

# Prime Minister's Challenge Fund: Improving Access to General Practice

## First Evaluation Report: October 2015



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# EXECUTIVE SUMMARY

In October 2013, the Prime Minister announced a new £50 million Challenge Fund<sup>1</sup> to help improve access to general practice and stimulate innovative ways of providing primary care services. 20 pilot sites were selected to participate in the Challenge Fund, covering 1,100 general practices and 7.5 million patients. Each scheme chose its own specific objectives, innovations and ways of organising services.

## The independent national evaluation of the Challenge Fund (wave one<sup>2</sup>)

These pilots are now over a year into delivery of their plans. This first evaluation report reviews their progress to date and assesses the extent to which the PMCF core programme objectives are being met. There will be another evaluation report at the end of 2015.

The evaluation focuses on three key national programme objectives:

- To provide additional hours of GP appointment time
- To improve patient and staff satisfaction with access to general practice
- To increase the range of contact modes

It also features several other lines of enquiry including looking at the Challenge Fund's contribution to reducing demand elsewhere in the system; facilitating learning; tackling health inequalities; identifying replicable delivery models; delivering value for money; and establishing sustainable and transformational change in the primary care sector.

In undertaking the evaluation, a multi-methods approach has been adopted incorporating both qualitative and quantitative assessment. This has comprised:

- Interviews with pilot leaders and those involved in implementation at multiple points during the programme
- Interviews with pilot partners and stakeholders involved in delivery
- Engagement with practices and other implementation staff through an online survey (to date, released at two points over the pilot implementation period)
- Collection and analysis of monthly data on key services and innovations being delivered as part of PMCF measured against a basket of nine metrics
- Assessment of the impacts and outcomes and identifying return on investment and value for money, through looking at how pilots have allocated their resources
- Identifying, examining and sharing good practice
- Showcasing innovation good practice through regular thematic papers

Metric data has been collected for pilots as they have become operational with their initiatives, although data remains patchy for a few pilots which has affected the ability to assess impacts and quantify savings in some cases. It is also essential to bear in mind the assumptions and limitations listed on page 7 of this interim report.

## The nine national data metrics:

### A. Patient contact, as a direct result of the change in access:

- The change in hours offered for patient contact
- The change in modes of contact
- The utilisation of additional hours offered

### B. Patient experience/satisfaction:

- Satisfaction with access arrangements
- Satisfaction with modes of contact available

### C. Staff experience/satisfaction:

- Satisfaction with new arrangements

### D. Wider system impacts:

- Impact on the A&E attendances
- Impact on emergency admissions
- Impact on the 'out of hours' service<sup>3</sup>.

1. The Prime Minister's Challenge Fund is hereafter referred to as PMCF or the Challenge Fund.

2. In September 2014 further funding of £100m was announced by the Prime Minister for 37 wave two pilots.

3. Out of hours primary medical care services are defined as those services required to be provided in all or part of the out of hours period which would be essential or additional services provided by a primary medical care contractor (i.e. a GP practice) to its patients during 'core hours'.

## Some key achievements to date

The 20 sites have been ambitious in implementing their Challenge Fund programmes. Their definition of improving GP access has been very wide and their innovations have extended far beyond increasing the number of hours that general practice is available for. Pilot schemes have included improvements aimed at providing patients with differing needs with access to the right care from the right professional at a time which is convenient for them. They have also used the opportunity to kick start or build upon collaborative working and embark upon transformational change of primary care delivery. Their innovations have been very broad in nature as indicated opposite.

### Key achievements to date include<sup>4</sup>:

Over **7 million patients** have access to a new or enhanced primary care service due to new projects or different approaches to service delivery.

During the week **4.9 million patients** have access to a new or enhanced GP appointment service after core working hours during the week due to Challenge Fund investment<sup>5</sup>

At the weekend **5.4 million patients** now have access to a new or enhanced GP appointment service due to Challenge Fund investment<sup>6</sup>

Approximately **400,000** additional appointments have been provided in extended hours to patients across the pilot schemes

Approximately **520,000** additional appointments have been provided in core hours to patients across the pilot schemes<sup>7</sup>

At May 2015, there had been a **15% reduction** in minor self-presenting A&E attendances across the pilot schemes compared with the same period in the previous year; representing 29,000 attendances.



<sup>4</sup> It is important to recognise that these figures reflect a point in time and pilot initiatives are ongoing  
<sup>5</sup> Core hours: 8am – 6.30pm, Monday – Friday. This is in addition to extended services that were already available during the week.

<sup>6</sup> This is in addition to extended services that were already available at the weekend.

<sup>7</sup> This is across 16 pilot schemes

# To what extent have the national Challenge Fund programme objectives been met?

## 1. To provide additional hours of GP appointment time

As part of the analysis of progress against this objective, the evaluation has considered additional hours of appointment time provided by GPs and other practitioners.

### Extended hours

From data collected to date, we estimate that the number of additional appointments being during extended working hours across the whole Challenge Fund Programme up to the end of May 2015 was potentially around 400,000 across all practitioners.

Based on data received from 16 out of the 20 pilot schemes 38,000 additional extended hours have been offered; an increase of over 100% from the baseline<sup>8</sup>. This is from the time that the pilots went live with their initiatives until May 2015. Of these additional 38,000 hours, over 70% have been provided by GPs. This translates into around 238,000 additional available appointments during extended hours, 184,000 of which were provided by GPs. Extrapolating this for the remaining four pilot sites<sup>9</sup>, then derives the estimate of 400,000 additional appointments.

There has been an increase in the number of available appointments per extended hour by 33% as a result of new ways of working.

Since the introduction of the Challenge Fund, average utilisation of appointments during extended working hours has been 75%. Whilst this is slightly lower than the baseline position of 80%, it should be recognised that this represents a revised position where there has been a significant increase in appointments being provided over seven days compared to the baseline. The vast majority of pilots suggest that utilisation of the extended hours appointments is generally high in the week. There is also evident demand on Saturdays (mornings more so than afternoons) but there is typically very low utilisation of Sunday GP appointments. A number of pilots adjusted staff capacity to better match demand during the course of the programme.

### Core hours

Pilots have also offered additional appointment hours during the normal working day. From the time that individual pilots went live with their initiatives until May 2015, a total of 66,000 additional hours have been provided, of which 26,000 have been provided by GPs. Also, as a consequence of introducing new modes of contact, the average number of available appointments has increased by 6%. In total, an additional 520,000 available appointments have been made available, of which 162,000 were provided by GPs.

<sup>8</sup> North West London has not participated in the national metric data collection because the focus of the pilot was to progress with organisational change and network development rather than the immediate delivery of services. Barking & Dagenham and Havering and Redbridge; Bristol and partners; and Derbyshire & Nottinghamshire pilot schemes were unable to submit baseline data so it has not been possible to derive the additionality.

Since the introduction of the Challenge Fund, the average utilisation of available appointments during core working hours across the whole programme is 94%. This is consistent with the baseline.

## 2. To improve patient satisfaction

### Patient experience and satisfaction

Patient satisfaction with appointment times at practices involved in the Challenge Fund is high. 90% of patients that responded to the national GP patient survey consider that appointments are either very or fairly convenient and around 60% of patients are able to see their preferred GP. As may be expected given the short length of time that the pilots have been implementing their initiatives, at a programme level, there has been little change in patients' levels of satisfaction and experience since the introduction of Challenge Fund initiatives<sup>10</sup>.

### Staff experience and satisfaction

An online survey has been undertaken twice to assess the impact on satisfaction amongst staff involved in delivering Challenge Fund activities. This shows that:

- Over 60% of respondents from both surveys rated their experience of extending access in primary care as either very good or good compared with between 12% and 15% who rated this as either poor or very poor.
- Just over half of respondents in both surveys have rated the impact of the Challenge Fund on staff as either very positive or positive within the second survey.

## 3. Increasing the range of contact modes

### Using technology

The majority of pilots (15 out of 20) have increased the variety of modes by which patients can access GP services.

- Ten pilots have extended or introduced GP telephone consultation facilities, providing telephone access to 1.9 million patients.
- Five pilots have introduced GP-led telephone triage systems in order to manage patient demand and match patients with a service appropriate to their needs. This is operating at over 120 practices, serving over 860,000 patients.
- Across these pilots, the percentage increase in telephone consultations and GP led telephone triage being offered in March 2015 compared with the baseline is 28% during core working hours and 220% during extended working hours.
- Six pilots have trialed GP e-consultations. This mode of access is currently available to over 250,000 patients across four pilots.
- Six pilots have introduced online diagnostic and/or video consultation tools to enhance patient access. These tools are available to over 270,000 patients.
- Five pilots have developed texting services, providing this facility to nearly 1.6 million patients across 265 practices.

<sup>9</sup> Please note the Assumptions and Limitations detailed in Section Two of the report.

<sup>10</sup> Note that the national GPs patient survey does not specifically focus on PMCF and is more generally reflective of patient's experience and satisfaction with primary care services.

- Eight practices have also introduced online access features, typically online registration and booking systems, as part of their pilot programmes.

### Introducing a wider range of practitioners

Another way in which pilots have increased the range of primary care contact modes is through integrating other service providers into their Challenge Fund programmes. This shows an appetite to collaborate and offer a more holistic package of primary care. Some examples include:

- Eight pilots have made more use of specialist nurses or Advanced Nurse Practitioners (ANPs). Despite some recruitment challenges, these initiatives have been a success in reducing pressures on GP time and adding more capacity in core and extended hours.
- Five pilots have integrated pharmacy into delivery of primary care services. There has been good buy-in from pharmacists and pilots report that these projects have been a success, helping to release GP time.
- Four of the pilots have undertaken targeted work with nursing and care homes in order to provide more proactive care to these patients and also reduce the number of care home visits by GPs. These initiatives are considered to be delivering benefits, releasing GP time and achieving patient satisfaction.
- Six pilots have engaged with the voluntary sector to offer a wider package of patient support and direct patients to community resources which can support them. Individual pilot examples show that these schemes are working well locally, releasing GP time and proving popular with patients.



## Wider learnings and achievements

The evaluation of PMCF has also pursued some other lines of enquiry to identify wider learnings from the programme:

### Stimulating transformational and sustainable change

The Challenge Fund has been successful in initiating a culture change amongst the primary care community. The injection of investment into primary care has had a catalytic effect, encouraging practices to move away from operating as independent small businesses and, instead, work collectively. This has been evidenced by the development of new networks, federations and legal entities, which applies to around half of the Wave One pilot schemes. Even in locations where there had been prior progress towards collaborative delivery, PMCF has boosted momentum and helped to mobilise federated working.

It should also be acknowledged that culture change and transformation are not easy to achieve; there have been some challenges along the way and pilots have often needed to proceed cautiously and work hard to engage GPs and secure buy in. Given this the degree of structural change across the programme marks a significant achievement, particularly because of the short amount of time that this has been achieved in.

