighbouring practices; and 10% favoured other arrangements, including a deputising service. There were no consistent variations between the replies of trainers with differing list sizes. Of the 107 trainers who replied to the second mailing, 64% were actually operating a rota system within the practice; 12% had a rota arrangement with neighbouring practices; and the remainder described arrangements involving more than one element. Trainers with lists of 2,250-2,499 were more likely than the rest to operate a rota system within the partnership.

5.9.2 The relationship between the standards and the performance of the 107

trainers who replied to both mailings is shown in table 5.19. Overall, 64% of the trainers had the same performance as the standard they had set, and 13% had a different performance. The latter consisted mainly of trainers who thought that there should be a rota arrangement with neighbouring practices, but who were actually operating rotas within their own partnerships. This discrepancy may reasonably be regarded as a case of performance being better than standard. The variations among trainers with differing list sizes are unreliable because of the large proportion for whom a sensible comparison between standards and performance could not be made.

5.10 Summary

5.10.1 In this section, data from the pilot study in the South East Thames region have been presented dealing with the trainers' standards and performance in eight facets of accessibility to their practices by patients. The presentation has highlighted the variations among the trainers in both their standards and their actual performance, and has related the performance of each trainer to the standards that he or she had set. For reasons discussed in an earlier section (see paras. 3.9-3.13), the analyses contain a number of imperfections, but they are illustrative of the type of results that can be obtained from the method used in the study. Three broad conclusions stand out.

5.10.2 First, there was a wide variability among the trainers both in their perceptions of standards and in their actual performance. The variability was more marked in relation to some of the eight facets of accessibility than to others. The 155 trainers who replied to the first mailing were more diverse in their standards about, for example, the number of hours that practice presmises should be open, the number of hours that a doctor should be available, and the desirability of weekend surgeries, than about the way in which a patient's request for an urgent consultation should be handled or about the arrangements that should be made for 'out-of-hours' care. In terms of performance, those who replied to the second mailing were more diverse in, for example, the hours of opening of their practice premises, the hours of

availability of a doctor, the delay in getting an appointment for a non-urgent matter, and the arrangements they made for 'out-of-hours' care, than in their provision of weekend surgeries or the delay experienced by patients in getting an appointment for an urgent matter.

5.10.3 Second, the relationship between the standards and the performance of those who replied to both mailings was favourable in the sense that only a minority of trainers had a performance that was worse than the standard they had set; but the relationship varied among the different facets of accessibility. On the one hand, 64% of the trainers had a <u>better</u> performance than standard in the time taken by patients to obtain an appointment for a non-urgent matter, 51% in the provision of weekend surgeries, and 49% in the time taken by patients to obtain an appointment for an urgent matter. On the other hand, 36% of the trainers had a <u>worse</u> performance than standard in the hours of opening of their practice premises, and 27% in the hours of availability of a doctor.

5.10.4 Third, there was no evidence of any systematic relationship between the trainers' list sizes and either their standards or their performance. There was certainly no evidence that, with increasing list size, trainers were consistently less likely to achieve the standards they had set, and in most cases there were no significant variations at all among trainers with differing list sizes.

TABLE 5.1 MEAN NUMBER OF HOURS PER DAY THAT PRACTICE PREMISES SHOULD BE, AND WERE, OPEN TO PATIENTS

MEAN NUMBER OF HOURS THAT PRACTICE PREMISES:	PERSONAL LIST SIZE less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
should be open	9.5	9.4	10.1	9.7	9.7
(number of cases)	(44)	(18)	(43)	(47)	(152)
were open	8.5	9.3	9.2	9.3	9.0
(number of cases)	(31)	(13)	(28)	(34)	(106)

TABLE 5.2 MEAN NUMBER OF HOURS PER DAY THAT PRACTICE PREMISES ARE OPEN TO PATIENTS: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	PERSONAL LIST SIZE less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Performance same as standard	12 (39%)	8 (62%)	13 (46%)	18 (51%)	51 (48%)
Performance better than standard	5 (16%)	1 (8%)	5 (18%)	5 (14%)	16 (15%)
Performance worse than standard	14 (45%)	4 (31%)	9 (32%)	11 (31%)	38 (36%)
No answer	0	0	1 (4%)	1 (3%)	2 (2%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 5.3 MEAN NUMBER OF HOURS PER DAY THAT A DOCTOR SHOULD BE, AND WAS, AVAILABLE ON MAIN PRACTICE PREMISES

MEAN NUMBER OF HOURS THAT A DOCTOR:	PERSONAL LIST SIZE less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
should be available	7.0	7.3	7.8	7.5	7.4
(number of cases)	(40)	(16)	(41)	(41)	(138)
was available	7.1	6.8	7.4	7.3	7.2
(number of cases)	(25)	(8)	(20)	(31)	(84)

TABLE 5.4 MEAN NUMBER OF HOURS PER DAY THAT A DOCTOR IS AVAILABLE ON PRACTICE PREMISES: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	PERSONAL LIST SIZE less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Performance same as standard	12 (39%)	3 (23%)	9 (32%)	10 (29%)	34 (32%)
Performance better than standard	2 (6%)	2 (15%)	2 (7%)	8 (23%)	14 (13%)
Performance worse than standard	9 (29%)	3 (23%)	8 (29%)	9 (26%)	29 (27%)
No answer	8 (26%)	5 (38%)	9 (32%)	8 (23%)	30 (28%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 5.5 WHETHER NORMAL SURGERIES SHOULD BE, AND WERE HELD IN THE EVENINGS

NORMAL EVENING SURGERIES:	PERSONAL LIST SIZE less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
should be held	34 (77%)	13 (72%)	36 (80%)	37 (77%)	120 (77%)
should not be held	10 (23%)	5 (28%)	9 (20%)	10 (21%)	34 (22%)
no answer	0	0	0	1 (2%)	1 (1%)
TOTAL	44 (100%)	18 (100%)	45 (100%)	48 (100%)	155 (100%)
were held	24 (77%)	9 (69%)	21 (75%)	30 (86%)	84 (79%)
were not held	6 (19%)	4 (31%)	7 (25%)	5 (14%)	22 (21%)
no answer	1 (3%)	0	0	0	1 (1%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 5.6 WHETHER NORMAL EVENING SURGERIES SHOULD BE HELD, AND END OF NORMAL CONSULTING HOURS

END OF NORMAL CONSULTING HOURS	WHETHER EVENING SURGERIES SHOULD BE HELD		TOTAL
	Yes	No	
Before 6.00 p.m.	10 (13%)	12 (40%)	22 (21%)
6.00 p.m.	37 (48%)	13 (43%)	50 (47%)
6.30 p.m.	13 (17%)	0	13 (12%)
7.00 p.m.	12 (16%)	1 (3%)	13 (12%)
7.30 p.m. or later	5 (6%)	2 (7%)	7 (7%)
No answer	0	2 (7%)	2 (2%)
TOTAL	77 (100%)	30 (100%)	107 (100%)

TABLE 5.7 EVENING SURGERIES: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	PERSONAL LIST SIZE				TOTAL
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	
Performance same as standard	25 (81%)	8 (62%)	19 (68%)	27 (77%)	79 (74%)
Performance better than standard	3 (10%)	3 (23%)	5 (18%)	5 (14%)	16 (15%)
Performance worse than standard	2 (6%)	2 (15%)	4 (14%)	2 (6%)	10 (9%)
No answer	1 (3%)	0	0	1 (3%)	2 (2%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 5.8 WHETHER NORMAL SURGERIES SHOULD BE, AND WERE, HELD AT WEEKENDS

NORMAL WEEKEND SURGERIES:	PERSONAL LIST SIZE less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
should be held	17 (39%)	8 (44%)	15 (33%)	23 (48%)	63 (41%)
should not be held	27 (61%)	10 (56%)	30 (67%)	25 (52%)	92 (59%)
TOTAL	44 (100%)	18 (100%)	45 (100%)	48 (100%)	155 (100%)
were held	28 (90%)	12 (92%)	27 (96%)	32 (91%)	99 (93%)
were not held	3 (10%)	1 (8%)	1 (4%)	3 (9%)	8 (7%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 5.9 WHETHER WEEKEND SURGERIES SHOULD BE HELD, AND FREQUENCY OF SATURDAY DUTIES

FREQUENCY OF SATURDAY DUTIES	WHETHER SATURDAY SURGERIES SHOULD BE HELD		TOTAL
	Yes	No	
Never	1 (2%)	7 (11%)	8 (7%)
Every week	11 (24%)	5 (8%)	16 (15%)
Every fortnight	12 (27%)	5 (8%)	17 (16%)
One week in three	8 (18%)	14 (22%)	22 (21%)
One week in four	8 (18%)	17 (28%)	25 (23%)
Less frequently	5 (11%)	14 (23%)	19 (18%)
TOTAL	45 (100%)	62 (100%)	107 (100%)

TABLE 5.10 WEEKEND SURGERIES: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	PERSONAL LIST SIZE				TOTAL
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	
Performance same as standard	14 (45%)	5 (38%)	10 (36%)	22 (63%)	51 (48%)
Performance better than standard	17 (55%)	7 (54%)	18 (64%)	13 (37%)	55 (51%)
Performance worse than standard	0	1 (8%)	0	0	1 (1%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 5.11 MAXIMUM DELAY THAT PATIENT SHOULD HAVE TO WAIT, AND TIME THAT PATIENT WOULD ACTUALLY WAIT, TO SEE USUAL DOCTOR FOR NON-URGENT MATTER

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
MAXIMUM TIME PATIENT SHOULD HAVE TO WAIT					
6 hours	2 (5%)	0	1 (2%)	2 (4%)	5 (3%)
24 hours	5 (11%)	5 (28%)	8 (18%)	10 (21%)	28 (18%)
48 hours	23 (52%)	10 (56%)	21 (47%)	18 (38%)	72 (46%)
more than 48 hours	14 (32%)	3 (17%)	15 (33%)	17 (35%)	49 (32%)
no answer	0	0	0	1 (2%)	1 (1%)
TOTAL	44 (100%)	18 (100%)	45 (100%)	48 (100%)	155 (100%)
ACTUAL TIME APPOINTMENT WOULD BE BOOKED					
same day	5 (16%)	4 (31%)	1 (4%)	5 (14%)	15 (14%)
following day	20 (65%)	5 (38%)	19 (68%)	22 (63%)	66 (62%)
2 or more days later	5 (16%)	4 (31%)	7 (25%)	8 (23%)	24 (22%)
no answer	1 (3%)	0	1 (4%)	0	2 (2%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 5.12 MAXIMUM DELAY THAT PATIENT SHOULD HAVE TO WAIT, AND TIME THAT PATIENT WOULD ACTUALLY WAIT, TO SEE USUAL DOCTOR FOR URGENT MATTER