The creation and development of collaborative arrangements and infrastructure represents an important legacy of this programme. Where federations with established governance structures and staff are in place, there is considerable confidence that they will continue to exist beyond the lifetime of PMCF. Federations are becoming a 'cog' in the system and the network approach or hub and spoke system are generally seen to work as delivery models.

Ultimately the sustainability of specific pilot initiatives is largely reliant on CCG funding going forward. It will be down to their discretion to continue with initiatives that have been shown to be locally popular and have demonstrated positive results.

## Reducing demand elsewhere in the system

Up to May 2015, at a programme level, there has been a statistically significant reduction in minor self-presenting A&E attendances by those patients registered to Challenge Fund GP practices. Overall, this has translated into a reduction of 29,000 minor self-presenting A&E attendances and represents a 15% reduction<sup>11</sup>. Nationally, there has been a 7% reduction in these minor A&E attendances.

Of the 20 pilot schemes, 13 have shown a statistical reduction in minor self-presenting A&E attendances, including, most notably, Barking & Dagenham and Havering & Redbridge, West Hertfordshire, Morecambe, and Brighton & Hove. These 13 pilots have seen a reduction of 34,000 minor self-presenting A&E attendances<sup>12,13</sup>.

To date there is no discernible change in emergency admissions or out-of-hours services at a programme level.

## Facilitating learning to better enable pilots to implement change

Sharing knowledge has been important at different stages throughout the lifecycle of the pilot schemes. Most pilots have developed their own locally appropriate mechanisms to do this. Approaches include engagement events (Brighton and Hove, HRW, Morecambe, Slough and Warrington); the establishment of action learning sets (Brighton and Hove); practice buddying (Slough and Warrington); and commissioning local evaluations (Care UK, DCIoS, Herefordshire and Morecambe).

Throughout the programme, the national team at NHS England and NHS Improving Quality have supported peer networking and knowledge exchange among pilot schemes. Some pilots have also undertaken their own dissemination activities. For wave two, NHS England is facilitating a buddying scheme, which pairs up wave two schemes with a wave one pilot.

## Tackling health inequalities in the local health economy

Some pilot schemes (Morecambe, Warrington and West Wakefield) have targeted projects at hard-to-reach groups or areas of socio-economic deprivation. Another popular strategy has been to target patient groups amongst which there is a known high demand for primary care services, for example the frail and elderly (Darlington, DCIoS and Herefordshire), children and young people (DCIoS, Herefordshire and Slough) and those with complex or long term conditions (BHR and Workington).

The impact of these developments is yet to be proven so there is little collective learning that can be disseminated at this point. More work will be undertaken with selected pilots in the next three months to understand these projects' contribution to tackling health inequalities.

<sup>11</sup> Please note the Assumptions and Limitations detailed in Section Two of the report.

<sup>12</sup> Comparing the weeks that pilot schemes have gone live with the same period in the previous year.

<sup>13</sup> A&E minor attendances have been defined as those attendances coded to HRG VB11Z. Statistical significance has been measured at 95% confidence levels.

## Identifying models which can be replicated for use in health economies elsewhere

The hub and spoke delivery model has the potential to be replicated across different health economies as a way in which to provide extended hours appointments through a number of designated locations, rather than at all practices. There is local variation in the detail of the model, however the common requirements are:

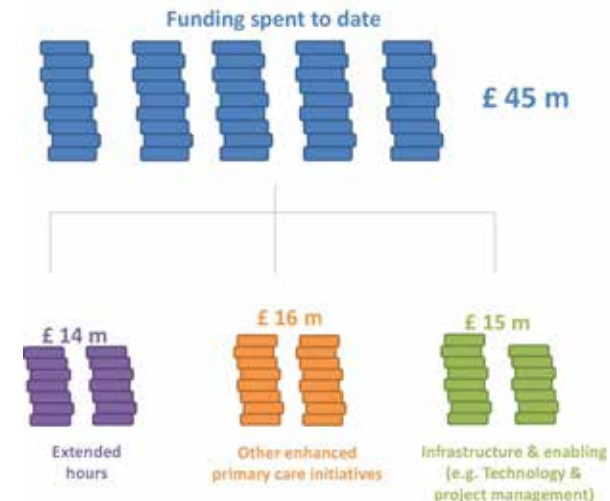
- Patients from all member practices need to be able to access extended hours appointments and wider services from the hub
- GPs providing the service need to have read and write access to patient records
- Integrated telephony, so that the hub can divert to practice systems and vice versa as necessary
- Hubs at an appropriate location and with sufficient capacity, based on robust modelling and planning

In addition, a large number of other innovations which improve access or other aspects of care have been shown to be feasible through this programme. More work will be done with pilots over the next three months to understand the transferability of these innovations.

## Delivering value for money

Up until March 2015 pilot schemes have identified that they had spent a total of £45 million; this comprises both original PMCF funding and also any match funding.

Selecting the metric data and financial returns from those pilot schemes with more consistently reliable data returns, the typical average cost per total extended hour is in the range of £200 - £280. Of this, the average cost per hour for the GP is typically 50% or more of this. The remainder of the cost per hour is accounted for by other staff, overheads and other supporting activities, including premises and for some pilots, one-off technology costs. The average cost per available appointment in extended hours is typically in the range of £30 to £50.





The cost per hour and the cost per appointment to support extended access is more expensive compared with the average GP hourly rate but more in line with locum GP rates and less expensive than an out-of-hours (OOH) contact. This is likely to be expected for a pilot scheme with economies of scale only taking effect over a longer period.

As detailed above, 13 of the pilot schemes have collectively seen a reduction in minor A&E attendances, the total reduction of which is 34,000 attendances to date. Assuming that these trends continue within these pilot schemes, the reduced number of attendances for a full financial year would be 56,000. This would generate a reduction in annual expenditure for commissioners in this service of £3.2 million.

For emergency admissions and out of hours services, there has been no demonstrable impact and, as such, there are unlikely to be any cost savings.

## Conclusions to date

### Extended hours

Collectively the pilots have been successful at providing additional appointment GP time as well as providing more hours for patients to access other clinicians. The feedback from across the wave one pilots is clear in that some extended hours slots have proved more successful than others. Whereas weekday slots have been well-utilised, patient demand for routine appointments on Sundays has been very low.

Based on the evidence on current provision and utilisation of extended hours it is suggested that 41-51 total extended hours per week are required per 100,000 registered population in order to meet the levels of demand experienced in these pilots<sup>14</sup>; of these 30-37 hours should be GP hours. Given reported low utilisation on Sundays in most locations, additional hours are most likely to be well utilised if provided during the week or on Saturdays (particularly Saturday mornings). Furthermore, where pilots do choose to make some appointment hours available at the weekend, evidence to date suggests that these might best be reserved for urgent care rather than pre-bookable slots.

### Contact modes

The Challenge Fund has considerably increased the number of patients who have a choice of modes by which they can contact and have an appointment with their GP. To date telephone-based GP consultation models have proved most popular and successful. There is growing evidence to suggest that investment in telephony infrastructure can be cost effective due to the GP time savings that are being achieved. More work needs to be done to understand the appropriate pilot scale and model that will realise most savings (i.e. a central call centre or individual practice telephone systems) and also deliver optimum patient and staff satisfaction, particularly in view of the importance of continuity of care for some patients.

Other non-traditional modes of contact (for example video or e-consultations) have yet to prove any significant benefits and have had low patient take-up; this will continue to be monitored.

### Collaboration and skills mix

Integration of other practitioners into primary care provision has been successful in almost all cases. Joint working with ANPs, pharmacists, the voluntary sector, care homes, physiotherapists and paramedics has released local GP capacity and more appropriately matched the needs of patients with practitioners. Collaboration has proved most effective when established working relationships have been built upon, engagement happens early on and there is buy-in from GPs and provider partners to a shared vision. Practices report that it is also often necessary to redesign care processes or other working patterns to gain the full benefit of new roles.

### Mobilisation and implementation

Effective mobilisation and implementation rely on a variety of factors. Most notably they require clinical leadership to secure and maintain GP buy-in; dedicated project management to drive change forward; sustained practice and patient engagement to ensure initiatives are positively received; and utilisation of existing resources (such as premises, staff and infrastructure) to minimise set-up and recruitment challenges. Successful pilot delivery teams need to be agile and responsive, adapting to lessons learned along the way. Phasing delivery also helps to manage implementation risks and workload during the resource intensive set-up stage.

### Scale and scope

The wave one pilots are very different in terms of their size and coverage. From the analysis undertaken to date there does not seem to be a 'perfect size' but size is a factor in achieving different outcomes. For example evidence suggests that smaller pilots are quicker to mobilise and find it easier to engage and maintain exposure with both practices and patients. However, larger pilots have the benefits of economies of scale and are perhaps better placed to achieve system-wide change. Wave one pilots suggest that federations will be most successful when they are 'naturally-forming', based on pre-existing relationships rather than being driven only by size.

Also relevant to consider are the different approaches adopted. All pilots have been ambitious. However, some have focused their attention on a relatively discrete set of objectives or deliverables, whilst others have chosen to trial a wide menu of projects simultaneously. A very broad scope of work can in itself act as a barrier to rapid progress.

### Understanding the local context and demand

Understanding the pattern of demand locally is important in order to provide the most relevant and value for money service for patients. The size of the local health economy, maturity of partner relationships, geographic profile and transport infrastructure are all key factors. An urban solution may not be appropriate for a rural local health economy for example. For any localities seeking to replicate wave one pilot models it will be critical to ensure that initiatives are locally tailored, bearing in mind these contextual factors.

<sup>14</sup> Given the uniqueness of its service model, this excludes Care UK.

## **Transformational change**

The establishment of federations and networks and delivery via hub and spoke models marks a culture change in primary care and in most pilot areas provides or fortifies the platform for transformational change. Where there is clear alignment with other CCG strategies (such as urgent care, integration with social care or reconfiguration of acute provision) the contribution of these developments is maximised. This change programme has also prompted federations to build their capabilities in leadership, management, service redesign and business intelligence, providing a more solid foundation for future service transformation.

## **Learning and sharing knowledge**

Sharing knowledge and lessons among participating practices has occurred at pilot level, with feedback loops and learning mechanisms established locally by the majority of pilots. Sharing between pilots and with the rest of the NHS has been facilitated by the national programme, with a few pilots undertaking their own dissemination as well. New lessons continue to emerge from wave one pilots' experience and it is important to retain flexibility in programme delivery in order to respond to them. It also remains imperative that this learning is constructively collated and shared with the wider primary care community to ensure that others are able to direct efforts into effective and proven initiatives.

## **Challenges**

The achievements that pilots have made have not been without challenges. Many of these challenges have been process related and have caused mobilisation delays and had cost implications. IT interoperability, information governance, securing indemnity insurance and CQC registration are the most commonly cited process barriers. Acknowledging these issues, NHS England has established support for wave two pilots to ease and expedite mobilisation of their programmes and minimise duplication of effort in the resolution of common problems.