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
MAXIMUM TIME PATIENT SHOULD HAVE TO WAIT					
6 hours	21 (48%)	6 (33%)	23 (51%)	26 (54%)	76 (49%)
24 hours	19 (43%)	9 (50%)	18 (40%)	19 (40%)	65 (42%)
48 hours	1 (2%)	3 (17%)	3 (7%)	1 (2%)	8 (5%)
more than 48 hours	2 (5%)	0	0	1 (2%)	3 (2%)
no answer	1 (2%)	0	1 (2%)	1 (2%)	3 (2%)
TOTAL	44 (100%)	18 (100%)	45 (100%)	48 (100%)	155 (100%)
ACTUAL TIME APPOINTMENT WOULD BE BOOKED					
same day	29 (94%)	12 (92%)	26 (93%)	34 (97%)	101 (94%)
following day	1 (3%)	1 (8%)	0	1 (3%)	3 (3%)
2 or more days later	0	0	1 (4%)	0	1 (1%)
no answer	1 (3%)	0	1 (4%)	0	2 (2%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 5.13 PATIENT DELAY IN SEEING USUAL DOCTOR FOR A NON-URGENT AND URGENT MATTER: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	PERSONAL LIST SIZE less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Non-urgent matter:					
performance same as standard	8 (26%)	7 (54%)	9 (32%)	11 (31%)	35 (33%)
performance better than standard	22 (71%)	6 (46%)	18 (64%)	22 (63%)	68 (64%)
performance worse than standard	1 (3%)	0	1 (4%)	2 (6%)	4 (4%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)
Urgent matter:					
performance same as standard	13 (42%)	6 (46%)	14 (50%)	19 (54%)	52 (49%)
performance better than standard	17 (55%)	7 (54%)	13 (46%)	15 (43%)	52 (49%)
performance worse than standard	1 (3%)	0	1 (4%)	1 (3%)	3 (3%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 5.14 METHOD THAT SHOULD NORMALLY BE, AND WAS, USED FOR DECIDING WHETHER A REQUEST FOR A SURGERY CONSULTATION IS TREATED AS URGENT OR NON-URGENT

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
METHOD THAT SHOULD NORMALLY BE USED					
patient's own assessment accepted	37 (84%)	11 (61%)	35 (78%)	33 (69%)	116 (75%)
receptionist decides for herself	2 (5%)	1 (6%)	0	5 (10%)	8 (5%)
receptionist refers to doctor	5 (11%)	3 (17%)	8 (18%)	8 (17%)	24 (15%)
other responses	0	3 (17%)	2 (4%)	2 (4%)	7 (5%)
TOTAL	44 (100%)	18 (100%)	45 (100%)	48 (100%)	155 (100%)
METHOD THAT WAS ACTUALLY USED NORMALLY					
patient's own assessment accepted	16 (52%)	7 (54%)	22 (79%)	18 (51%)	63 (59%)
receptionist decides for herself	1 (3%)	3 (23%)	0	1 (3%)	5 (5%)
receptionist refers to doctor	9 (29%)	0	2 (7%)	6 (17%)	17 (16%)
other responses	5 (16%)	3 (23%)	4 (14%)	10 (29%)	22 (21%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 5.15 DECIDING WHETHER A REQUEST FOR A SURGERY CONSULTATION IS TREATED AS URGENT OR NON-URGENT: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Performance same as standard	18 (58%)	8 (62%)	21 (75%)	21 (60%)	68 (64%)
Performance different to standard	10 (32%)	3 (23%)	5 (18%)	8 (23%)	26 (24%)
No answer	3 (10%)	2 (15%)	2 (7%)	6 (17%)	13 (12%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 5.16 METHOD THAT SHOULD NORMALLY BE, AND WAS, USED FOR DECIDING WHETHER A REQUEST FOR A HOME VISIT IS MET

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
METHOD THAT SHOULD NORMALLY BE USED					
patient's own assessment accepted	29 (66%)	7 (39%)	26 (58%)	24 (50%)	86 (55%)
receptionist decides for herself	2 (5%)	3 (17%)	2 (4%)	5 (10%)	12 (8%)
receptionist refers to doctor	11 (25%)	5 (28%)	13 (29%)	18 (38%)	47 (30%)
other responses	2 (5%)	3 (17%)	4 (9%)	1 (2%)	10 (6%)
TOTAL	44 (100%)	18 (100%)	45 (100%)	48 (100%)	155 (100%)
METHOD THAT WAS ACTUALLY USED NORMALLY					
patient's own assessment accepted	13 (42%)	6 (46%)	20 (71%)	18 (51%)	57 (53%)
receptionist decides for herself	11 (35%)	6 (46%)	6 (21%)	17 (49%)	40 (37%)
receptionist refers to doctor	9 (29%)	3 (23%)	4 (14%)	8 (23%)	24 (22%)
doctor telephones back to patient	10 (32%)	6 (46%)	12 (43%)	8 (23%)	36 (34%)
N (= 100%)	31	13	28	35	107

NOTE: some respondents gave more than one answer to the second question; the cumulative percentages therefore exceed 100.

TABLE 5.17 DECIDING WHETHER A REQUEST FOR A HOME VISIT IS MET: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Performance same as standard	65%	54%	61%	60%	61%
N (= 100%)	31	13	28	35	107

TABLE 5.18 ARRANGEMENTS THAT SHOULD BE MADE, AND WERE ACTUALLY MADE, FOR 'OUT-OF-HOURS' CARE

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
ARRANGEMENTS THAT SHOULD BE MADE					
rota within the practice	32 (73%)	11 (61%)	37 (82%)	31 (65%)	111 (72%)
rota with neighbouring practices	9 (20%)	6 (33%)	5 (11%)	9 (19%)	29 (19%)
other replies	3 (7%)	1 (6%)	3 (7%)	8 (17%)	15 (10%)
TOTAL	44 (100%)	18 (100%)	45 (100%)	48 (100%)	155 (100%)
ARRANGEMENTS THAT WERE ACTUALLY MADE					
rota within the practice	19 (61%)	11 (85%)	19 (68%)	20 (57%)	69 (64%)
rota with neighbouring practices	4 (13%)	1 (8%)	4 (14%)	4 (11%)	13 (12%)
other replies	8 (26%)	1 (8%)	5 (18%)	11 (31%)	25 (23%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 5.19 ARRANGEMENTS FOR 'OUT-OF-HOURS' CARE: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500 2,749	2,750 and above	TOTAL
Performance same as standard	20 (65%)	9 (69%)	22 (79%)	17 (49%)	68 (64%)
Performance different to standard	3 (10%)	3 (23%)	1 (4%)	7 (20%)	14 (13%)
No comparison possible	8 (26%)	1 (8%)	5 (18%)	11 (31%)	25 (23%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

6. CONSULTATION LENGTH

6.1 Introduction

The second aspect of practice with which the project is concerned is consultation length (see para. 2.9). The questioning concentrated mainly on the time interval used in booking surgery appointments, but some information was also collected about the length of surgery consultations and home visits, the arrangements made for patients needing a longer consultation than the normal booking interval, the relationship between consultation length and outcome, and the procedure followed when the doctor was unsure whether a follow-up consultation might be necessary. In all of these latter areas, however, insufficient information was collected to enable exact comparisons to be made between standards and performance.

6.2 Booking interval

6.2.1 In the first mailing trainers were asked what they thought the normal booking interval should be when an appointment system was used, and in the second mailing receptionists were asked what booking interval was actually used by the trainers. The replies, to the nearest whole minute, are shown in table 6.1. There was a wide variation among the trainers in both their standards (from 5 minutes to more than 10 minutes) and their performance (from 4 minutes to 15 minutes). The average standard booking interval was 8.0 minutes compared with an average actual interval of 7.0 minutes. There were no large differences in either the standard or the actual booking intervals of trainers with differing list sizes, although those with lists of less than 2,500 had somewhat higher mean actual intervals than those with larger lists.

6.2.2 The 107 trainers who replied to both mailings (that is, those who provided information about both standards and performance) were divided into three categories: those whose actual booking interval was the same as their standard (performance same as standard); those whose interval was longer than their standard (performance better than standard); and those whose interval was shorter than their standard (performance worse than standard). The distribution is shown in table 6.2. Overall, 33% of the trainers had the same performance as the standard they had set; 14% had a better performance; and 45% had a worse performance. There were no consistent differences among trainers with differing list sizes.

6.3 Average length of surgery consultations and home visits

6.3.1 Little direct information was collected about the average length of surgery consultations (as opposed to the booking interval used in the appointment system), but a crude indirect calculation can be made by dividing each trainer's subjective estimate of the average time spent each week on surgery consultations (table 4.9) by his estimate of the average number of patients seen each week (table 4.14). Calculated in this way, the average time spent per patient included interruptions and breaks between patients. The mean number of minutes spent per patient for all trainers was 8.4, with individual estimates ranging from 4 minutes to 24 minutes (table 6.3). A similar calculation was derived from the returns of the receptionists by dividing the normal consulting hours by the number of patients recorded during one week. The mean number of minutes was 7.6, with a range of 3 to 15 minutes (table 6.3). The receptionists' estimate was closer to the actual booking interval than that of the trainers, although it is to be expected that the time estimated by trainers would be higher than either the actual booking interval or the receptionists' estimates based on normal consulting hours. There were no significant variations for either estimate among trainers with differing list sizes, although there was a tendency for the average length to fall with increasing list size. This is consistent with the findings in table 6.1.

6.3.2 Little direct information was collected about the average length of home visits, but an indirect calculation can be made, in the manner described above, by dividing each trainer's subjective estimate of the average time spent each week on home visits (including travelling time) by his estimate of the average number of visits made. Calculated in this way, the mean length of home visits ranged widely from trainer to trainer, from 10 minutes to over 1½ hours with an overall mean of 29 minutes and a median of 25 minutes. No equivalent information was obtained in the second mailing. There was no significant difference by list size.

6.4 Arrangements for patients needing a longer consultation than the normal booking interval

6.4.1 Trainers were asked in the first mailing what arrangements they thought should be made in an appointment system for patients who needed a longer consultation than the booking interval allowed. In the second mailing the receptionists were asked about the arrangements that were actually made in their practices. The format of the questions allowed multiple responses to be given. Table 6.4 shows the replies. Overall, 63% of

the 155 trainers who replied to the first mailing thought that a further appointment ought to be made (either as a single arrangement or in conjunction with other arrangements): 35% thought that the patient should be given the time he needed; 28% thought that occasional gaps should be left in the appointment book to allow for patients who needed a longer consultation; and 23% thought that the patient should be booked for 2 or more slots if his need was known in advance. The actual arrangements reported by the receptionists were necessarily confined to instances in which patients were known in advance to be likely to require a slightly longer consultation than the normal booking interval. Eighty-six per cent of the receptionists who replied to the second mailing said that patients were normally booked in 2 or more slots, and only 13% said that gaps were left in the appointment book.

6.4.2 Because of the multiple replies that were given by many trainers to these questions, an exact comparison between standards and performance is not possible. However, a partial comparison can be made by taking some of the pairings separately. Of those who replied to both mailings, 29 thought that gaps should be left in the appointment book, of whom 5 reported that this actually happened. Twenty two of the trainers thought that the patient should be booked for two or three slots if the need was known in advance, of whom 16 said that such an arrangement was actually followed in their practices. The relationship between standards and performance was thus somewhat variable.

6.5 Relationship between consultation length and outcome

6.5.1 Trainers were asked in the first mailing to estimate the proportion of consultations that they felt would produce a better outcome for the patients if more time were available. Nineteen per cent thought that at least half their consultations would produce a better outcome with more time available, and 22% thought that the proportion was less than one-tenth (table 6.5). On average, just over a quarter of all consultations were thought likely to produce a better outcome with more time. There were, however, no consistent variations among the replies of trainers with differing list sizes, and there was certainly no evidence that those with larger lists felt more handicapped in this way than those with smaller lists.