## **Sustainability**

In order to sustain those initiatives that are demonstrating positive impacts, CCG support and buy-in is critical. Pilot programmes which are co-designed by CCGs or have engaged commissioners throughout implementation are better placed to secure future funding. This is especially the case given that the timescales of pilot delivery and commissioner planning have not necessarily aligned. As many pilots were not able to demonstrate impacts early enough to influence spending decisions; close working with commissioners as well as undertaking locally appropriate evaluation makes it easier to reassure them of anticipated benefits.

## **Capacity in the system**

Wave one pilots did experience some capacity issues, which manifested themselves often as difficulties in recruiting or competing with OOH providers for GP time. The short term nature of the contracts of the pilot schemes also contributed to this. There remains some concern around the availability of ANPs in particular, which are likely to be exacerbated as more local health economies press ahead with seven day services and introducing skills mix. Similarly, to date some pilots have relied on incentivising GPs to resource PMCF initiatives and this may not be sustainable in the long term. These are issues likely to face all local health economies progressing towards extended access service models.

## **Equality of access**

Some wave one pilots have reported inequalities to access whereby patients whose practice is a hub have benefited more from extended access initiatives than those whose practice is not. Rotation of hubs can be a way of overcoming this issue, although it may create other logistical issues. In addition, by the very nature of a pilot programme, there is potential to create some access inequities within local health economies because patients' access to new and enhanced services is dependent on whether their practice is a member of the pilot scheme or not. This issue could arise where not all practices within a CCG are participating in a pilot. However, this latter issue is unlikely to be a long term problem given the national agenda and move towards extended hours countrywide.

## **Benefits of working together**

The hub and spoke models and federated delivery enable practices to deliver a wider range of services to patients over more hours in the week. Large and small pilots have also highlighted some wider benefits that can be achieved through collaboration. For example, working together has made it possible to share new specialist staff or resources and has created a 'critical mass' enabling them to negotiate better deals, attract additional support or assist in recruitment. However, as more federations are established nationwide in response to the Challenge Fund and the seven day services agenda, any competitive advantage, particularly with regard to recruitment might be short-lived.

## **Added value**

Finally the Challenge Fund has provided a much-welcomed injection of investment into the primary care sector. This additional funding has provided the resource for local health economies to press ahead with collaborative working, create federations and extend patient access to GPs and other practitioners. Pilots are largely unanimous in their view that they could not have progressed with their agendas at the same pace if Challenge Fund resources had not been available. The considerable success achieved over the last year in moving away from independent working to delivering services at scale through joint working is added value in itself, even if some of the wider impacts and system outcomes are not yet fully tangible or measurable.

# 1 SECTION ONE: Background and context

## Introduction: the national agenda

It is recognised that further significant improvements in service delivery are required to meet the future challenges faced by the NHS.

Over the last 15 years the NHS has achieved much success in improving how it provides patient care and in responding to the needs of a growing population, an ageing population<sup>15</sup>, and a sicker population. However, notwithstanding these achievements, it also recognises that there are fundamental challenges facing the NHS now and over the coming years. These include:

- Changes in patients' health needs and personal preferences for involvement in their own care
- Changes in treatments and technologies which impact on how care is delivered
- Financial constraints and budgetary pressures

## Primary care

A key enabler to support the trialling of new and innovative ways of working and improving access to primary care services has been through new funding sources such as the Prime Minister's Challenge Fund & Primary Care Infrastructure Fund

General practice and wider primary care services are facing increasingly unsustainable pressures. The current model of primary care delivery no longer fits with the changing lifestyle and needs of patients. However, there is recognition that primary care wants and needs to transform the way it has traditionally provided services and enhance the accessibility of services<sup>16</sup>.

The Call to Action for general practice emphasised that with the highly systematic use of technology in primary care, the service was in a better position to consider the coordination of care across a practice network, seven days a week. This also then provided the opportunity to consider demands over the working week by for example, offering patients a wider range of appointment times, using skill mix and spreading the workload differently<sup>17</sup>.

To facilitate this, the NHS Five Year Forward view has now set out a new deal for primary care with a commitment for more investment in resources and infrastructure. It recognises the need for more readily accessible GP and primary care services, reducing variation in access, reshaping care delivery and harnessing the use of technology to meet patients' changing needs.



<sup>15</sup> Five Year Forward View, NHS England, October 2014

<sup>16</sup> It's time to embrace seven day services, NHS England website, October 2013

<sup>17</sup> Improving General Practice – A Call to Action, NHS England, 2013

## The Prime Minister's Challenge Fund (PMCF<sup>18</sup>): Improving access to general practice

### Wave one pilot schemes

In October 2013, the Prime Minister announced a £50 million Challenge Fund to help improve access to general practice. The Challenge Fund is designed to stimulate and test innovative ways of providing primary care services. A total of 254 expressions of interest were received from GP practices across the country to be part of this Challenge Fund. In April 2014 20 of these were selected to act as pilot sites, covering 1,100 general practices and 7.5 million patients.

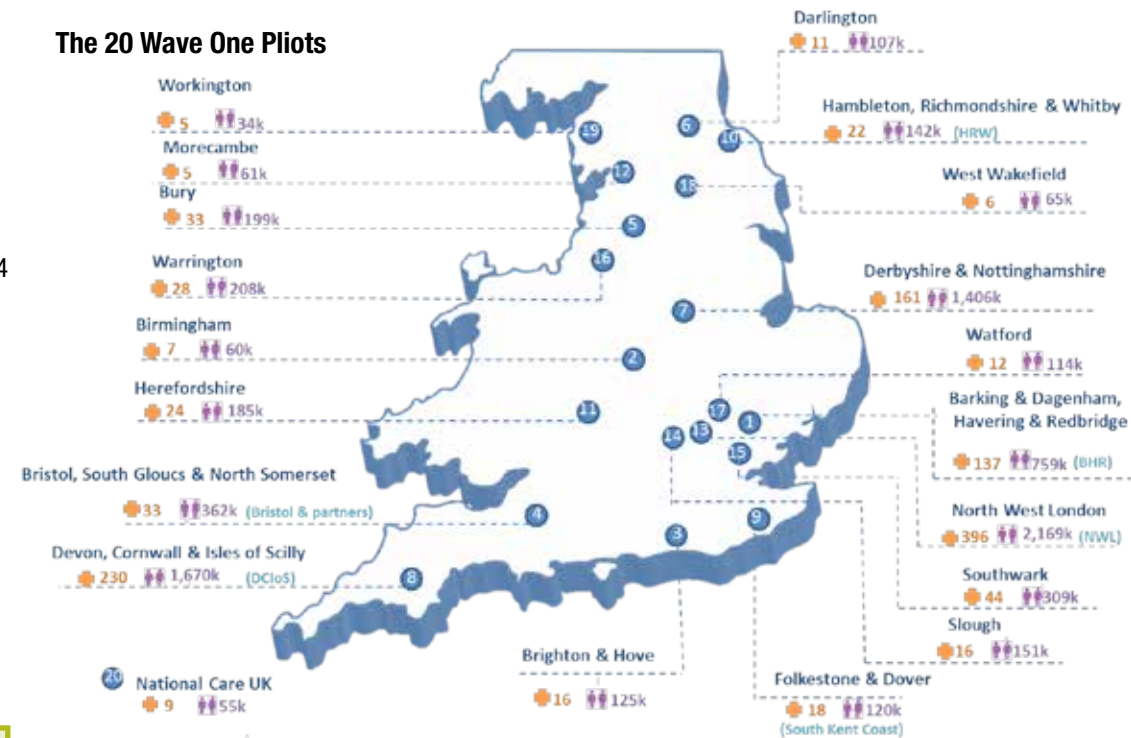
Pilots were selected based on their public and patient engagement; sustainability prospects; scale and ambition; leadership and commitment; links to local strategy; capacity for rapid implementation and their monitoring and evaluation plans. Following the selection of the 20 pilots, ten national objectives were agreed by which to measure their success.

Following the selection of the 20 pilots, three national objectives were agreed by which to measure their success in the evaluation.

### The national Challenge Fund objectives:

1. To provide additional hours of GP appointment time
2. To improve patient and staff satisfaction with access
3. To increase the range of contact modes

### The 20 Wave One Pilots



Key		GP Practices Involved	Patient Population (to nearest 1000)	Pilot Location
1. Better Access, Better Care, Better Standards	8. Shaping Services to Meet Community Needs			15. Extending Access to Primary Care
2. Health United	9. Integrated South Kent Coast			16. Primary Care Home
3. Extended Primary Integrated Care	10. Together as One Community			17. Transformational Innovations for Primary Care in West Hertfordshire
4. One Care Consortium	11. Improving Access, Supporting Primary Care Integration and Whole System Change			18. Moving Primary Care to a Wellbeing Approach
5. Easy GP Project	12. Opening Doors- Aligning & Integrating Health & Care Services			19. Better Together
6. Caring for Darlington Beyond Tomorrow	13. Transforming Access to General Practice			20. Transforming the Access Experience at Scale across England
7. Transforming General Practice	14. Steps to the Future			

<sup>18</sup> The Prime Minister's Challenge Fund is hereafter referred to as PMCF or the Challenge Fund

The size, scale, delivery models and intervention priorities vary significantly across the pilot schemes. They have all sought their own locally appropriate solutions to meet the objectives of the Challenge Fund. Common amongst the 20 schemes however, is the level of ambition that each pilot has demonstrated. All of the schemes have grasped the opportunity to go far beyond extending hours and traditional modes of access to GP services; there is an appetite to use this opportunity to transform primary care delivery more widely through integration with a range of delivery partners and redefining traditional ways of working and making access more convenient for patients.

	Activity symbol	Berking & Dagenham and Havering & Redbridge	Birmingham	Brighton and Hove (EPIC)	Bristol, South Gloucestershire and North Somerset	Bury	Darlington	Derbyshire and Nottinghamshire	Devon, Cornwall and Isles of Scilly	Hambledon, Richmondshire, Whitby	Herefordshire (Taurus)	Morecambe	National (Care UK)	North West London	Slough	South Kent Coast	Southwark	Warrington	Watford (WCA)	West Wakefield	Workington	
Extended GP appointment hours																						
Extended access to other health professionals																						
GP triage																						
Access to GPs in outside-of-practice settings																						
Telephone consultations																						
Online/web based consultation																						
Video consultations																						
Online registration, booking and access systems																						
Texting services																						
Working with the voluntary sector																						
Establishment of multi-disciplinary teams																						
Working collaboratively with A&E, NHS 111																						
Self-management tools																						
Collaboration with nursing and care homes																						
Providing more specialist treatment																						
Focus on patients with complex needs																						
Focus on older people																						
Focus on children and younger people																						
Education & community outreach																						
Facilitating learning and development																						
Patient engagement																						

## The independent national evaluation of PMCF wave one

Putting in place an evaluation of the pilots is regarded by NHS England as central to the Challenge Fund programme.

At a local site level, evaluation provides a means by which pilots can test and refine their innovation ideas based on data that is gathered. At a strategic level, it provides NHS England with valuable knowledge and insight into models and innovations which are (and are not) yielding positive results. This helps inform wider policy planning in the primary care sector itself and the wider seven day services agenda.

In June 2014 following a competitive procurement process Mott MacDonald, working with SQW, was appointed by NHS England as the national evaluation partner for wave one. The evaluation is examining the models which are being put in place to deliver change; the extent to which impacts, outputs and outcomes are being achieved; the delivery barriers pilots are facing and how these challenges are being addressed; key factors which are enabling success and an assessment of value for money.

The four goals of the wave one evaluation process are to:

- **Support local progress:** inform rapid testing and implementation of changes within practices and across the pilot.
- **Demonstrate progress:** describe and measure the impact of the Challenge Fund programme in driving innovation and improvement within pilot sites.
- **Spread innovation:** produce 'rolling case studies' describing the innovations being used and critical success factors, to spread learning rapidly across the NHS.
- **Learn from innovation:** evaluate the innovations tested and the means of implementing them, sharing actionable learning about the conditions and methodologies for successful innovation and improvement in general practice.

As well as assessing progress against the three national programme objectives (GP appointment hours; satisfaction with access; and the range of contact modes) the evaluation has also featured several other lines of enquiry including looking at the Challenge Fund's contribution:

- establishing sustainable and transformational change in the primary care sector;
- reducing demand elsewhere in the system;
- facilitating learning;
- tackling health economies;
- identifying replicable delivery models; and
- delivering value for money.

### About this first report

The wave one pilots are now over a year into delivery of their plans. This first evaluation report reviews their progress to date and assesses the extent to which the PMCF core programme objectives are being met. The report will be accompanied by 20 pilot evaluation papers which review the individual PMCF programmes, and how they meet the national objectives, in more detail.

As all 20 schemes were awarded some sustainability funding to continue with their initiatives beyond the original twelve month timetable, there will be a final evaluation report at the end of 2015, which will take on board further data.

### Local evaluation

Many pilot schemes have undertaken their own evaluation activities at a local level in addition to participating in the national evaluation. This served service improvement needs as well as providing additional insights about specific innovations for practices and CCGs. Schemes made use of peer networking, workshops and masterclasses facilitated by the national programme to plan their approach. Four schemes commissioned or collaborated with external agencies.

### Wave two pilot schemes and additional funding

In September 2014, further funding of £100m was announced by the Prime Minister for a second wave of pilot schemes of which 156 applications were received. Following the selection process, 37 pilot schemes were announced in March 2015. This second wave covers 1,417 practices, serving over 10.6 million patients. These pilot schemes are now in the process of mobilising although they are not the subject of this evaluation report. £25m has also been made available to the pilots via the Primary Care Infrastructure fund.

Part of the further funding has been used by NHS England to support wave one pilot schemes for a further six months. This additional 'sustainability funding' is in recognition of many mobilisation issues at the beginning of the programme (e.g. the set up of IT systems) and the detailed due diligence process, which was undertaken in order to gain reassurance of the robustness of implementation plans prior to the release of funding and needed to be completed before contracts could be signed and money released.

## Overview of approach

The evaluation has adopted a multi-methods approach incorporating both qualitative and quantitative assessment with an iterative and collaborative approach to interpretation and rolling publication of lessons and showcases

The methodology has comprised:

- Interviews with pilot leaders and those involved in implementation at multiple points during the programme
- Interviews with pilot partners and stakeholders involved in delivery
- Engagement with staff at practices and other implementation providers through an online survey released twice over the pilot implementation period to date
- Assessment of the impacts and outcomes measured against a basket of nine national metrics
- Identifying, examining and sharing good practice
- Identifying return on investment and value for money, through looking at how pilots have allocated their resources
- Showcasing innovation good practice through regular thematic papers
- Collection and analysis of monthly data on key services and innovations being delivered as part of PMCF

## Quantitative evaluation

### The national metrics

A basket of nine national metrics was developed in partnership with the pilots. These were distilled from over 280 metric indicators, as detailed in their original application submissions for Challenge Fund pilot status. The metrics were agreed by looking across the 20 pilot localities to identify the 'best fit' in terms of assessing activities being undertaken and also meeting the needs of NHS England in terms of understanding the impacts and outcomes of the Challenge Fund investment. This basket of national metrics have been organised under four categories.

<sup>19</sup> Out of hours primary medical care services are defined as those services required to be provided in all or part of the out of hours period which would be essential or additional services provided by a primary medical care contractor (i.e. a GP practice) to its patients during 'core hours'.

### A. Patient contact, as a direct result of the change in access:

- The change in hours offered for patient contact
- The change in modes of contact
- The utilisation of additional hours offered

### B. Patient experience/satisfaction:

- Satisfaction with access arrangements
- Satisfaction with modes of contact available

### C. Staff experience/satisfaction:

- Satisfaction with new arrangements

### D. Wider system change:

- Impact on the wider system attendances
- Impact on emergency admissions
- Impact on the 'out of hours' service<sup>19</sup>.

## The data collection and analysis process

Pilots have taken responsibility for collating practice based data against those metrics under Category A (patient contact), as a direct result of the change in access. Each month, pilots have been requested to submit weekly practice level data of hours provided, contacts available and contacts used, broken down by staff practitioner type and mode of contact within both core and non-core working hours<sup>20</sup>. In addition pilots have provided monthly statistics on the use of GP out of hours services by their patient population.

Centralised support has coordinated the collection of the remaining five national metrics. Pilot-supplied data has been combined monthly with the metrics under Category D: Wider system change and periodically with the findings of the National GP Patient Survey to support Category B metrics and a bespoke staff survey managed by Mott MacDonald for the Category C metric. Each month data metric progress update briefings have been shared with the central NHS England team.

<sup>20</sup> Core hours: 8am - 6:30pm Monday to Friday

Non-core hours: extended hours on Monday to Friday, anytime at weekends

A combination of centralised and local processes has been used to support the data collection.

### The challenges encountered

The quantitative data collection and analytical processing has not been without its challenges. Chief amongst these has been the lack of facility for the extraction of routine appointment and contact data from practice level IT systems. Many pilots under-estimated the effort required to extract data from their GP systems. For example, some pilots were required to resort to manual data collection processes using practice appointment ledgers.

There have also been issues around data quality; variations in the completeness of data submissions; and a lack of standardised definitions being used across practices within pilots. For a few pilots, there has also been unease across their GP community about providing practice level data with concern about how this will be used and interpreted at a national level. Federations of practices within some pilots have struggled to gain out-of-hours data..

Since the end of March 2015, when all pilots were operational with delivery of their extended access and other initiatives, metric data has been collected for 19 out of the 20 pilots<sup>21</sup>, although this still remains patchy for a few pilots.

Challenges with data collection have hampered some of the metric analysis undertaken by the evaluation team.

### Qualitative evaluation

The evaluation has enabled the team to establish a detailed understanding of what that pilot was seeking to achieve; explore the full range of activities and why these are locally appropriate; what has been working well; where the challenges have been; the key success factors and; the lessons that are being learned. Interviews and visits have taken place at key points over the last year in order to develop these relationships and gather information to produce updates for NHS England.

Several pilots have also been invited to have discussions about services in which they are demonstrating good practice or noteworthy achievements.

The evaluation team has produced seven thematic innovation showcases as a way in which to spread learning. These showcases can be found on NHS England's website. The topics considered are:

- Delivering at pace
- Innovative use of technology
- Patient engagement
- Practice engagement
- Delivery at scale
- Collaborating with other providers
- Effective leadership

Future showcase topics planned over the next few months include: more use of specialist nursing; tackling health inequalities; and building sustainability.

The continuous iterative approach taken to gathering and analysing qualitative data has provided added value to the national programme. For example, it alerted NHS England to important areas requiring national support, such as IT, and has informed the ongoing development of the innovation support programme. Additionally, it facilitated the early publication of key lessons about success factors for implementation of at-scale primary care innovation for the benefit of the wider NHS<sup>22</sup>.

An evaluation lead was assigned to each of the 20 wave one pilots to work with the scheme over the implementation period.



21 The exception is **North West London (NWL)** the funding received from the Challenge Fund was being used to support its infrastructure set-up for transformational change, and not specifically for service delivery. Therefore NWL was exempted from this process. This pilot has shared its survey findings and other qualitative evidence.

22 Prime Minister's Challenge Fund Wave Two: Learning from wave one, NHS England, December 2014 [hyperlink <http://www.england.nhs.uk/wp-content/uploads/2014/12/pmcf-wave-2-lessons.pdf>]



The evaluation is not designed to examine each of the pilot's local initiatives in detail

The report highlights examples of particular innovation, success and challenge and how these can be learned from, rather than naming every pilot that has delivered a certain initiative.

## Assumptions and limitations

There are some key considerations that are essential to bear in mind when reading this evaluation report:

- This is an independent national evaluation that is designed to assess pilots' collective progress against the national PMCF objectives and draw out key themes in terms of delivery. Figures presented in this report are at an aggregate programme level unless otherwise stated. Accompanying this main report are individual reports for each pilot.
  - The national set of quantitative metrics looked to ensure consistency of data collection across the pilot schemes against some key indicators. It was recognised that most pilots were planning to implement a range of other initiatives against which the national set of metrics would not provide appropriate assessment.
  - Metric data received from pilots has not been quality assured other than for obvious gaps and anomalies.
  - Each pilot has been encouraged by NHS England to undertake local monitoring and evaluation activity to complement the national evaluation and support local decision making around sustainability.
  - Given the range and complexity of initiatives being implemented across each of the pilot schemes and the context within which each is working, it has proved difficult to:
    - draw too many comparisons between pilot schemes; and
    - assign attribution of outcomes and impacts; particularly the impact of changes observed in the wider system metrics.
  - In the 'reducing demand elsewhere in the system' section, hospitals may not record A&E attendances and emergency admissions consistently which could contribute to the observed variations.
  - The report draws on many examples of pilot initiatives in order to illustrate key points. Given that there are twenty different pilot programmes, most of which have multiple project components, this evaluation cannot and is not intended to discuss every development or activity. However, there are 20 individual pilot reports discussing local issues in more detail, which accompany this overall report.
- The findings presented in this report, and the individual pilot are based on the information that has been provided to us by the pilots either through interviews, metric data submissions or monthly service data examples. These have been reviewed on receipt but the pilots themselves are responsible for the accuracy of the primary data.
  - The most up-to-date metric data has been used for this report. For practice based data, A&E, emergency admissions and out-of-hours, this is May 2015. For the patient survey this is June 2015. The staff survey was run in January and July 2015.
  - Figures on the number of practices providing, and the numbers of patients with access to, services has been taken from the monthly highlight templates which are collated by the evaluation team. The figures are from June 2015.
  - It is acknowledged that upon publication of the report, there will be continuing data collection which will be reflected in later evaluation deliverables.
  - Further work is obviously required to better refine the underpinning assumptions where there are gaps in the data. This programme of work will be undertaken over the next few months through close liaison with those particular pilots and will be reported as part of the final evaluation report.
  - It has not been possible to collect data for NHS 111 contacts. Whilst this data is published nationally and broken down by regions, there is insufficient granularity within this source of data to match NHS 111 contacts with those particular GP practices included within the Challenge Fund pilot schemes.
  - Finally, as has been identified earlier, attribution of impact to the Challenge Fund pilot schemes is inherently difficult to prove with many other initiatives, either as part of a national programme or as local drivers for change, being implemented.