6.6 Procedure when doctor is unsure whether follow-up consultation is necessary

6.6.1 Trainers were asked in the first mailing what procedure they thought should normally be followed when the doctor was uncertain whether a follow-up consultation might be necessary. The replies are shown in table 6.6. Forty-three per cent of the 155 trainers who replied to the first mailing thought that the patient should be asked to make an appointment for a further consultation only if he (the patient) felt it became necessary, and 35% thought that the patient should be asked to make a provisional appointment, whilst being told that he could cancel it if he felt it became unnecessary. A small proportion (17%) favoured making a firm appointment, with no provision for cancellation. List size did not appear to be related to the responses.

6.7 Summary

6.7.1 In this section, data from the pilot study in the South East Thames region have been presented dealing with consultation length. This aspect of practice was selected for inclusion in the study because of the widespread belief that it might constitute a link between list size and standards of care in general practice. Using the booking interval as a proxy measure of the length of consultations, the results from the study offered some support for this belief. Both the mean standard and actual booking interval was lower for trainers with lists of 2,750 and above than for those with lists of less than 2,250. However, the relationship between the standard and the actual booking interval did not differ consistently with list size. Irrespective of list size, almost half of the trainers used a shorter booking interval than they thought should be used, the average actual interval being more than 10% below their own standard. One-fifth thought that at least half their consultations would produce a better outcome if more time were available. It may also be recalled that 83% would have liked to spend more time on consultations if they could have achieved their ideal list size (table 4.2)

TABLE 6.1 BOOKING INTERVAL THAT SHOULD BE, AND WAS, USED FOR SURGERY CONSULTATIONS

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
BOOKING INTERVAL SHOULD BE:					
5-7 minutes	19 (43%)	10 (56%)	15 (33%	23 (48%)	67 (43%)
8 minutes	5 (11%)	2 (11%)	12 (27%)	11 (23%)	30 (19%)
9 or more minutes	19 (43%)	6 (33%)	18 (40%)	12 (25%)	55 (35%)
variable	1 (2%)	0	0	2 (4%)	3 (2%)
TOTAL	44 (100%)	18 (100%)	45 (100%)	48 (100%)	155 (100%)
MEAN	8.5	7.6	8.0	7.7	8.0
BOOKING INTERVAL ACTUALLY USED:					
4 or 5 minutes	6 (19%)	3 (23%)	10 (36%)	15 (43%)	34 (32%)
6 or 7 minutes	5 (16%)	1 (8%)	8 (29%)	10 (29%)	24 (22%)
8 minutes	8 (26%)	4 (30%)	6 (21%)	4 (11%)	22 (21%)
9 or more minutes	9 (29%)	5 (38%)	2 (7%)	5 (14%)	21 (20%)
no answer/no booking system	3 (10%)	0	2 (7%)	1 (3%)	6 (6%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)
MEAN	7.5	7.8	6.5	6.7	7.0

TABLE 6.2 BOOKING INTERVAL USED FOR SURGERY CONSULTATIONS: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	PERSONAL LIST SIZE: less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Performance same as standard	9 (29%)	6 (46%)	10 (36%)	10 (29%)	35 (33%)
Performance better than standard	2 (6%)	4 (31%)	3 (11%)	6 (17%)	15 (14%)
Performance worse than standard	16 (51%)	3 (23%)	13 (46%)	16 (46%)	48 (45%)
No answer	4 (13%)	0	2 (7%)	3 (8%)	9 (8%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 6.3 MEAN NUMBER OF MINUTES SPENT PER SURGERY CONSULTATION: ESTIMATES FROM TRAINERS AND RECEPTIONISTS

SOURCE OF ESTIMATE	PERSONAL LIST SIZE: less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Trainers	8.9	8.4	8.5	7.9	8.4
(number of cases)	(44)	(15)	(44)	(48)	(151)
Receptionists	7.9	7.6	7.6	7.3	7.6
(number of cases)	(30)	(13)	(28)	(34)	(105)

TABLE 6.4 ARRANGEMENTS THAT SHOULD BE MADE, AND WERE MADE, FOR PATIENTS NEEDING A LONGER CONSULTATION THAN THE NORMAL BOOKING INTERVAL

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
ARRANGEMENTS THAT SHOULD BE MADE					
gaps left in appointment book	14 (32%)	9 (50%)	8 (18%)	12 (25%)	43 (28%)
patient given time needed	18 (41%)	7 (39%)	16 (36%)	13 (27%)	54 (35%)
patient booked for 2+ slots	10 (23%)	3 (17%)	12 (27%)	10 (21%)	35 (23%)
further appointment made	29 (66%)	6 (33%)	32 (71%)	30 (63%)	97 (63%)
N (= 100%)	44	18	45	48	155
ARRANGEMENTS THAT WERE MADE					
gaps left in appointment book	4 (13%)	2 (15%)	4 (14%)	4 (11%)	14 (13%)
patient booked for 2+ slots	24 (77%)	13 (100%)	23 (82%)	32 (91%)	92 (86%)
no special allowance made	3 (10%)	0	3 (11%)	2 (6%)	7 (7%)
other replies	3 (10%)	0	2 (7%)	2 (6%)	7 (7%)
N (= 100%)	31	13	28	35	107

NOTE: some respondents gave more than one answer, and the cumulative percentages therefore exceed 100.

TABLE 6.5 ESTIMATED PROPORTION OF CONSULTATIONS THAT WOULD PRODUCE A BETTER OUTCOME FOR PATIENTS IF MORE TIME WERE AVAILABLE

PROPORTION OF CONSULTATIONS	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
50% or more	10 (23%)	3 (17%)	10 (22%)	7 (15%)	30 (19%)
25%-49%	8 (18%)	4 (22%)	15 (33%)	11 (23%)	38 (25%)
10%-24%	13 (30%)	5 (28%)	9 (20%)	19 (40%)	46 (30%)
less than 10%	10 (23%)	5 (28%)	9 (20%)	10 (21%)	34 (22%)
No answer	3 (7%)	1 (6%)	2 (4%)	1 (2%)	7 (5%)
TOTAL	44 (100%)	18 (100%)	45 (100%)	48 (100%)	155 (100%)

TABLE 6.6 PROCEDURE THAT SHOULD NORMALLY BE USED IF DOCTOR IS UNSURE WHETHER FOLLOW-UP CONSULTATION IS NECESSARY

PROCEDURE THAT SHOULD NORMALLY BE USED	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Patient makes firm appointment	7 (16%)	0	11 (24%)	9 (18%)	27 (17%)
Patient makes provisional appointment	12 (27%)	11 (61%)	13 (29%)	18 (38%)	54 (35%)
Patient makes appointment if necessary	23 (52%)	7 (39%)	18 (40%)	19 (40%)	67 (43%)
Other response	2 (5%)	0	3 (7%)	2 (4%)	7 (5%)
TOTAL	44 (100%)	18 (100%)	45 (100%)	48 (100%)	155 (100%)

7. THE RANGE OF SERVICES OFFERED THROUGH THE PRACTICE

7.1 Introduction

The third aspect of practice with which the project is concerned is the range of services offered to patients through the practice, in addition to the basic services of surgery consultations and home visits (para. 2.9). In the first mailing trainers were presented with a list of 15 specific services that might be provided in general practice, and they were asked whether they thought each service should be actively promoted, and if so, whether the doctor should be the main person involved in providing it (rather than other members of the primary health care team). In the second mailing trainers were asked whether each service was actually available in their practices, and if so, who was involved in its provision, and whether the trainer's own contribution was made in special sessions or during normal consultations. In this section the replies are analysed in three stages: the availability of each service, the involvement of the doctor in providing the service, and the overall relationship between standards and performance.

7.2 The availability of services

7.2.1 The replies to the questions of whether each service should be actively promoted and was actually available are shown in tables 7.1 and 7.2. A majority of the 155 trainers who replied to the first mailing thought that all but one of the 15 listed services should be actively promoted in general practice, with at least 90% favouring the promotion of 8 of them, and at least 50% favouring the promotion of 14 of them (table 7.1). The exception was the provision of well-person check-ups, which was favoured by only 30% of the trainers. In view of the large measure of support given to most of the services, the variations among trainers with differing list sizes were insignificant. Eleven of the 15 services were actually available in the practices of a majority of the 107 trainers who replied to the second mailing, 8 of them being available in the practices of at least three-quarters of them (table 7.2). The least available services, provided in the practices of fewer than half of the trainers, were diabetes screening, physiotherapy, chiropody and well-person check-ups. There were few large or systematic variations among trainers with differing

list sizes in their provision of services, although those with lists of less than 2,250 were less likely than the others to be providing hypertension screening, and those with lists of 2,750 and above less likely to be providing minor casualty services.

7.2.2 The relationship between standards and performance in the provision of services is shown in table 7.3, which gives the percentage of trainers in each list size group whose practices were failing to provide a service that they felt should be actively promoted in general practice (that is, whose performance was worse than their standards). The pattern varied markedly from one service to another. For 5 of the 15 services, fewer than a tenth of the trainers were failing to provide a service that they thought should be promoted (antenatal care, family planning, immunisation, cervical cytology and weight-control advice). At the other extreme, for 3 of the 15 services more than a third of the trainers were failing to provide a service that they thought should be promoted (diabetes screening, physiotherapy, and chiropody). There were quite large variations among trainers with differing list sizes, but they were not, for the most part, consistent variations. Since trainers with lists of less than 2,250 were less likely than the others to be providing hypertension screening, they were correspondingly more likely to have a worse performance than standard. But there was no evidence to support the proposition that larger lists (or, for that matter, smaller lists) are consistently associated with a reduced likelihood of providing services that ought to be provided.

7.3 The involvement of the doctor in the provision of services

7.3.1 In the first mailing, trainers who thought that each of the specified services should be provided were further asked whether they thought that the doctor should be the main person involved in providing it. In the second mailing trainers who were actually providing each service were asked who in the practice provided the service, and whether their own contribution was during normal consultations or during special sessions. Table 7.4 shows the replies. The first column shows the percentages of trainers in the first mailing who thought that the doctor should be the main person involved, and the second column shows the percentages in the second mailing who were personally involved in providing each

service. This involvement frequently included nurses and partners as well as the trainers themselves. In most cases a higher proportion of trainers was actually involved in providing the services than thought that the doctor should be the main person involved. However no information was sought about the actual division of work between trainers, partners, and other members of the team, and it is possible that the extent of the trainers' own contributions varied considerably from service to service.

7.4 The relationship between standards and performance

7.4.1 The relationship between the standards and the performance of the 107 trainers who replied to both mailings was classified, for each of the 15 services, into three groups:

i performance same as standard (that is, where the trainer thought that the service should be provided, and was actually providing it in his or her practice, either by the doctor or some other member of the team);

ii performance better than standard (that is, where the service was actually provided, either by the doctor or some other member of the team, but the trainer thought it should not be);

iii performance worse than standard (that is, where the service was not provided at all, but the trainer thought it should be, either by the doctor or some other member of the team).

The results are shown in table 7.5.