# SECTION THREE: Meeting the national programme objectives

## 3

This section of the report is dedicated to examining the progress towards the three national PMCF programme objectives.

### Objective one: To provide additional hours of GP appointment time

Over 60% of respondents to the online staff survey consider there has been either a very positive or positive impact against this objective.

Prior to the Challenge Fund initiative, a number of GP practices were offering patients some access to appointments during extended working hours in the weekday and at the weekends largely through extended access Directed Enhanced Services (DES). As the Challenge Fund initiatives have been implemented by the pilot schemes, the number of GP practices offering access to a more comprehensive extending working hours service for their patients has dramatically increased. As at June 2015, it is estimated that net of the baseline service prior to the start of the Challenge Fund initiative, almost 5 million more patients now have access and a choice to a new or enhanced extended hours service during the week and almost 5.4 million more patients at the weekend.

Staff consider that the provision of additional GP hours to be the highest ranked impact of their pilot schemes

#### Hours and appointments

Across 16 out of the 20 pilot schemes, a total of 75,000 extended hours of access to primary care services have been provided between the time that individual pilot schemes went live with their initiatives to the of May 2015. Of this, 55,000 hours (73%) were provided by GPs. Net of the baseline, the additional extended hours being offered across these 16 pilot schemes was 38,000 hours of which 28,000 were provided by GPs.

The cumulative impact of additional core hours being provided over and above the baseline for the 16 pilot schemes up to May 2015 was 66,000 hours of which 26,000 (19%) were directly provided by GPs.

This increased service provision and the change in modes of contact (see objective three) has translated into additional appointment slots being offered to patients and from the time that individual pilot schemes went operational with their initiatives up to the end of May 2015, the combined impact of 16 out of the 20 pilot schemes was:

- Around 238,000 additional available appointments during non-core (extended working) hours of which 184,000 additional available appointments were provided by GPs; and
- Around 520,000 additional available appointments during core working hours of which 162,000 were provided by GPs.



In total, 758,000 additional appointments have been made available to date (as at May 2015).

On this basis, the number of additional extended working hours and appointments being offered up to May 2015 across the whole Challenge Fund Programme could potentially be around 70,000 hours and 400,000 appointments.

### Data Caveats

It is important to note that:

- The analysis reflects the cumulative impact of the continued implementation of pilot scheme’s extended working hours initiatives post June 2014 up to May 2015. It is important to recognise that pilots have phased their going live. Some pilots have been live since August 2014 whilst others have gone live later in the year or early 2015, with practices and hubs coming on stream at different times in some cases.
- The breakdown of additional hours and contacts provided masks how some pilot schemes are offering their services and, in particular, the implementation of new ways of working by GPs as part of a multidisciplinary team and therefore not recorded as a direct GP appointment but recorded as a ‘mixed’ appointment in the data returns.
- The change in service provision for some pilot schemes can result in identified reductions in hours and available appointments compared against the baseline. A reduction in available contacts may be due, for example, to longer appointment times being offered and a reduction in available hours may be due to possible recruitment and retention issues of clinical staff outside the influence of the Challenge Fund initiative.
- As stated, these headline figures reflect data for 16 out of the 20 pilots. The analysis does not include data for: **North West London (NWL); BHR; Bristol and partners; and Derbyshire & Nottinghamshire.**<sup>23</sup>

The four pilot schemes for which there are gaps in the data provided are some of the larger scale pilot schemes. Therefore, their likely contribution to the understanding of additional appointments being made through the Challenge Fund initiative is an important consideration.

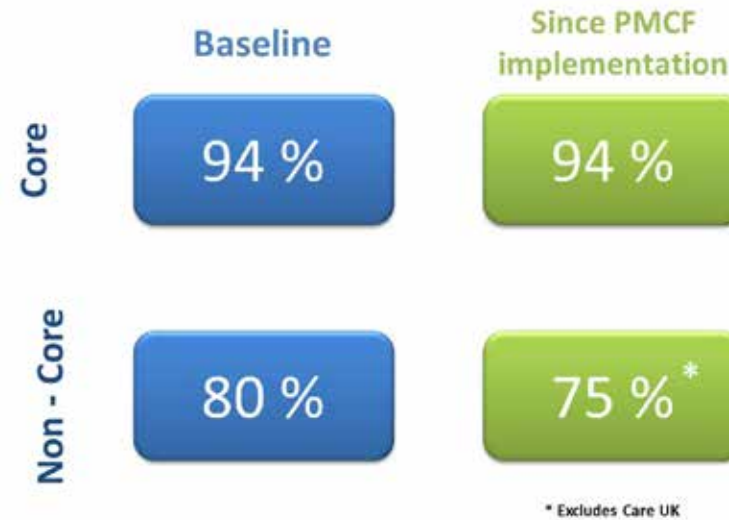
As a crude approximation to estimate the potential scale of the additional appointments being offered across these four pilots, we have assumed the live pilot data received for Bristol and partners and BHR are all additional and then pro-rated additional appointments being offered across the pilot schemes in line with the proportional split of patients who now have access to extended hours services for the remaining two pilot schemes compared to the other pilot schemes.

On this basis, the number of additional appointments being offered across the Challenge Fund programme is estimated at around 400,000 across all practitioners.

<sup>23</sup> These are pilot schemes where either no data has been provided or no baseline data has been provided against which to derive the additionality. As illustration of the data which has been provided, in Bristol between August 2014 and March 2015 3,362 hours of extended access has been provided and within the Barking pilot 23,283 planned appointments have been made available between Sept 2014 and May 2015.

### Utilisation

Whilst the provision of additional hours and available contacts is a key objective of the Challenge Fund Programme, a key consideration is how well primary care services are being utilised. Comparing the total available and used appointments from the time that pilot schemes went operational up the end of May 2015, the average utilisation of available appointments during core working hours was 94% and 75% during extended working (non-core) hours. This latter figure compares with a baseline utilisation of extended hours appointments of 80%. There is no change in core working hours.



This analysis may overstate utilisation slightly given that in some pilot schemes not all used contacts have an assigned per-booked appointment slot e.g. time set aside for urgent same day appointments.

The lower utilisation of appointments during extended working (non-core) hours resonates with pilot schemes’ own experience of lower take-up rates for weekend appointments; particularly on Sundays.

This aggregate utilisation analysis also masks the variation that exists between pilot schemes in the take-up rate of additional appointments. For example, **Care UK** provide extended access via their 24/7 call centre service and typically utilisation has been seen to be quite low compared to almost complete utilisation of hours within the **Slough** pilot scheme which undertook significant patient engagement from the outset.



This pattern of low demand on Sundays has been evident nationwide. There are exceptions (for example, **Bury**, **Morecambe** and **South Kent Coast** do not report any utilisation problems at weekends) but the vast majority of pilots have highlighted this in their feedback including **Derbyshire and Nottinghamshire**, **Darlington**, **DCIoS**, **BHR**, **Care UK**, **Herefordshire**, **Birmingham**, **HRW**, **Warrington**, **Workington** and **Watford**. Often these pilots are reporting that low take-up on Sundays and some (although far fewer) also highlighting low demand on Saturday afternoons and evenings. For example, across Darlington, local analysis of its pre-bookable appointments between October 2014 and March 2015 identified that on a Saturday 54% of appointments were booked compared to 12% on a Sunday. Several pilots have suggested that very low weekend utilisation figures mask success of the weekday non-core slots.

As a result of Sunday trends, many pilots have begun reducing their weekend service offer to fewer hours, with some ceasing provision on Sundays completely (**Watford**, **HRW**, **Darlington**) or are monitoring the situation with a view to potential discontinuation (**BHR**, **Brighton and Hove**, **Warrington**).

The wave one pilots have recognised that there are critical success factors with regard to provision and use of extended hours appointments. These include securing GP buy-in, raising patient awareness and adequate receptionist training. However, there is general agreement that the lack of success with certain weekend extended hours slots is not necessarily attributable to the delivery and design of projects or an ineffective communications strategy; rather it as a result of entrenched patient behaviours.

### Rate per population of extended hours

A comparative analysis has been undertaken to assess the current range of extended hours per registered population being offered across pilot schemes in March 2015. This analysis includes the totality of extended hours provision and not simply the additional capacity being provided.

This analysis shows a range of extended working hours per week per 1,000 registered practice population. For illustration, the rate per 1,000 population in **Bristol**, **North Somerset** and **South Gloucestershire** is 0.11 (reflecting weekend extended access) and across Care UK practices is 14.1. **Slough** and **Warrington** pilot schemes offer around 1.9 and 2.0 extended working hours per week per 1,000 registered practice population respectively.



Smaller scale pilot schemes are offering an average of 0.55 extended hours per week per 1,000 practice population<sup>24</sup> and those medium scale pilot schemes are offering an average of 0.68 extended working hours per week per 1,000 practice population.

Therefore, for a pilot scheme covering 100,000 patients, this analysis would translate into the provision of around 55-68 hours for extended access per week. However, this does not factor in utilisation which has shown that, to date, 75% of extended working hours contacts are being utilised.

Taking account of this it suggests that the number of extended working hours per week which could be considered to maximise utilisation should be 41-51 hours per 100,000 patient population pilot scheme. For extended working hours provided specifically by GPs, this would translate to between 30-37 hours per week per 100,000 registered population (once utilisation has been accounted for).

Whilst this analysis provides a reasonable estimation it still remains too simplistic to define a “recommended” rate without reference to current service levels and pressures. There is known to be wide variation of patient experience with GP access, and local needs assessments should guide any new or additional services. The wider features of the innovations and models must also be taken into consideration. In particular, it should be noted that schemes varied widely in their use of innovations which promote self care and improve productivity. It will also be critical to consider when these additional hours are provided. Evidence to date indicates that it would be more sensible to allocate additional hours to weekday slots or possibly Saturday, rather than trying to establish a Sunday service.

**Birmingham** has concluded that their most effective delivery model lies not exclusively in providing additional hours, but in using core hours more effectively. In **HRW** overall low utilisation (between 50-60%) has suggested that extended hours is not a suitable or sustainable solution across the region. In fact, the initial focus on the extended hours element of delivery served to disengage some local GPs, later creating challenges with securing buy-in for some of the pilot’s other projects. The pilot has now ceased extended hours provision and is directing further investment towards other PMCF projects which are more aligned with local need. In turn the Alliance and the broader network of GPs are now more positive about the future.



<sup>24</sup> Given the uniqueness of the Care UK service model, this has been excluded from the analysis.

## Objective two: Improving satisfaction with access to primary care

Overall 84% of patients rated their experience of their GP surgery as either very good or fairly good.