7.4.2 The most consistent feature of table 7.5 is the nil or very low proportions of trainers with a better performance than the standards they had set. In other words, very few of the trainers were actually providing services that they did not feel should be actively promoted in general practice. The proportions of trainers with a worse performance than standard ranged from zero (in the case of antenatal care, family planning and immunisation) to over 50% (in the case of diabetes screening and physiotherapy). The proportions with the same performance as standard

were almost a mirror-image of the proportions with a worse performance, ranging from 100% in case of these three services to 43% for diabetes screening. The services for which the highest proportions of trainers fell short of their standards were those of an innovative nature (such as hypertension and diabetes screening) which are increasingly regarded as desirable but not yet fully attainable, and those (such as physiotherapy and chiropody) which require the co-operation of authorities beyond general practice.

7.4.3 The distribution by list size of trainers with a worse performance than standard was discussed in para. 7.2.2, where it was noted that, with the exception of a relatively large proportion of trainers with small list sizes (less than 2,250) who had a worse performance than standard in the provision of hypertension screening, there was no consistent association with list size. The same conclusion holds good for trainers with the same performance and a different performance to the standard: although quite large variations occurred among those with differing list sizes, there was no systematic tendency for those with either larger or smaller lists to have either the same or a different performance to the standards they had set.

7.5 Summary

7.5.1 In this section, data from the pilot study in the South East Thames region have been presented dealing with the range of services offered through the practice. This aspect was selected for inclusion in the study because of the possibility that practitioners with larger lists would have insufficient time to provide the variety of services that they might wish. The results offer very little support for this possibility.

7.5.2 There was quite widespread agreement among the trainers that most of the 15 specified services should be actively promoted in general practice: indeed, all but three of the services (physiotherapy, chiropody and well-person check-ups) were supported by at least three-quarters of the trainers, and eight were supported by at least 90%. Moreover, most of the trainers were actually providing most of the services although the proportion of trainers who thought that each service <u>should</u> be provided was usually greater than the proportion whose practices were <u>actually</u> providing them.

The relationsnip between standards and performance at the level of the individual trainer varied considerably from service to service: it was strong for antenatal care, family planning, immunisation and cervical cytology, but it was quite weak for diabetes screening, physiotherapy, chiropody and hypertension screening. However, although quite a large proportion of the trainers were failing to provide a service that they felt should be promoted, there was no general tendency for these trainers to have the largest lists.

TABLE 7.1 PERCENTAGE OF TRAINERS WHO THOUGHT THAT SPECIFIC SERVICES SHOULD BE ACTIVELY PROMOTED IN GENERAL PRACTICE

SERVICE	PERSONAL LIST SIZE				TOTAL
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	
Antenatal care	100	100	100	100	100
Anti-smoking advice	98	89	91	96	94
Family planning	100	100	98	100	99
Immunisation	100	94	100	100	99
Cervical cytology	98	100	100	100	99
Hypertension screening	95	100	98	98	97
Diabetic care	100	94	96	100	98
Well-baby care	93	78	89	92	90
Weight-control advice	91	89	84	92	89
Minor casualty	82	78	71	75	76
Diabetes screening	84	94	87	85	86
Counselling	80	78	80	79	79
Physiotherapy	66	72	67	67	67
Chiropody	50	61	44	60	53
Well-person check-ups	36	28	27	29	30
N (= 100%)	44	18	45	48	155

TABLE 7.2 PERCENTAGE OF TRAINERS IN WHOSE PRACTICES SPECIFIC SERVICES WERE AVAILABLE

SERVICE	PERSONAL LIST SIZE: less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Antenatal care	100	100	100	100	100
Anti-smoking advice	81	62	79	86	79
Family planning	100	100	96	100	99
Immunisation	100	100	100	100	100
Cervical cytology	97	100	100	97	98
Hypertension screening	55	85	75	71	69
Diabetic care	71	62	79	86	77
Well-baby care	71	92	79	74	77
Weight-control advice	87	85	86	94	89
Minor casualty	71	62	79	46	64
Diabetes screening	32	46	29	43	36
Counselling	61	77	57	77	67
Physiotherapy	10	8	7	26	14
Chiropody	23	38	25	23	25
Well-person check-ups	13	15	7	9	10
N (= 100%)	31	13	28	35	107

TABLE 7.3 THE PROVISION OF SPECIFIC SERVICES IN GENERAL PRACTICE: PERCENTAGE OF TRAINERS FAILING TO PROVIDE A SERVICE THAT THEY FELT SHOULD BE PROMOTED (PERFORMANCE WORSE THAN STANDARD)

	PERSONAL LIST SIZE				
SERVICE	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Antenatal care	0	0	0	0	0
Anti-smoking advice	17	33	14	14	17
Family planning	0	0	0	0	0
Immunisation	0	0	0	0	0
Cervical cytology	3	0	0	3	2
Hypertension screening	45	15	25	26	30
Diabetic care	29	31	14	15	21
Well-baby care	26	8	7	20	17
Weight-control advice	13	17	7	3	9
Minor casualty	19	31	11	34	24
Diabetes screening	61	46	57	46	53
Counselling	24	17	27	12	20
Physiotherapy	58	69	46	44	52
Chiropody	33	38	29	41	35
Well-person check-ups	29	23	14	23	22
N (= 100%)	31	13	28	35	107

TABLE 7.4 PERCENTAGE OF TRAINERS WHO THOUGHT THAT THE DOCTOR SHOULD BE, AND WHO WERE THEMSELVES PERSONALLY INVOLVED IN, THE PROVISION OF SPECIFIC SERVICES

SERVICE	PERCENTAGE OF TRAINERS REPLYING THAT:	
	the doctor <u>should</u> be main person involved	they were personally involved in providing the service
Antenatal care	87	86
Anti-smoking advice	47	76
Family planning	80	80
Immunisation	28	59
Cervical cytology	53	74
Hypertension screening	29	56
Diabetic care	67	66
Well-baby care	30	32
Weight-control advice	18	62
Minor casualty	38	53
Diabetes screening	20	27
Counselling	31	49
Physiotherapy	6	1
Chiropody	1	1
Well-person check-ups	12	6
N (= 100%)	155	107

TABLE 7.5 THE RANGE OF SERVICES OFFERED THROUGH THE PRACTICE: PERCENTAGE OF TRAINERS WHOSE PERFORMANCE WAS THE SAME AS, BETTER THAN AND WORSE THAN, THEIR STANDARDS

SERVICE	PERCENTAGE OF TRAINERS WHOSE PERFORMANCE WAS			N (= 100)
	same	better	worse	
Antenatal care	100	0	0	106
Anti-smoking advice	80	3	17	104
Family planning	100	0	0	106
Immunisation	100	0	0	107
Cervical cytology	97	1	2	107
Hypertension screening	69	1	30	107
Diabetic care	79	0	21	105
Well-baby care	80	3	17	107
Weight-control advice	80	11	9	104
Minor casualty	73	3	24	106
Diabetes screening	43	4	53	107
Counselling	71	9	20	101
Physiotherapy	46	2	52	106
Chiropody	61	4	35	105
Well-person check-ups	71	7	22	107

8. SPECIAL CARE OF THE HOUSEBOUND CHRONICALLY ILL

8.1 Introduction

8.1.1 The fourth aspect of practice with which the project is concerned is the special arrangements made for the care of housebound chronically ill patients (para. 2.9). In the first mailing trainers were asked to indicate how strongly they felt that certain special arrangements should be made in general practice for these patients, in addition to the usual care given when patients request a consultation. Six particular arrangements were presented, and trainers were asked to record their responses on a six-point scale. Point 1 was defined as 'I feel very strongly that it should not be provided'; point 6 was defined as 'I feel very strongly that it should be provided'. In the second mailing trainers were asked whether each arrangement was actually made in their practices. The arrangements were: regular visiting by the doctor; regular visiting by the district nurse or health visitor; the maintenance of an at-risk register of vulnerable patients; a special system for the regular review of medication; meetings of members of the primary health care team to review and co-ordinate care; and the provision by the practice of transport to the surgery.

8.2 Regular visiting by the doctor

8.2.1 The trainers' ratings of the importance of the regular visiting of housebound chronically ill patients by the doctor, and their actual pattern of visiting, are shown in table 8.1. Although not shown in the table, the scale scores of the 154 trainers in the first mailing who expressed an opinion were widely distributed: 20 trainers (13%) chose point 1; 32 (21%) chose point 2; 27 (18%) chose point 3; 34 (22%) chose point 4; 25 (16%) chose point 5; and 16 (10%) chose point 6. The mean scores did not vary significantly among trainers with differing list sizes. Fifty-five per cent of the 107 trainers who replied to the second mailing said they actually visited their housebound chronically ill patients regularly, and 31% said they usually visited only when requested. Trainers with lists of less than 2,250 were a little less likely than those with larger lists to visit regularly.

8.2.2 The analysis of the relationship between the trainers' standards and their performance in their visiting of housebound chronically ill patients is complicated by the lack of direct comparability between the two questions.

If, however, it is assumed that those who chose points 1 or 2 on the scale were generally not in favour of regular visiting by the doctor, and that those who chose points 5 or 6 were substantially in favour of regular visiting, then a limited comparison is possible. Of the 107 trainers who replied to both mailings, 35 chose points 1 or 2 on the scale and 26 chose points 5 or 6. These 61 trainers were then classified into three groups:

i performance same as standard (that is, those who were not in favour of regular visiting and were not actually visiting, together with those who were in favour and were visiting);

ii performance better than standard (that is, those who were not in favour but were visiting);

iii performance worse than standard (that is, those who were in favour but were not visiting).

The distribution is shown in table 8.2 Overall, 62% of these trainers had the same performance as the standard they had set, 18% had a better standard, and 5% had a worse standard. A small number of trainers could not be classified on the basis of their answers to the 'performance' question. With these excluded, there were no significant differences among trainers with differing list sizes.

8.3 Regular visiting by the district nurse or health visitor

8.3.1 The trainers' ratings of the importance of the regular visiting of housebound chronically ill patients by the district nurse or health visitor, and the actual pattern of visiting in their practices, are shown in table 8.3 The scale scores of the 155 trainers who replied to the first mailing were less widely dispersed than in the case of regular visiting by the doctor (see para. 8.2.1). Only one chose point 1; 7 (4%) chose point 2; 11 (7%) chose point 3; 24 (15%) chose point 4; 61 (40%) chose point 5; and 51 (33%) chose point 6. The mean scores show that the trainers rated the regular visiting by nurses as more important than visiting themselves, although there were no significant variations among the mean scores of trainers with differing list sizes. Of the 107 trainers who replied to the second mailing, 80 (75%) said that the district nurse(s) or health visitor(s) in their

practices did visit the housebound chronically ill patients regularly. There were no consistent variations among trainers with differing list sizes.

8.3.2 The relationship between standards and performance was analysed in the same way as for visiting by the doctor (para. 8.2.2). Of the 107 trainers who replied to both mailings, 7 chose points 1 or 2 on the scale, and 77 chose points 5 or 6. The distribution of this subset of 84 trainers is shown in table 8.4. Overall, 77% of the trainers had the same performance as the standard they had set, and fewer than 10% had either a better or a worse performance. There were no marked variations among trainers with differing list sizes, particularly when those whose replies could not be classified are omitted.

8.4 At-risk register of vulnerable patients

8.4.1 The trainers' ratings of the importance of keeping an at-risk register of vulnerable housebound chronically ill patients, and their actual practice in this regard, are shown in table 8.5. The scale scores of the 152 trainers in the first mailing who expressed an opinion were quite widely dispersed: 17 (11%) chose points 1 or 2; 27 (17%) chose point 3; 32 (21%) chose point 4; 36 (23%) chose point 5; and 40 (26%) chose point 6. The mean scores show that the trainers generally regarded the keeping of such a register as less important than regular visiting by the nurse but more important than regular visiting by the doctor. Trainers with lists of less than 2,500 had somewhat higher mean scores than those with lists about 2,500. Overall, 31% of the 107 trainers who replied to the second mailing reported that they actually kept a register, but there were no consistent variations among trainers with differing list sizes.

8.4.2 The relationship between standards and performance was analysed in the same way as for the other arrangements (para. 8.2.2). Of the 107 trainers who replied to both mailings, 12 chose points 1 or 2 on the scale, and 52 chose points 5 or 6. The distribution of this subset of 64 trainers is shown in table 8.6. Overall, 38% had the same performance as the standard they had set; 8% had a better standard; and 55% had a worse standard. Trainers with lists of 2,250-2,499 were less likely than the others to have the same performance as their standard and correspondingly more like to have a worse performance.

8.5 Special system for the regular review of medication

8.5.1 The trainers' ratings of the importance of a special system for the regular review of the medications of housebound chronically ill patients, and their actual practice in this regard, are shown in table 8.7. The scale scores of the 154 trainers in the first mailing who expressed an opinion were almost as widely dispersed as in the case of an at-risk register (see para. 8.4.1). Thirteen trainers (8%) chose points 1 or 2; 21 (14%) chose point 3; 23 (15%) chose point 4; 34 (22%) chose point 5; and 63 (41%) chose point 6. The mean scores show that the trainers generally rated the importance of a medication review system a little more highly than an at-risk register, but there was no consistent association with list size. Overall, 45% of the 107 trainers who replied to the second mailing reported that they actually used a review system for housebound chronically ill patients, the proportion being somewhat higher among those with larger (more than 2,500) lists than smaller lists. Some trainers thought that their system of repeat prescription cards was adequate and in fact 75% used this system in their practice.

8.5.2. The relationship between standards and performance was analysed in the same way as for the other arrangements (para. 8.2.2). Of the 107 trainers who replied to both mailings, 12 chose points 1 or 2 on the scale, and 61 chose points 5 or 6. The distribution of this sub-set of 73 trainers is shown in table 8.8. Overall, 51% of these trainers had the same performance as the standard they had set; 5% had a better performance; and 44% had a worse performance. Differences by list size were not significant.

8.6 Meetings of members of the primary health care team to review and co-ordinate care

8.6.1 The trainers' ratings of the importance of regular and informal meetings of members of the primary health care team to review and co-ordinate the care of housebound chronically ill patients are shown in tables 8.9 and 8.10. Trainers rated informal meetings higher than regular meetings. Scale points 1 or 2 were chosen by 17% for regular meetings and 12% for informal meetings. In the second mailing trainers were asked about their actual contacts with nurses, distinguishing between nurses working mainly in the practice, in the district, and health visitors. Overall, 36% reported regular meetings with the district nurse and 36% with the health visitor, compared with 89% and 80% who reported frequent informal meetings with district nurses and health visitors respectively. Regular meetings with the practice nurse were reported

by 21% and frequent informal meetings by 63%. These are lower proportions than for other nurses, but they are explained almost entirely by the relatively fewer number of trainers with practice nurses than with DNs or HVs. A comparison by list size shows that trainers with lists of less than 2,250 were more likely to report both regular and informal contacts, and they also had a higher rating of the importance of such contacts.

8.6.2 The relationship between standards and performance was analysed in the same way as for the other arrangements (para. 8.2.2). With regard to regular meetings of team members, 16 of the 107 trainers who replied to both mailings chose points 1 or 2 on the scale and 54 chose points 5 or 6. The distribution of this sub-set of 70 trainers is shown in table 8.11. For reasons explained in the previous paragraph, the picture is a little different between the practice nurse on the one hand and the district nurse and health visitor on the other, although not as marked in this region as in some of the others. Sixty per cent of this sub-set of trainers had the same performance as their standard in their meetings with the district nurse and 59% in their meetings with the health visitor, compared with 50% in their meeting with the practice nurse. Conversely, a slightly higher proportion of the trainers had a worse performance than standard in their meetings with the practice nurse (49%) than with the district nurse or health visitor (37%). There were no clear variations with list size.

8.6.3 With regard to informal meetings of team members, 12 of the 107 trainers who replied to both mailings chose points 1 or 2 on the scale and 75 chose points 5 or 6. The distribution of this sub-set of 87 trainers is shown in table 8.12. Overall, the proportion who had the same performance as their standard was much higher than for regular meetings: 84% for informal meetings with the district nurse, 79% for meetings with the health visitor, and 61% for meetings with the practice nurse. The proportion with a worse performance was 15% for health visitors, 6% for district nurses, and 32% for practice nurses. There were no consistent variations among trainers with differing list sizes.

8.7 The provision of transport to the surgery

8.7.1 The trainers' ratings of the importance of provision by the practice of transport to the surgery for housebound chronically ill patients, and their actual arrangements, are shown in table 8.13. The scale scores of the 155 trainers who replied to the first mailing were widely dispersed: 41 (26%) chose point 1; 38 (25%) chose point 2; 28 (18%) chose point 3; 26 (17%)

chose point 4; 15 (10%) chose point 5;and 7 (5%) chose point 6. The mean scores show that the trainers rated the importance of transport less highly than any of the other arrangements (including regular visiting by the doctor), and there were no consistent variations in the score of trainers with differing list sizes. Only one of the 107 trainers who replied to the second mailing was actually providing transport to the surgery for his housebound chronically ill patients.

8.7.2 The relationship between standards and performance was analysed in the same way as for the other arrangements (see para. 8.2.2). Of the 107 trainers who replied to both mailings, 55 chose point 1 or 2 on the scale, and 8 chose points 5 or 6. The distribution of this sub-set of 63 trainers is shown in table 8.14. Overall, only one of these trainers had a better performance than the standard they had set; 86% had the same performance (these consisting almost entirely of trainers who gave a low rating to the provision of transport and who were themselves not providing any); and 13% had a worse performance than their standard. There were no significant variations among trainers with differing list sizes.

8.8 Summary

8.8.1 In this section, data from the pilot study in the South East Thames region have been presented dealing with six different arrangements for the special care of housebound chronically ill patients. The trainers' standards were elicited through the use of a rating scale on which they indicated the importance they attached to the provision of each arrangement. This method of categorising the trainers' standards did not enable an exact comparison to be made with their actual performance, but by focusing the analysis on those who clustered at the extremes of the scale, a reasonable comparison was possible for sub-sets of the trainers. The central theme emerging from the data is that of variability.

8.8.2 First, the trainers rated the importance of each of the six arrangements differently. The highest importance was attached to regular visiting by the district nurse or health visitor, and the lowest importance was given to the provision of transport to the surgery.

8.8.3 Second, the trainers differed considerably among themselves in their ratings of each arrangement. In all but one of the arrangements the scores ranged across all six points of the scale, and in some cases (notably the provision

of transport to the surgery, regular review meetings of members of the primary health care team, and regular visiting by the doctor) there was a considerable difference of opinion about their importance.

8.8.4 Third, the trainers differed in the actual provision of some of the arrangements within their own practices. There was virtually no variation in the provision of transport to the surgery (which was not provided by all but one of the trainers) and little variation in regular visiting by the district nurse or health visitor (which was done in the practices of 71% of the trainers); but it was rather more marked in the other arrangements. Just over half of the trainers said that they visited their housebound chronically ill patients regularly; just under half did not. One-third said they kept an at-risk register of vulnerable patients; two-thirds did not. Just under half said they had a system for the regular review of medications; just over half did not.

8.8.5 Fourth, the relationship between performance and standards varied within and between each arrangement. For example, whereas the trainers divided almost equally into those with the same and a worse performance than standard in maintaining a system of medication review, they were overwhelmingly concentrated among those with the same performance as standard in the provision of transport to the surgery. Moreover, the proportion of trainers with a worse performance than the standard they had set ranged from 13% (for the provision of transport) to 55% (for the maintenance of an at-risk register). As in the previous section on the range of services offered through the practice (see para. 7.5.3), the results presented here show a certain failure among some trainers to achieve the level of performance they would wish.

8.8.6 Fifth, however, there were few significant or systematic variations, in either standards, performance or the relationship between them, among trainers with differing list sizes. There is certainly no evidence in this section to support the proposition that doctors with larger lists are generally less likely than those with smaller lists to attain the standards they set for themselves. As in the previous section, the conclusion must be drawn that the large degree of variability in the data was not consistently related to the number of patients on the trainers' lists.

TABLE 8.1 IMPORTANCE OF REGULAR VISITING BY DOCTOR, AND ACTUAL ARRANGEMENTS FOR VISITING, OF HOUSEBOUND CHRONICALLY ILL PATIENTS

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
IMPORTANCE OF REGULAR VISITING BY DOCTOR					
mean scale score (number of cases)	3.4 (44)	3.1 (18)	3.4 (45)	3.4 (47)	3.4 (154)
ACTUAL ARRANGEMENTS					
doctor visits regularly	13 (42%)	9 (69%)	17 (61%)	20 (57%)	59 (55%)
doctor visits only when requested	12 (39%)	4 (31%)	5 (18%)	12 (34%)	33 (31%)
other responses	6 (19%)	0	6 (21%)	3 (9%)	15 (14%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 8.2 REGULAR VISITING BY DOCTOR OF HOUSEBOUND CHRONICALLY ILL PATIENTS: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

	PERSONAL LIST SIZE				
RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Performance same as standard	12 (63%)	5 (83%)	10 (56%)	11 (61%)	38 (62%)
Performance better than standard	3 (16%)	1 (17%)	4 (22%)	3 (17%)	11 (18%)
Performance worse than standard	2 (11%)	0	0	1 (6%)	3 (5%)
Not classifiable	2 (11%)	0	4 (22%)	3 (17%)	9 (15%)
TOTAL	19 (100%)	6 (100%)	18 (100%)	18 (100%)	61 (100%)

NOTE: this table excludes 46 trainers who chose points 3 or 4 on the scale of the importance of regular visiting by the doctor.

TABLE 8.3 IMPORTANCE OF REGULAR VISITING BY THE DISTRICT NURSE OR HEALTH VISITOR, AND ACTUAL ARRANGEMENTS FOR VISITING, OF HOUSEBOUND CHRONICALLY ILL PATIENTS

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
IMPORTANCE OF REGULAR VISITING BY DN/HV					
mean scale score	4.8	4.8	5.0	4.8	4.9
(number of cases	(44)	(18)	(45)	(48)	(155)
ACTUAL ARRANGEMENTS					
DN/HV visits regularly	22 (71%)	11 (85%)	21 (75%)	26 (74%)	80 (75%)
other responses	9 (29%)	2 (15%)	7 (25%)	9 (26%)	27 (25%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 8.4 REGULAR VISITING BY DISTRICT NURSE OR HEALTH VISITOR OF HOUSEBOUND CHRONICALLY ILL PATIENTS: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

	PERSONAL LIST SIZE				
RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Performance same as standard	20 (74%)	8 (89%)	18 (82%)	19 (73%)	65 (77%)
Performance better than standard	3 (11%)	0	0	1 (4%)	4 (5%)
Performance worse than standard	0	1 (11%)	1 (5%)	5 (19%)	7 (8%)
Not classifiable	4 (15%)	0	3 (14%)	1 (4%)	8 (10%)
TOTAL	27 (100%)	9 (100%)	22 (100%)	26 (100%)	84 (100%)

NOTE: this table excludes 23 trainers who chose points 3 or 4 on the scale of importance of regular visiting by the nurse.