### Patient experience and satisfaction

To assess the extent to which the PMCF pilot schemes have improved levels of patient satisfaction, findings from the National GP Patient Survey have been used. The latest survey results published in July 2015 combine the survey responses collected over the previous 12 months at two periods, July 2014 to September 2014 and January 2015 to March 2015. This represents the time period during which the pilot schemes have been up and running<sup>25</sup>.

Comparative analysis with previous survey findings has been undertaken to assess the extent to which there have been changes in patients' perceptions about access to primary care services.

#### Findings from the national GP Patient Survey

Given the limited time that pilots have gone live with their initiatives, it is still too early to make an impact and, at a programme level, there has been little change in patients' levels of satisfaction and experience. Seventy five per cent of patients who responded to the most recent survey are satisfied with their GP practice's opening times and consider that opening times are convenient for them. Of those patients who considered that additional opening times would make it easier to see or speak to someone, there was a 70% response rate for additional opening times on a Saturday, 65% after 6.30pm and 38% on a Sunday. Over 90% of patients across the Challenge Fund GP practices consider that appointments are either very or fairly convenient and around 60% of patients are able to see their preferred GP. Three quarters of respondents consider that their experience of making an appointment is either very good or fairly good. These findings are very similar to the national profile.

Notable pilot scheme exceptions to the overall Programme level trend include:

- A greater than 4% increase in the positive response to the convenience of appointments at the **Morecambe and Birmingham** pilot schemes.
- A 9% increase in the patient's experience in making an appointment but a 7% reduction in the convenience of opening times at the **Workington** pilot scheme.
- A 3% increase in patients' who state that they either always or a lot of the time get to see their preferred GP at the **Brighton and Hove** pilot scheme.
- A 12% reduction in those satisfied with surgery opening times at the **Birmingham** pilot scheme. This may reflect the removal of the extended hours services at the end of March 2015.

#### Findings from local data

Most pilots have undertaken local patient satisfaction surveys and other patient engagement activities to support their Challenge Fund initiatives. Without exception, feedback reported by the pilot schemes has been positive with the majority of patients asked stating that they would recommend the service to their friends and family. For example, in Herefordshire 93% of patients surveyed described the Taurus Healthcare Hub as excellent or very good and in Slough 97% are very satisfied or satisfied with the extended hours service. To support the promotion and feedback of local Challenge Fund initiatives, some pilot schemes have provided patient engagement activities, including patient educational support sessions and open days.

#### Findings from the staff survey

Findings from the two staff surveys have identified over 70% of respondents rate the Challenge Fund initiative as having had either a very significant or significant improvement in their patients' experience with:

- Between 62% and 64% of respondents within the surveys either strongly agreeing or agreeing that there has been a change in how the needs of patients are being met.
- 56% of respondents either strongly agreeing or agreeing that they are now providing care which more appropriately meets the needs of patients in terms of access.
- 45% of respondents either strongly agreeing or agreeing that they are now providing care which more appropriately meets the treatment needs of patients.

<sup>25</sup> Note that the national GP patient survey does not specifically focus on PMCF and is more generally reflective of patient's experience and satisfaction with primary care services.

## Staff experience and satisfaction

The national evaluation team has sought to understand and assess changes in staff satisfaction in pilot schemes through their experience of the Challenge Fund and their perceptions of the pilot's impact on patients, other staff colleagues and the overall primary care system. To do this an online staff survey which to date has been run twice, has been facilitated by Mott MacDonald.

Almost 1,000 responses were received to these two initial surveys. They include GPs, practice administration staff, nurses, and other clinical professional staff and practice management staff all of whom have had involvement in their pilot's Challenge Fund initiative. All pilots have participated in the online survey with the exception of one, **Warrington**, which intends to undertake its own staff survey in September 2015.

Across both surveys, findings have been consistent with:

Around 70% of respondents feeling either very satisfied or satisfied with the pilot's arrangements of how primary care services are being offered. Fourteen per cent of respondents rated either dissatisfaction or very dissatisfied with current arrangements.

Over 60% of respondents from both surveys rating their experience of extending access in primary care as either very good or good compared with between 12% and 15% who rated this as either poor or very poor.

Just over half of respondents in both surveys have rated the impact of the Challenge Fund on staff as either very positive or positive.

Respondents rating their current job satisfaction compared with that before the Challenge Fund showed a 3% improvement in job satisfaction within the initial survey findings. Findings from the second survey have shown that this has increased with respondents rating their current job satisfaction 6% higher than prior to the Challenge Fund. However, the second survey findings have shown that 20% of respondents are either dissatisfied or very dissatisfied; a marginal increase from the initial survey findings. This is predominantly GP and administrative staff and may be due to wider issues at a time of considerable pressure on general practice across England.

Pilots have also highlighted some of the increased staff engagement activities which have taken place to increase and maintain interest and participation in the pilot scheme. This has included videos and guides on new ways of working for members of staff in **Herefordshire**; establishment of a steering group for doctors and practice managers and IT training for receptionists in **West Hertfordshire**; using a range of media and a staff survey in **Darlington**; assignment of project managers to develop relationships with practices in **NWL**; and events and working groups to co-design initiatives in **Southwark** and **Workington**.

Whilst much of the feedback from staff has been positive, the staff survey has also received many additional comments from respondents which have been more critical and provide an opportunity to learn lessons for potential future waves of pilot schemes. These comments suggest the need to:

- Ensure patient accessibility and use of extended hours hubs in more rural locations.
- Ensure equitable access to additional appointment slots for non-host GP practices.
- Take into account the differing needs of patients, some of whom prefer to see their own GP rather than attend an extended hours appointment with another GP.
- Achieve improved alignment with other urgent care services, particularly out of hours services.
- Focus additional funding on core hour services.



## Objective three: Increasing the range of contact modes

### Using technology

The pilots have demonstrated considerable ambition

The majority of pilots (15 out of 20) have increased the modes of contact, usually with the aim of reducing face-to-face appointments (which take longer than some other contact modes) and/or making access more convenient for patients.

#### Telephone-based GP contact

Prior to the Challenge Fund initiative, the dominant mode of GP contacts in both core and non-core hours was face-to-face, with a comparatively small amount of telephone consultation hours:

- Core hours: 80% of appointments were face-to-face; of the remaining, 17% were telephone consultations and 2% were home based appointments<sup>26</sup>.
- Extended hours: 91% of appointments were face-to-face and 8% were telephone consultations.
- Just over 450 practices were providing some level of telephone consultation.



The introduction or expansion of telephone access has been a popular component of the wave one pilot programmes, with two thirds of the pilots introducing schemes to expand this type of access. PMCF has increased the scale of provision considerably, supporting the development of telephone consultation facilities<sup>27</sup> at nearly 400 practices (serving over 2.5 million patients).

Despite this uplift of telephone access, March 2015 metric data suggests that the overall profile of patient appointments during core hours had not changed. However, there has been variation to the contact profile during extended working (non-core hours), which is characterised as:

- 87% face to face clinic appointments (compared to the 91% baseline)
- 11% telephone appointments (compared to the 8% baseline)
- 2% other

15 out of 20 pilots have increased the variety of modes by which patients can access GP services.

Some of the pilots are evidencing considerable success with this service development, as evidenced below.

#### Birmingham

In **Birmingham** the provision of telephone based consultations has been a major part of its offer; it has established a central telephony hub which books patients into an appointment or routes calls to patients' own practices for local matters (e.g. nurse appointments or test results). On average its telephony hub takes around 1,300 calls on a Monday, and around 800 on other weekdays. The metric data collected for the national evaluation indicates the investment in the hub system has been a success at re-balancing the appointment profile. During core hours 60% of appointments are now over the telephone compared to Birmingham's baseline position of 35%. GPs have reported increased capacity and greater control over their own workloads, as a direct result of the telephony offer. Local data from practices participating in the pilot are reporting consulting approximately 10% more patients without taking any additional hours into account.

*"As well as making it easier to make contact, to book appointments and get support from the surgery, these new systems offer new routes to rapid and excellent professional advice and reassurance"*

#### Birmingham patient

The Birmingham pilot suggests that to maximise the effectiveness of a telephone based model, it is important to ensure that the consultation procedure itself is an integral part of service design rather than focusing only on the telephony infrastructure. Patients need to speak to a practice doctor (ideally their own GP) with full access to the patient's notes. The effectiveness of the process is reduced where there is a mixture of staff involved in dealing with the patient, and where locums are used.

The proportion of telephone appointments in con-core hours has grown

<sup>26</sup> 1% use "other"

<sup>27</sup> The pilots have introduced a range of telephone models by different names (e.g. telephone consultations; telephone triage; call centres)

### Brighton and Hove

In **Brighton and Hove** local data suggests that the majority of practices implementing the telephone triage model are noticing some positive impacts, particularly in terms of GP time saved. In addition, this model has helped to shift the profile of GP appointments so that now 34% of core hours appointments are over the telephone, compared to a baseline of 10%. The pilot has found that the success of its telephone model is dependent on how GPs use it; some are reluctant to deal with patients entirely over the phone and ask patients to visit the surgery anyway.

### Nottingham North East (Derbyshire and Nottinghamshire)

Nottingham North East (NNE) has enjoyed success with an ANP & GP telephone triage trial in one of its practices. The model was designed to better match the practitioner to the patient, allowing GPs to focus on patients with more complex care needs. Local data suggests that it has led to a reduction in the number of face-to-face GP appointments. The local patient survey recorded a 100% satisfaction rate with the service.

*“We are now seeing more appropriate patients and we can clinically prioritise who we see when and decide the length of the appointment. We are therefore able to provide improved quality of care.”*

GP

**Care UK** has seen some significant shifts towards telephone consultations in its contact profile in both core hours (from 10% to 27%) and extended hours (from 20% to 42%). Its offer is based around a central telephony hub. This national pilot was able to make use of existing 111 telephone infrastructure to implement this service.

*“I was very impressed with such a quick turnaround; this was the best experience [of general practice] I’ve had yet.”*

Care UK patient

### Morecambe

Similarly in **Morecambe**, local patient feedback suggests that its telephone triage service is perceived as more responsive to need than NHS 111. 72% of the Morecambe pilot scheme’s extended hours appointments are telephone based, via its triage model.



### Video consultations

Six pilots have experimented with video consultations, using video technology. 20 practices are trying this contact mode with potential access for over 250,000 patients. There have been challenges with this mode of consultation. **Herefordshire** attempted to introduce care home videolink activities but found that there was inadequate on-premise broadband provision to support mobile devices. In **Birmingham** video appointments were launched at all of its participating practices in September 2014 but they have not yet proved to be popular with patients. The pilot feels that intensive marketing would be required to increase take-up of this offer. **DCIoS** trialled, and has since discontinued, video appointments in Devon. It also found there to be a lack of patient demand, pointing towards the patient demographic as the possible reason behind low take-up.

### Online patient diagnostic and e-consultations

Six pilots have introduced online patient diagnostic tools. These include self-help content, sign posting options, symptom checkers, access to 111 clinicians and ultimately the ability to consult remotely with a GP via e-consultations (e.g. WebGP, SystemOnline, MyGP24/7).