TABLE 8.5 IMPORTANCE OF KEEPING AN AT-RISK REGISTER OF VULNERABLE HOUSEBOUND CHRONICALLY ILL PATIENTS, AND ACTUAL ARRANGEMENTS

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
IMPORTANCE OF KEEPING AN AT-RISK REGISTER					
mean scale score (number of cases)	4.6 (44)	4.5 (17)	4.0 (45)	4.3 (46)	4.4 (152)
ACTUAL ARRANGEMENTS					
register kept	12 (39%)	3 (23%)	10 (36%)	8 (23%)	33 (31%)
register not kept	19 (61%)	10 (77%)	18 (64%)	27 (77%)	74 (69%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 8.6 MAINTENANCE OF AN AT-RISK REGISTER OF VULNERABLE HOUSEBOUND CHRONICALLY ILL PATIENTS: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

	PERSONAL LIST SIZE				
RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Performance same as standard	9 (45%)	2 (20%)	6 (40%)	7 (37%)	24 (38%)
Performance better than standard	1 (5%)	1 (10%)	3 (20%)	0	5 (8%)
Performance worse than standard	10 (50%)	7 (70%)	6 (40%)	12 (63%)	35 (55%)
TOTAL	20 (100%)	10 (100%)	15 (100%)	19 (100%)	64 (100%)

NOTE: this table excludes 43 trainers who chose points 3 or 4 on the scale of importance of maintaining an at-risk register.

TABLE 8.7 IMPORTANCE OF A SPECIAL SYSTEM FOR THE REGULAR REVIEW OF THE MEDICATIONS OF HOUSEBOUND CHRONICALLY ILL PATIENTS, AND ACTUAL ARRANGEMENTS

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
IMPORTANCE OF SPECIAL SYSTEM FOR REVIEW					
mean scale score (number of cases)	4.8 (44)	4.6 (18)	4.5 (45)	4.9 (47)	4.7 (154)
ACTUAL ARRANGEMENTS					
system used	10 (32%)	4 (31%)	14 (50%)	20 (57%)	48 (45%)
system not used	21 (68%)	9 (69%)	14 (50%)	15 (43%)	59 (55%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 8.8 USE OF A SPECIAL SYSTEM FOR THE REGULAR REVIEW OF THE MEDICATIONS OF HOUSEBOUND CHRONICALLY ILL PATIENTS: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

	PERSONAL LIST SIZE				
RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Performance same as standard	13 (54%)	3 (33%)	7 (44%)	14 (58%)	37 (51%)
Performance better than standard	1 (4%)	0	2 (13%)	1 (4%)	4 (5%)
Performance worse than standard	10 (42%)	6 (67%)	7 (44%)	9 (38%)	32 (44%)
TOTAL	24 (100%)	9 (100%)	16 (100%)	24 (100%)	73 (100%)

NOTE: this table excludes 34 trainers who chose points 3 or 4 on the scale of importance of reviewing medication.

TABLE 8.9 IMPORTANCE OF REGULAR MEETINGS OF MEMBERS OF THE PRIMARY HEALTH CARE TEAM TO REVIEW AND CO-ORDINATE THE CARE OF HOUSEBOUND CHRONICALLY ILL PATIENTS, AND ACTUAL ARRANGEMENTS

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
IMPORTANCE OF REGULAR MEETINGS					
mean scale score	4.5	4.3	4.3	4.1	4.3
(number of cases)	(44)	(18)	(45)	(48)	(155)
REGULAR MEETINGS ACTUALLY HELD WITH:					
practice nurse	32%	8%	14%	23%	21%
district nurse	55%	8%	25%	37%	36%
health visitor	58%	8%	21%	37%	36%
N (= 100%)	(31)	(13)	(28)	(35)	(107)

TABLE 8.10 IMPORTANCE OF INFORMAL MEETINGS OF MEMBERS OF THE PRIMARY HEALTH CARE TEAM TO REVIEW AND CO-ORDINATE THE CARE OF HOUSEBOUND CHRONICALLY ILL PATIENTS, AND ACTUAL ARRANGEMENTS

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
IMPORTANCE OF INFORMAL MEETINGS					
mean scale score	4.9	4.4	4.5	4.9	4.7
(number of cases)	(42)	(18)	(44)	(48)	(152)
INFORMAL MEETINGS ACTUALLY HELD WITH:					
practice nurse	71%	46%	61%	63%	63%
district nurse	97%	92%	79%	89%	89%
health visitor	84%	85%	75%	80%	80%
N (= 100%)	(31)	(13)	(28)	(35)	(107)

TABLE 8.11 REGULAR MEETINGS OF MEMBERS OF THE PRIMARY HEALTH CARE TEAM TO REVIEW AND CO-ORDINATE THE CARE OF HOUSEBOUND CHRONICALLY ILL PATIENTS: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
PRACTICE NURSE					
performance same	48%	29%	50%	58%	50%
performance better	4%	0	0	0	1%
performance worse	48%	71%	50%	42%	49%
DISTRICT NURSE					
performance same	61%	29%	69%	63%	60%
performance better	9%	0	0	0	3%
performance worse	30%	71%	31%	37%	37%
HEALTH VISITOR					
performance same	52%	29%	63%	71%	59%
performance better	13%	0	0	0	4%
performance worse	35%	71%	37%	29%	37%
N (= 100%)	23	7	16	24	70

NOTE: This table excludes 37 trainers who chose points 3 or 4 on the scale of the importance of regular meetings.

TABLE 8.12 INFORMAL MEETINGS OF MEMBERS OF THE PRIMARY HEALTH CARE TEAM TO REVIEW AND CO-ORDINATE THE CARE OF HOUSEBOUND CHRONICALLY ILL PATIENTS: RELATIONSHIPS BETWEEN PERFORMANCE AND STANDARDS

RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	PERSONAL LIST SIZE				TOTAL
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	
PRACTICE NURSE					
performance same	74%	50%	45%	64%	61%
performance better	7%	0	14%	4%	7%
performance worse	19%	50%	41%	32%	32%
DISTRICT NURSE					
performance same	85%	90%	82%	82%	84%
performance better	15%	10%	4%	11%	10%
performance worse	0	0	14%	7%	6%
HEALTH VISITOR					
performance same	85%	90%	77%	71%	79%
performance better	7%	0	4%	7%	6%
performance worse	7%	10%	18%	21%	15%
N (= 100%)	27	10	22	28	87

NOTE: this table excludes 20 trainers who chose points 3 or 4 on the scale of the importance of informal meetings.

TABLE 8.13 IMPORTANCE OF PROVISION OF TRANSPORT TO THE SURGERY FOR HOUSEBOUND CHRONICALLY ILL PATIENTS, AND ACTUAL ARRANGEMENTS

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
IMPORTANCE OF PROVISION OF TRANSPORT					
mean scale score	2.9	2.6	2.9	2.5	2.7
(number of cases	(44)	(18)	(45)	(48)	(155)
ACTUAL ARRANGEMENTS					
transport provided	1 (3%)	0	0	0	1 (1%)
transport not provided	30 (97%)	13 (100%)	28 (100%)	35 (100%)	106 (99%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 8.14 THE PROVISION OF TRANSPORT TO THE SURGERY FOR HOUSEBOUND CHRONICALLY ILL PATIENTS: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

	PERSONAL LIST SIZE				
RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Performance same as standard	15 (78%)	7 (88%)	14 (88%)	18 (90%)	54 (86%)
Performance better than standard	1 (5%)	0	0	0	1 (2%)
Performance worse than standard	3 (16%)	1 (12%)	2 (12%)	2 (10%)	8 (13%)
TOTAL	19 (100%)	8 (100%)	16 (100%)	20 (100%)	63 (100%)

NOTE: this table excludes 44 trainers who chose points 3 or 4 on the scale of importance of the provision of transport

9. SPECIAL CARE OF THE ELDERLY

9.1 Introduction

9.1.1 The fifth aspect of practice with which the project is concerned is the special arrangements made for the care of the elderly patients (para. 2.9). In the first mailing trainers were asked to indicate how strongly they felt that certain special arrangements should be made in general practice for these patients, in addition to the usual care given when patients request a consultation. A similar set of arrangements was presented as in the case of housebound chronically ill patients (para. 8.1.1), with the addition of special clinics for the elderly. Trainers were asked to record their responses on a six-point scale, point 1 being defined as 'I feel very strongly that it should not be provided', and point 6 as 'I feel very strongly that it should be provided'. In the second mailing questions were asked about the arrangements that were actually made in the trainers' practices; but a comparison between standards and performance has been possible in only three cases. They are: the maintenance of an at-risk register of vulnerable patients, the provision of clinics for elderly patients, and the provision by the practice of transport to the surgery.

9.2 At-risk register of vulnerable patients

9.2.1 The trainers' ratings of the importance of keeping an at-risk register of vulnerable elderly patients, and their actual practice, are shown in table 9.1. Although not shown in the table, the scale scores of the 151 trainers in the first mailing who expressed an opinion were fairly well distributed: 11 trainers (7%) chose points 1 or 2; 25 (17%) chose point 3; 40 (26%) chose point 4; 35(23%) chose point 5; and 40 (26%) chose point 6. The mean scores were very similar to those for the corresponding question in the case of housebound chronically ill patients (see table 8.5), and although there were some variations among the scores of trainers with differing list sizes, they were not systematically related to list size. Overall, 24% of the 107 trainers who replied to the second mailing said that they actually kept a register - a slightly lower proportion than those who reported keeping a register of vulnerable housebound chronically ill patients. Again, however, there were no systematic variations among trainers with differing list sizes, although those with lists of more than 2,500 patients were less likely than the others to keep a register.

9.2.2 The analysis of the relationship between the trainers' standards and their performance is complicated by the lack of direct comparability between the

two questions. If, however, it is assumed that trainers who chose points 1 or 2 on the scale were generally not in favour of such a register, and that those who chose points 5 or 6 were substantially in favour, then a limited comparison is possible. Of the 107 trainers who replied to both mailings, 7 chose points 1 or 2 on the scale, and 52 chose points 5 or 6. This sub-set of 59 trainers was then classified into three groups:

i performance same as standard (that is, those who were not in favour of a register and who did not keep one, together with those who were in favour and did keep one);

ii performance better than standard (that is, those who were not in favour but were keeping a register);

iii performance worse than standard (that is, those who were in favour but were not keeping a register).

The distribution is shown in table 9.2 Overall, 37% of these trainers had the same performance as the standard they had set; 61% had a worse performance; and the small remainder of 2% had a better performance. These proportions are very similar to those in the corresponding case of housebound chronically ill patients (see table 8.6). Although the numbers are small, there was a slight tendency for trainers with lists of 2,750 and above to be more likely to have a worse performance than standard compared with those with smaller lists.

9.3 Special clinics for the elderly

9.3.1 The trainers' ratings of the importance of special clinics for elderly patients, and their actual practice in this regard, are shown in table 9.3. In general, the 149 trainers in the first mailing who expressed an opinion were not in favour of special clinics: 38 of them (26%) chose point 1 on the scale; 65 (41%) chose points 2 or 3; and only 17 (11%) chose points 5 or 6. Many trainers felt that it would be a mistake to treat the healthy elderly as a special group. The overall mean score was as low as for any of the other arrangements for either elderly or housebound chronically ill patients, and there were no significant variations among the mean scores of trainers with differing list sizes. Moreover, only 3 of the 107 trainers who replied to the second mailing reported that they actually held special

clinics for elderly patients.

9.3.2 The relationship between standards and performance was analysed in the same way as for the other arrangements (see para. 9.2.2). Of the 107 trainers who replied to both mailings, 56 chose points 1 or 2 on the scale, and 10 chose points 5 or 6. The distribution of this sub-set of 66 trainers is shown in table 9.4. Overall, 89% of these trainers had the same performance as their standard (most of these being trainers who neither favoured nor provided special clinics), and the remaining 11% had a worse performance. There were no variations among trainers with differing list sizes.

9.4 The provision of transport to the surgery

9.4.1 The trainers' ratings of the importance of provision by the practice of transport to the surgery for elderly patients, and their actual practice in this regard, are shown in table 9.5. The scale scores of the 150 trainers in the first mailing who expressed an opinion were concentrated towards the lower end: 76 (51%) chose point 1 or 2; 52 (35%) chose points 3 or 4; and 22 (15%) chose points 5 or 6. The mean scores were similar to those for the corresponding question about housebound chronically ill patients. Only one of the 107 trainers who replied to the second mailing was actually providing transport to the surgery for his elderly patients.

9.4.2 The relationship between standards and performance was analysed in the same way as for the other arrangements (see para. 9.2.2). Of the 107 trainers who replied to both mailings, 53 chose points 1 or 2 on the scale, and 14 chose points 5 or 6. The distribution of this sub-set of 67 trainers is shown in table 9.6 Overall, 79% of these trainers had the same performance as the standard they had set; 19% had a worse performance; and just one trainer had a better performance. There were no variations by list size.

9.5 Summary

9.5.1 In this section, data from the pilot study in the South East Thames region have been presented dealing with three different arrangements for the special care of elderly patients. The trainers' standards were elicited through the use of a rating scale on which they indicated the importance they attached to the provision of each arrangement. This method of categorising the trainers' standards did not enable an exact comparison to be made with their actual performance, but by focusing the analysis on those clustered at the extremes of the scale, a reasonable

comparison was possible for sub-sets of the trainers. As in the previous section, the central theme of the data is that of variability.

9.5.2 First, the trainers rated the importance of each of the three arrangements differently. The maintenance of an at-risk register was rated higher than special clinics for the elderly or transport provided by the practice.

9.5.3 Second, the trainers differed considerably among themselves in their ratings of each arrangement: in each case, for example, the scores ranged across all six points of the scale.

9.5.4 Third, the trainers differed in the actual provision of some of the arrangements within their own practices. There was little variation in the provision of special clinics and of transport to the surgery (which were not provided by 97% and 99% of the trainers respectively), but there was more variation in the maintenance of an at-risk register.

9.5.5 Fourth, however, there were few significant or systematic variations in either standards, performance, or the relationship between them, among trainers with differing list sizes. The large degree of variability observed in the data is not, for the most part, related to the numbers of patients on the trainers' lists.

TABLE 9.1 IMPORTANCE OF KEEPING AN AT-RISK REGISTER OF VULNERABLE ELDERLY PATIENTS AND ACTUAL ARRANGEMENTS

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
IMPORTANCE OF KEEPING AN AT-RISK REGISTER					
mean scale score (number of cases)	4.4 (42)	4.6 (17)	4.2 (44)	4.7 (48)	4.5 (151)
ACTUAL ARRANGEMENTS					
register kept	11 (35%)	4 (31%)	5 (18%)	6 (17%)	26 (24%)
register not kept	20 (65%)	9 (69%)	23 (82%)	29 (83%)	81 (76%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 9.2 MAINTENANCE OF AN AT-RISK REGISTER OF VULNERABLE ELDERLY PATIENTS: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

	PERSONAL LIST SIZE				
RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Performance same as standard	8 (47%)	3 (38%)	5 (56%)	6 (24%)	22 (37%)
Performance better than standard	1 (6%)	0	0	0	1 (2%)
Performance worse than standard	8 (47%)	5 (62%)	4 (44%)	19 (76%)	36 (61%)
TOTAL	17 (100%)	8 (100%)	9 (100%)	25 (100%)	59 (100%)

NOTE: this table excludes 48 trainers who chose points 3 or 4 on the scale of the importance of keeping an at-risk register of vulnerable elderly patients.

TABLE 9.3 IMPORTANCE OF SPECIAL CLINICS FOR ELDERLY PATIENTS, AND ACTUAL ARRANGEMENTS

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
IMPORTANCE OF SPECIAL CLINICS					
mean scale scores (number of cases)	2.7 (42)	2.6 (17)	2.5 (43)	2.7 (47)	2.7 (149)
ACTUAL ARRANGEMENTS					
clinics held	0	0	2 (7%)	1 (3%)	3 (3%)
clinics not held	31 (100%)	13 (100%)	26 (93%)	34 (97%)	104 (97%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 9.4 SPECIAL CLINICS FOR ELDERLY PATIENTS: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

	PERSONAL LIST SIZE				
RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Performance same as standard	16 (89%)	5 (83%)	18 (95%)	20 (87%)	59 (89%)
Performance better than standard	0	0	0	0	0
Performance worse than standard	2 (11%)	1 (17%)	1 (5%)	3 (13%)	7 (11%)
TOTAL	18 (100%)	6 (100%)	19 (100%)	23 (100%)	66 (100%)

NOTE: this table excludes 41 trainers who chose points 3 or 4 on the scale of importance of special clinics for elderly patients.

TABLE 9.5 IMPORTANCE OF PROVISION OF TRANSPORT TO THE SURGERY FOR ELDERLY PATIENTS, AND ACTUAL ARRANGEMENTS

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
IMPORTANCE OF PROVISION OF TRANSPORT					
mean scale score (number of cases)	2.7 (43)	2.5 (17)	3.1 (43)	2.4 (47)	2.7 (150)
ACTUAL ARRANGEMENTS					
transport provided	1 (3%)	0	0	0	1 (1%)
transport not provided	30 (97%)	13 (100%)	28 (100%)	35 (100%)	106 (99%)
TOTAL	31 (100%)	13 (100%)	28 (100%)	35 (100%)	107 (100%)

TABLE 9.6 THE PROVISION OF TRANSPORT TO THE SURGERY FOR ELDERLY PATIENTS: RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS

	PERSONAL LIST SIZE				
RELATIONSHIP BETWEEN PERFORMANCE AND STANDARDS	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Performance same as standard	15 (75%)	7 (88%)	12 (80%)	19 (79%)	53 (79%)
Performance better than standard	1 (5%)	0	0	0	1 (1%)
Performance worse than standard	4 (20%)	1 (12%)	3 (20%)	5 (21%)	13 (19%)
TOTAL	20 (100%)	8 (100%)	15 (100%)	24 (100%)	67 (100%)

NOTE: this table excludes 40 trainers who chose points 3 or 4 on the scale of importance of providing transport for elderly patients.

10. REPEAT PRESCRIBING

10.1 Introduction

10.1.1 The sixth aspect of practice with which the project is concerned is repeat prescribing (para. 2.9).

10.2 Arrangements for dealing with patients' requests for repeat prescriptions

10.2.1 Trainers were asked in the first mailing how a patient's request for a repeat prescription should be dealt with, and in the second mailing how such requests were actually handled in their practices. The format of the questions allowed multiple responses in the second mailing but not in the first. Table 10.1 shows the replies. Overall, 50% of the 155 trainers who replied to the first mailing thought that the doctor should normally see the patient or review his or her record if a specified period of time had passed or a specified number of prescriptions had already been issued. A smaller proportion (44%) thought that the doctors should normally review the patient's record on each occasion that a repeat script is requested. The arrangements that were actually made in the trainers' practices differed somewhat from those they thought ought to be made. Of the 105 trainers who replied to this question, 75% used repeat prescription cards (or a similar limiting system), 49% said that they normally reviewed the patient's record each time before signing repeat scripts, and 6% said they would not sign without a consultation. Trainers with lists of less than 2,250 were a little more likely to review the patient's record each time that those with larger lists.

10.2.2 Because of the multiple replies that were given by some trainers to the 'performance' question, an exact comparison between standards and performance is not possible. However, a partial comparison can be made by taking each pairing separately. Of the 107 trainers who replied to both mailings, none thought that the doctor should normally see the patient each time before issuing a repeat prescription, but 6 actually did so. Forty-nine thought that the doctor should normally review the patient's record before issuing a repeat prescription, and of these 27 reported that they usually did so. Fifty-two thought that the doctor should normally see the patient or review the record after the elapse of a specified period of time or the issue of a specified number of repeat prescriptions, and of these, 38 indicated that they used repeat prescription cards or some other system that limited the number of repeats or the period of time over which they were given. Approximately two-thirds of these sub-sets of trainers were therefore adopting ap-

proaches to repeat prescribing that were the same as their standards, and there were no significant variations among those with differing list sizes.

10.3 Volume of repeat prescribing

10.3.1 Trainers were asked in the second mailing to estimate the average number of repeat prescriptions they signed each day without having seen the patients. The replies, which are summarised in table 10.2, showed a very wide range of response, from nil to 60 scripts a day. The average number among the 101 trainers in the second mailing who replied to the question was 17.7, the figure being somewhat lower among trainers with lists of less than 2,250 than those with larger lists. However, when expressed as a rate per 100 patients on the list, the number of scripts signed each day diminished as the trainers' lists increased. The differences were, however, too slight to be significant.

10.4 Summary

10.4.1 In this section, data from the pilot study in the South East Thames region have been presented dealing with repeat prescribing. This aspect of practice was selected for inclusion in the study because of the possibility that GPs with larger lists may be more ready than those with smaller lists to issue repeat prescriptions, particularly without having seen the patient.

10.4.2 The results provide little support for the possibility. The trainers' estimates of the actual number of repeat prescriptions issued each day without seeing the patients were lowest among those with the smallest lists, but this tendency was reversed when expressed as a rate per 100 patients on the list. Moreover, there were no significant variations among the trainers with differing list sizes in the relationship between their standards and their performance about repeat prescribing: irrespective of list size, over half of those who thought that doctors should review the patient's record on each occasion were actually doing so, and about three-quarters of those who favoured the use of repeat prescription cards (or some equivalent system) had actually adopted such an arrangement.

TABLE 10.1 ARRANGEMENTS THAT SHOULD BE MADE, AND WERE MADE, FOR PATIENTS REQUESTING A REPEAT PRESCRIPTION

	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
ARRANGEMENTS THAT SHOULD BE MADE					
doctor normally sees patient each time	0	0	0	0	0
doctor normally reviews record each time	21 (48%)	5 (28%)	20 (44%)	22 (46%)	68 (44%)
doctor normally sees patient/reviews record after specified time or number of scripts	22 (50%)	11 (61%)	23 (51%)	21 (44%)	77 (50%)
other responses	1 (2%)	2 (11%)	2 (4%)	5 (10%)	10 (6%)
TOTAL	44 (100%)	18 (100%)	45 (100%)	48 (100%)	155 (100%)
ARRANGEMENTS THAT WERE MADE					
doctor sees patient each time	3 (10%)	1 (8%)	1 (4%)	1 (3%)	6 (6%)
doctor reviews record each time	17 (59%)	5 (38%)	12 (43%)	17 (49%)	51 (49%)
doctor uses repeat prescription cards or system	21 (72%)	11 (85%)	21 (75%)	26 (74%)	79 (75%)
N (= 100%)	29	13	28	35	105

NOTE: some respondents gave more than one answer to the second question; the cumulative percentages therefore exceed 100%.