To date these have met with a mixed reception from both GPs and patients. In **Bristol** 13 practices adopted e-consultations and, despite some technological set up issues, the trial was seen as a success. Elsewhere, prior to implementation, (**Brighton and Hove** and **Southwark**) some GPs had concerns that patients might not fully understand the front end advice process and were also apprehensive about being inundated with e-consultation requests. This led to some reluctance to implement the system. **Care UK** implemented a diagnostic and e-consultation system at all eight of its practices but experience suggests that it has a limited appeal for patients; they tend to prefer the pilot’s telephone access offer, which provides patients with a GP response more quickly. Since going live, the pilot has provided 470 on-line consultations up to the end of May 2015.

Eight practices have also introduced online access features, typically online registration and booking systems, as part of their pilot programmes. Approximately 250 practices have provided these facilities across **Birmingham, Bury, Care UK, Derbyshire and Nottinghamshire, NWL, Slough** and **Warrington**.



Video consultations have been challenging to implement



Few pilots have implemented e-consultations and reception has been mixed





## Introducing a wider range of practitioners

Wave one pilots have invested considerable resource and effort in engaging with the wider healthcare community to deliver services in partnership and more appropriately match patients to need, reduce exacerbations of conditions and free up GP time.

### Making more of nursing staff

The evidence to date suggests that the strategy of making more use of nursing staff, particularly Advanced Nurse Practitioners (ANPs), is resulting in benefits including releasing GP capacity.



A few pilots have chosen to employ specialist nurses. For example, **Workington** appointed three specialist nurses (one for each of chronic obstructive pulmonary disease (COPD), diabetes and liaison with care home patients). **Herefordshire** has implemented a link nurse initiative to facilitate the discharge of patients in order to reduce the likelihood of miscommunication between primary and hospital care, avoid prolonged stays in hospital and the associated exacerbation of health issues. The pilot's local evaluation highlights that the project has avoided the need for post-hospital GP intervention in 25 cases and Taurus has secured further funding from the CCG to continue it.

*"The link nurse has been acting as a link between my Father, our family, the GP surgery in Belmont and Hereford County Hospital. It has been really helpful to have someone who appears to be thinking about the whole picture concerning my father and his cancer as well as my mother and her difficulties"*

Patient's son

The use of ANPs has been a key strategy to try to release GP capacity. Models vary, with ANP capacity being provided in both core and extended hours, delivered from practices, hubs or working remotely. By and large these initiatives have demonstrated success. In Erewash (in **Derbyshire and Nottinghamshire**), local data for the first quarter of 2015 suggests that their ANP care home work stream has resulted in the avoidance of 118 unplanned admissions as well as freeing up GP time; of 136 urgent visit requests from care homes 23 were attended by GPs and 113 were attended by ANPs. In **Brighton and Hove**, data shows that an additional 2,000 hours of nursing time (net of baseline) have been provided during core working hours. Utilisation of ANP appointments has been very high, particularly during extended hours.

However there have been key issues around ANP recruitment and other nursing staff (community and district nurses) (see section 6), which have been exacerbated by the short-term nature of contracts. Pilots have also found it necessary to ensure the right balance between giving nurses sufficient additional hours to make the change in shifts worth their while, but also not overburdening them. **Slough** found it important to spread the extended hours load across the workforce, but also give nursing staff regular shifts to make it easier for them to manage. There have also been technological challenges, particularly for nurses working outside of practices. In Herefordshire, EMIS restrictions meant that the link nurse was unable to input directly to primary care records, meaning the project had to be flexed accordingly.

### Pharmacy



Making more use of nursing staff, both in terms of extra capacity and also enhancing their roles, has been a popular wave one intervention.



That there have been several hurdles to overcome in order to introduce wider roles for nurses

Various pharmacy models have been chosen, some more successful than others.

*“Collaborating in this way has helped us to build strong relationships with GP practices; we work together to mutually help each other. PMCF has been really helpful in changing the nature of the relationships between pharmacy and GPs in practices.”*

**DCIoS pharmacist**

DCIoS piloted a Pharmacy First scheme, originally launched in NEW Devon with services later extended to South Devon and Torbay. Local data suggests that this scheme saved nearly 3,000 GP appointments, over 1,000 OOH appointments and 150 A&E appointments over its first five months of operation, resulting in potential saving of nearly £165,000. Key to the success of this initiative has been the strong working relationships between GP practices and pharmacies, which for the most part preceded PMCF. A business case for the further integration of pharmacies and GP practices had previously been prepared and PMCF was used to further develop this. Local pharmacists have been fully supportive of the opportunity to further integrate with primary care and visited GP practices to build momentum and advertise the service. The pilot has found that the service is a particularly good access point for people in rural or remote communities.

*“Absolutely invaluable service to our patients and us. Very useful also for temporary residents.”*

**DCIoS**

**HRW** introduced the use of clinical pharmacists to support primary care in the community in five of its practices. Most of the HRW practices have used the pharmacist for home visits to help ensure that patients are following their medication advice. Local data suggests that nearly 140 patients have benefited from this service; each receiving between four and five interventions. The success of the initiative has led to one practice identifying a second cohort of patients for pharmacist visits and the pilot suggests that 14 out of its 22 practices have expressed an interest in benefiting from this initiative in the future.

The experience of **Brighton and Hove’s** pharmacy initiative has been more mixed. Part of its scheme has involved using independent pharmacists to work in three GP practices to treat common conditions and work with some patients with long term condition. This has shown to be a success, with local data showing that utilisation rates remain consistently high for these services (averaging between 80-100%) and patient feedback for these services is also good. However, the community pharmacy element of this work stream has been a significant challenge. Whilst there has been good buy-in from local pharmacists and good local satisfaction data from patients who have used the service, utilisation of appointments has been typically less than 5%.

## Working with care homes



Recognising that older people are a key GP patient group, four pilots have undertaken targeted activity with nursing and care homes. In **Workington** a specific frail and elderly multi-disciplinary team has been established to improve care of people aged over 75 with a specialist care homes nurse to lead it. Local data suggests that in its first month in operation the team had seen over 85 patients and had saved over 100 GP visits.

**Herefordshire** also experimented with a range of work to enhance access to primary care within nursing homes in order to reduce pressures on GP time; it experienced mixed success. For example, it investigated using videolink technology to allow virtual access to GPs from residential homes but this was hampered by the limited on-site broadband capacity. More successfully, it implemented carer support packages to enable more confident identification of early signs of Ambulatory Care Sensitive conditions together with advice on instigating appropriate care to help prevent unnecessary hospital admissions. Local patient feedback has been 100% positive and more carers feel confident in testing for key conditions.





## Voluntary sector / Community navigation



*"I have never spoken to anyone about this. I love talking it through with you, this has been really useful"*

**Service user  
community navigation**

*"Why haven't we done this before? It's simple and I can see it really helps some of our patients"*

**GP**

*"I am feeling really valued and appreciated and the support given is fantastic"*

**Community Navigator**

Marking another shift away from the traditional suite of services, six of the wave one pilots opted to partner with the voluntary sector in order to offer a wider package of patient support, often with the objective of reducing pressure on GP time.

Perhaps the best example of this is in **Brighton and Hove** which has been working collaboratively with Age UK and a local charity, recruiting 18 'community navigators' to work with patients with complex needs (usually low-level mental health conditions or older people who suffer from social isolation) to signpost them to third sector resources as necessary. Working with the voluntary sector has brought with it some challenges. There were issues around using the 'right language'; the time taken to recruit and train volunteers; and also ensuring the collection of appropriate monitoring data. Such challenges have been overcome through effective partnership working and through including the voluntary organisations on the programme board. At a GP level, the initiative has worked best where practices are inclusive, fully involving their volunteers and ensuring they are visible.

**West Wakefield** has undertaken in-practice activities to encourage patients to access wider self-care and community resources. It has trained 73 practice staff as Care Navigators so that they can provide guidance and support to patients as the first point of call. This has been complemented by the launch of the West Wakefield Health and Wellbeing website, which provides a directory of services to allow patients to manage their care more independently as well as in-practice self-service kiosks at two practices to improve accessibility to the information. Local data suggests that up to 400 GP appointments were saved per month.

## A&E

Aware of both national and local agendas to reduce pressure in the A&E system, some pilots have experimented with closer working with A&E providers. Both **BHR** and **Darlington** linked with their local A&Es so that patients can be referred into extended hours slots.

**Herefordshire** attempted to place an emergency care doctor into the A&E waiting room to investigate the referral process from A&E into primary care. The eventual aim was to facilitate access to EMIS via an EMIS electronic patient record (EPR) viewer and train A&E staff to book patients directly into PMCF seven-day service appointments. However these projects have been slow to deliver with technical issues inhibiting interoperability. There is a resistance to having the EPR viewer installed in the A&E department (particularly because they could not book directly into the Hubs) and a lack of understanding of the Hub service offer. A&E staff made it clear that they intended to continue directing patients requiring primary care towards the OOH provider. Whilst interoperability issues have now been resolved the considerable delays have reduced the effectiveness of this intervention.



## Targeted clinical specialists

Two other pilots are worth mentioning due to the local impact that they are having.

### South Kent

In South Kent, they have deployed paramedic practitioners to work seven days a week (10am – 7pm) providing home visits and who are specially trained to provide primary care and dispense certain medications (such as emergency antibiotics). GPs refer cases to the service and the paramedic reports back with details of any treatment and medication given. Local data estimates that in a three month period (November 2014 and January 2015) the paramedic practitioner service saved around 720 GP appointments at the Folkestone hub alone<sup>28</sup>. This pilot has also appointed two mental health specialists (one full time, one part time) based at its Folkestone hub five days a week so that a GP can make an immediate referral to this specialist rather than needing to escalate the case to mental health services. Feedback from patients, practitioners and especially GPs suggests that both the paramedic practitioner and mental health specialist have been very well received and have reduced pressure in the practices.



### West Wakefield

West Wakefield introduced a scheme involving direct referrals to a physiotherapist, via their trained Care Navigators, rather than patients being required to see a GP first. The pilot is confident its PhysioFirst, which was designed to save GP time and provide patients with quicker access to the service they needed, has achieved its objectives. Local evaluation data suggest that it has saved nearly 100 hours of GP time since the start of the project. Although West Wakefield has noted that perhaps the service has not reached its full potential, this could be achieved through more advertisement of PhysioFirst as well as awareness-raising with Care Navigators so they can better signpost this service. Feedback from patients<sup>29</sup> has been positive, with all those who responded saying they are extremely likely or likely to recommend the service to a friend or a family member.



<sup>28</sup> Data for Dover has not been analysed at the time of writing this report. In Dover the paramedic practitioner service is expected to address a formerly unmet need, and therefore the data will not directly translate into GP hours saved.

<sup>29</sup> Collected using the Family & Friends survey.

# 4

## SECTION FOUR: Wider learnings and lines of enquiry

As well as exploring progress against the three national programme objectives, the evaluation has also taken some additional lines of enquiry to identify the wider impacts and outcomes of the Challenge Fund. The main findings are presented in this chapter.