TABLE 10.2 ESTIMATED MEAN NUMBER OF REPEAT PRESCRIPTIONS SIGNED EACH DAY WITHOUT THE PATIENTS HAVING BEEN SEEN AND RATE PER 100 PATIENTS ON LIST

NUMBER OF REPEAT PRESCRIPTIONS	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Mean number	15.0	19.1	18.9	18.7	17.7
Rate per 100 patients on list	0.8	0.8	0.7	0.6	0.7
(Number of cases)	(29)	(12)	(27)	(33)	(101)

11. THE PREVENTION OF DISEASE AND THE PROMOTION OF HEALTH

11.1 The final aspect of practice with which the project is concerned is the prevention of disease and the promotion of health. Although it is important in the context of the research, it was not developed at all fully in the pilot studies, and must be expanded as a component in the main survey.

11.2 Many of the services reported upon in section 7 (the range of services offered through the practice) had more to do with prevention than treatment, and the data presented in that section give some indications of the trainers' standards and performance in the field of prevention. It was shown in table 7.3, for example, that the proportion of trainers who were failing to provide a service that they thought should be actively promoted in general practice was low for some preventive services, particularly those for which a fee is paid, (antenatal care, family planning, immunisation and cervical cytology), but high for others (screening for hypertension and diabetes).

11.3 In addition, trainers were asked in the first mailing to indicate on a 6-point scale what they thought the role of the GP should be in the active prevention of disease and the promotion of good health. Point 1 on the scale was defined as 'Prevention and the promotion of good health should not be part of the doctor's job at all'; point 6 was defined as 'Prevention and the promotion of good health should be the most important aspect of the doctor's job'. Of the 155 trainers who replied to the first mailing, 59% chose points 5 or 6, and the mean scale score was 4.7. There was, therefore, a fairly high degree of support for the broad concept of prevention in general practice, and this is consistent with the support given to the promotion of specific preventive services (table 7.1). There were no significant variations in the mean scores of trainers with differing list sizes.

11.4 No corresponding question was asked about performance, but it is hoped to use the insights gained from the pilot studies to develop a set of 'performance' questions in the main survey.

12. CONCLUSIONS

12.1 The pilot studies in the South East Thames region and elsewhere had three purposes: to test the feasibility of collecting information about GPs' standards and performance in selected aspects of their work; to produce data that would be useful to the general practice educational and training programmes within the participating regions; and to provide tentative answers to the substantive research questions in the event of the main survey not taking place (see para. 1.3). This concluding section is arranged around these three purposes.

12.2 To test the feasibility of collecting information on GPs' standards and performance

12.2.1 The results of the pilot study generally endorse the feasibility of collecting the kind of information needed to fulfill the objectives of the project. The response rates in the SE Thames region and elsewhere were good, and although some of the questions proved to be inadequate, most were answered seriously and satisfactorily. Some trainers were manifestly irritated by what they regarded as trite or misleading questions, but many more took the trouble to add helpful and interesting comments. Moreover, the variable relationship between the standards set by the trainers and their reported patterns of performance confirms their willingness to think about each concept separately, and to avoid the easy or comfortable option of always selecting standards that are identical to performance.

12.2.2 At the same time, however, the pilot studies have left some questions unresolved and have raised some new ones. The fact that high response rates were obtained from groups of GP trainers does not ensure that similar rates will be obtained from a random sample of general practitioners. There was some evidence in the pilot studies that trainers were motivated to reply by the endorsement given to the study by the Regional Advisers in General Practice, and it will almost certainly be necessary to secure an appropriate form of endorsement in the main survey. Doubts were also raised in the pilot studies about the repeatability of some of the standards questions, and about the accuracy of some of the data on performance. No checks were made in the pilot studies, and the data have been presented at face value. It would, however, be prudent to build some such checks into the main survey.

12.2.3 As noted earlier (para. 3.3), the forms of questioning used in the pilot studies differed in the fifth region from those used in the first four regions. Further work remains to be done in comparing the results of the two different methods and in compiling the best set of instruments for use in the main survey. Nevertheless, the experiences of the pilot phase of the project confirm the feasibility of the research objectives, and work has already commenced on the main phase. The results of the main phase are expected to be available by 1986.

12.3 To produce data of use to the general practice educational and training programmes within the participating regions

12.3.1 The intra-regional results, such as those presented in this report for the South East Thames region, are of limited substantive value due mainly to the small number of trainers involved. It is hoped, nevertheless, that the material contained in this report will be of considerable interest and value to those involved in the general practice training and educational programmes in the region, particularly if it is used as the basis for further discussion and analysis of the standards that are held by the trainers and of the extent to which they are met in practice. It would, for example, be disappointing if the wide variability in standards revealed in the study did not stimulate a corporate interest in exploring their suitability and implications.

12.3.2 Subject to the availability of resources within the Health Services Research Unit, additional analyses from the South East Thames data will be supplied on request.

12.4 To provide tentative answers to the substantive research questions

12.4.1 For reasons already discussed (paras. 3.9-3.13), the data from the region are of limited value in answering the substantive research questions, and the fact that the main phase of the project is already underway diminishes the need to use the pilot data for this purpose. Nevertheless, the dominant trends emerging from them are of interest as pointers towards some answers, and it is hoped that they will be useful within the region for this purpose. Three broad observations are offered.

12.4.2 First, a striking feature of the data is the degree of heterogeneity they reveal among the participating trainers. In almost all the aspects of practice included in the study, the trainers exhibited a wide range in

their standards, in their reported performance, and in the extent to which their performance matched their standards. Whilst such diversity is consistent with the traditional image of the independent practitioner, it is difficult to reconcile with the notion of a generally appropriate list size based upon considerations of standards. A similar degree of diversity in the main survey would confound any argument about a national average list size.

12.4.3 Second, in virtually every aspect of practice included in the study a gap existed between the standards set by the trainers and the performance they reportedly achieved. This is summarised in the last column of table 12.1, which shows the proportion of the 107 trainers replying to both mailings whose performance was the same as, or better than, their standards in 39 separate aspects of practice. These summary figures are drawn from the detailed tables in the body of the report, and readers are referred to those tables, and the associated commentary, for their proper context. Of the 39 aspects, the proportion of trainers with the same or better performance exceeded 90% in 9 aspects; it lay between 80% and 89% in 10 aspects; it lay between 70% and 79% in 6 aspects; between 60% and 69% in 6 aspects; and below 60% in the remaining 8 aspects. How these findings are evaluated will depend upon the expectations of the reader, and there are few guidelines in the existing literature upon which to base such expectations. Some readers may find it encouraging that so many general practitioners are able to achieve what they regard as appropriate standards of care for practices similar to their own; others may find it disquieting that so many are unable to achieve their standards.

12.4.4 Third, there is little evidence in the presentation of the data that the standards or the performance of the trainers were systematically related to the size of their lists. There is, in other words, little indication that trainers with smaller lists were consistently more likely than those with larger lists to have a similar or better performance than the standards they had set (table 12.1). It is possible, however, that this conclusion is influenced by the limited form of analysis used in the report. There was, for example, an insufficient number of trainers in the study to examine the effect of extremely large or small lists, or to control for other characteristics that appeared to be associated with list size. Trainers with lists of less than 2,250 differed from the others in a number of ways; they were younger, they worked in smaller partnerships with smaller health care teams,

they spent less time on surgery consultations and home visits and they were less likely to feel overworked; and these characteristics need to be controlled in a multivariate analysis for the true effects of list size to become apparent.

12.4.5 In summary, then, the data from the South East Thames region suggest that, whilst quite widespread discrepancies existed between the standards that GPs set for themselves and the level of performance they actually achieve, these discrepancies were largely unrelated to the numbers of patients on their lists. However, more extensive analyses need to be carried out on the combined data from the regional pilot studies before this conclusion can be applied firmly to trainers as a whole, and a larger survey among a national random sample of GPs must be concluded before its truth can be assessed in relation to the profession as a whole.

TABLE 12.1 PERCENTAGE OF TRAINERS WHOSE PERFORMANCE WAS THE SAME AS, OR BETTER THAN, THE STANDARDS THEY HAD SET (NUMBER OF TABLE OF ORIGIN IN BRACKETS)

ASPECT OF PRACTICE	PERSONAL LIST SIZE				
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Hours of opening of practice premises (5.2)	55	70	64	65	63
Hours of availability of doctor (5.4)	45	38	39	52	45
Evening surgeries (5.7)	91	85	86	91	89
Weekend surgeries (5.10)	100	92	100	100	99
Delay in appointment: non-urgent matter (5.13)	97	100	96	94	97
Delay in appointment: urgent matter (5.13)	97	100	96	97	97
Request for urgent consultation (5.15)	90	85	93	83	88
Request for home visit (5.17)	65	54	61	60	61
Arrangements for out-of-hours care (5.19)	75	92	83	69	77
Booking interval (6.2)	35	77	47	46	47
Provision of services (7.3):					
antenatal care	100	100	100	100	100
anti-smoking advice	83	67	86	86	83
family planning	100	100	100	100	100
immunisation	100	100	100	100	100
cervical cytology	97	100	100	97	98
hypertension screening	55	85	75	74	70
diabetic care	71	69	86	85	79

TABLE 12.1 (continued)

ASPECT OF PRACTICE	PERSONAL LIST SIZE less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	TOTAL
Provision of services (cont)					
well-baby care	74	92	93	80	83
weight-control advice	87	83	93	97	91
minor casualty	81	69	89	66	76
diabetes screening	39	54	43	54	47
physiotherapy	42	31	54	56	48
chiropody	67	62	71	59	65
well-person check-ups	71	77	86	77	78
counselling	76	83	73	88	80
Special arrangements: care of housebound chronically ill patients					
regular visiting by doctor (8.2)	79	100	78	78	80
regular visiting by nurse (8.4)	85	89	82	77	82
at-risk register (8.6)	50	30	60	37	46
medication review (8.8)	58	33	57	62	56
Regular review meetings with:					
practice nurse (8.11)	52	29	50	58	51
district nurse (8.11)	70	29	69	63	63
health visitor (8.11)	65	29	63	71	63
Informal review meetings with:					
practice nurse (8.12)	81	50	59	68	68
district nurse (8.12)	100	100	86	93	94
health visitor (8.12)	92	90	81	78	85

TABLE 12.1 (continued)

ASPECT OF PRACTICE	PERSONAL LIST SIZE				TOTAL
	less than 2,250	2,250-2,499	2,500-2,749	2,750 and above	
Provision of transport (8.14)	83	88	88	90	88
Special arrangements for care of elderly patients					
at-risk register (9.2)	53	38	56	24	39
special clinics (9.4)	89	83	95	87	89
provision of transport (9.6)	80	88	80	79	79