### Stimulating transformational and sustainable change

#### Service delivery is transforming

In some pilot locations there was already evidence of GPs collaborating in order to deliver greater access or an enhanced service to patients. For example, federations or networks were already present in **BHR, Bury, Herefordshire, Warrington, Southwark** and some of the CCGs in **NWL**. For all of the participating localities the Challenge Fund has had a catalytic effect. It has provided the cause, confidence, resource and created some 'headspace' to encourage practices to move away from operating as independent small businesses and, instead, work collectively. Even in locations where there had been prior progress towards collaborative delivery, PMCF has boosted momentum and helped to mobilise federated working. Across the programme as a whole this marks a significant departure, not least because of the short amount of time that this has been achieved in.

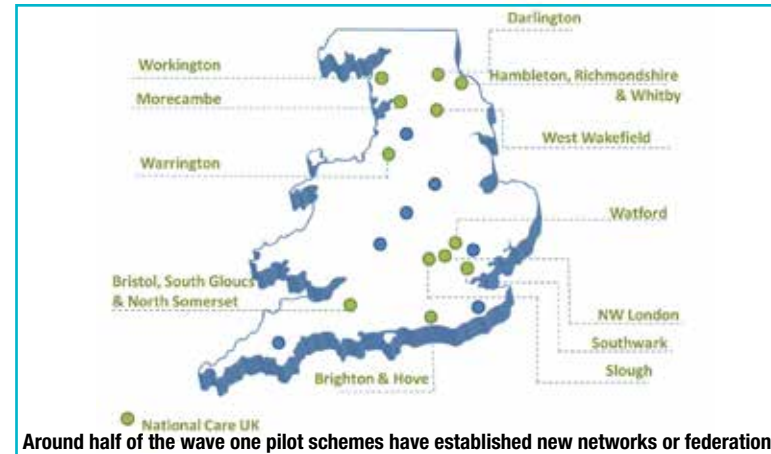
This change in ways of working has been characterised in several ways. Most common has been the development of new networks, federations and legal entities. For example federations are now present in **Bristol, Darlington, Workington** and **West Wakefield** as a result of PMCF involvement, whilst **Brighton and Hove, Care UK** and **Slough** established new practice networks to deliver their programmes. For those pilot areas with federations already in place, they have used PMCF to build on their existing working relationships and move forward into service delivery. PMCF, through providing the investment to help localities move forward with innovative primary care plans, has helped to highlight that practices cannot provide extended hours, or many other initiatives, by working on their own.

As a result even the biggest pilot, NWL, has achieved full coverage in terms of structural, organisational change; it has tangible networks in each of its eight CCG areas, which is a considerable achievement given that it covers nearly 400 practices which serve around 2 million patients. For West

Across the programme as a whole, PMCF has been successful in initiating a culture change amongst the primary care community.

*"One Care is the most exciting and engaging thing that practices have been involved in across the whole of the NHS locally for the last few years. It's because we have the opportunity to drive and lead the programme."*

**Practice Manager, Bristol and partners**



Around half of the wave one pilot schemes have established new networks or federations

A commitment has grown to working together in order to provide additional hours, capacity, flexibility and economies of scale.

Wakefield and Birmingham PMCF has helped create a platform for securing Vanguard status.

The formal establishment of federations and networks over the last year in many pilot areas has set up a legacy of PMCF. Networks and federations are becoming a 'cog' in the system and the network approach or hub and spoke system are generally seen to work as delivery models. Some federations and alliances are also looking to expand their portfolios through further integration with other services and bidding for other community contracts.

At the same time as collaborating with each other, a shift in working behaviours has also been evidenced by the widespread introduction of new modes of contact as well as considerable ambitious cross-system collaboration plans to deliver services in a more innovative way and reduce pressures on GP time (see Section Two above for more details on these different initiatives).

Some wave one pilots have also pointed to specific interventions which they feel will be self-sustaining, rather than needing any significant future investment. These include **Brighton and Hove's** redirection of workflow initiative; the urgent care model and Pharmacy First in **DCIoS**; and patient self-help groups in **Slough**. These will be further explored with the pilots over the next few months.

*"Delivering PMCF weekend access has brought us together as practices and had made the Federation 'real' for the first time"*

**GP, DCIoSs**

Shifting trends and behaviours has required dedicated effort by pilot teams to ensure that buy-in has been maintained.

Achieving wholesale culture change, and the associated impacts and outcomes, cannot be expected in a short implementation period.

### Shifts in working culture take time

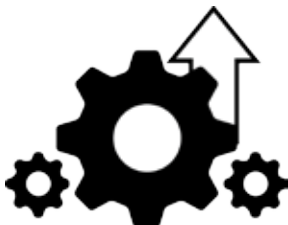
Whilst the Challenge Fund has certainly helped to initiate transformational and sustainable change, this has not necessarily been easy to achieve as reflected in the staff survey which indicated that less than 50% of respondents consider that there has been a positive impact towards achieving a culture change amongst staff involved in the delivery of general practice. Moving towards cluster-based delivery, with services offered from new hubs or non-traditional settings represents a significant change for the many GPs that have never collaborated or provided joint services before. As such, there have been some challenges along the way.

Certain elements of some pilot programmes still face resistance and there is still not universal buy-in to the principle of 8am – 8pm seven days a week access. Some practices have struggled to move away from an independent mind-set whilst a couple of pilots have reported concern from GPs that ‘competing’ services are being established. In **BHR**, for example, there has been some anxiety around the potential of the Health1000<sup>30</sup> complex care initiative to affect practice lists. These issues have affected buy-in and in some places have stalled the progress towards a new working culture.

To build continued buy-in from GPs there has been a need to proceed with caution rather than rush forward with initiatives. **Bury, Herefordshire** and other pilots report that it has taken time to build GP confidence about the safety and reliability of the new extended hours services. It is important to accommodate this time in project implementation plans. Given this context, one year is considered insufficient to fully instil (or measure) permanent behaviour and mind-set change amongst both patients and GPs, especially given the process barriers that were faced in the first few months.

### Looking ahead

Findings from the online staff survey undertaken to support the evaluation show that 41% of respondents consider that there has been either a very positive or positive impact towards establishing models which will be sustainable beyond the lifetime of the Challenge Fund. Some pilots have already made deliberate decisions to discontinue with projects that have been exhibiting low impact or lack of demand (e.g. **Darlington, HRW, Herefordshire** have scaled back their extended hours offer) to suit local demand.



The Challenge Fund was not established to launch permanent programmes in every pilot locality; it was acknowledged that some projects would be more successful than others. It will ultimately be down to the discretion of CCGs to continue with initiatives that have been shown to be locally popular and have demonstrated positive results.

Some pilots have highlighted that the relatively short implementation of the Challenge Fund programme has made it difficult to sufficiently demonstrate the impact of their projects; for some this has limited the ability to influence CCG commissioning decisions. This has emphasised the need for close working with the CCG throughout the implementation period. This is critical in terms of sustainability, as is alignment with other local strategies so the initiatives established through PMCF are embedded within wider transformation and future delivery models.

In **Bristol, North Somerset and South Gloucestershire** the One Care Consortium directly involves the CCGs in all three areas. The team considers it a positive sign that CCGs want to collaborate with One Care and a sign of recognition that this project is part of a new solution. CCG involvement has also meant that sustainability has been a consideration and on the agenda from the outset of the project.

In **Derbyshire and Nottinghamshire** PMCF coincided with the development of the Derbyshire & Nottinghamshire Strategy for Primary Care Transformation. The synergies between PMCF and the Strategy have given momentum to the pilot projects.

In **Slough** the PMCF project is embedded in the work of the CCG which has been particularly beneficial for governance and decision making. It has enabled there to be non-clinical challenge and managerial support and has been beneficial for the longer term strategy and direction of primary care.

In **Workington** the pilot has worked closely throughout with the CCG. The CCG has been happy to share the pilot’s achievements and has encouraged the pilot to bid for additional work and other contracts to become more sustainable.

Where federations with established governance structures and staff are in place, there is considerable confidence that they will continue to exist beyond the lifetime of PMCF

<sup>30</sup> Health1000 is an initiative set up to move patients with complex needs from a standard GP practice into an organisation specifically set up to manage this type of patient. It is located in the King George Hospital and staffed by several GPs (who are part-time in order to maintain their ability to do standard GP practice), a geriatrician, a nurse, an occupational therapist and a physiotherapist.

NWL, Southwark and Warrington have used PMCF resources to establish sustainable models for future delivery.

### Building for sustainability from the outset

Three models deserve mention due to the deliberate ambition to use the Challenge Fund to create sustainable systems for the future of primary care delivery. These pilots saw PMCF as part of wider or more long-term transformational change rather than an opportunity to increase GP transactions or experiment with new access modes. Therefore they have purposefully used Challenge Fund investment to set up structures that will outlive the official lifetime of the pilot.

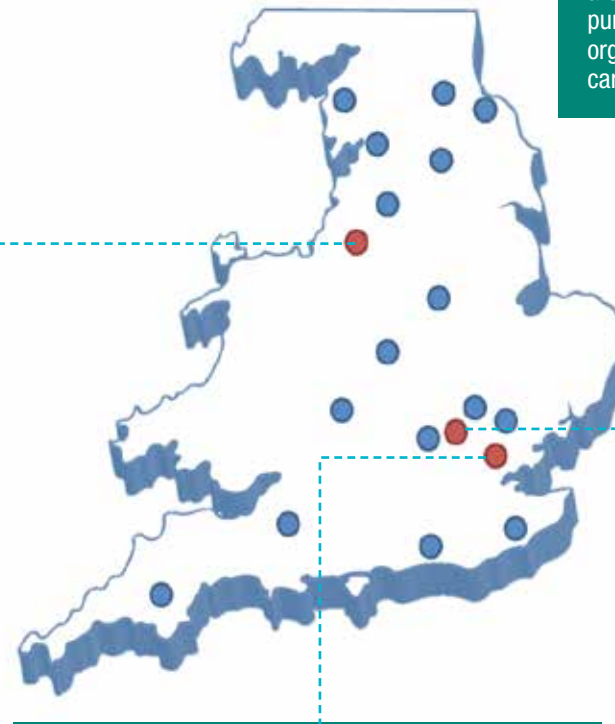
Across **NWL**, **Southwark** and **Warrington** there has been close cooperation with and buy-in from their respective CCGs as well as a strong foundation of previous joint-working.

#### Warrington

**Warrington's** pilot has been focused on sustainably transforming primary care. Its model is based on seven Primary Care Home (PCH) clusters which have been established through collaborative clinical leadership; relational working and whole system engagement; and actions to further integrate wider health and care services. Local commissioning intentions from the CCG and local authority have been aligned to the cluster model, supporting this as a sustainable model.

#### NWL

In **NWL** the Challenge Fund investment was used to advance the formation of networks and federations across the eight constituent CCGs as part of its Whole Systems Transformation Strategy. NWL CCGs have always seen networks and federations as new providers from which primary care services should be contracted from. Many of the CCGs have already contracted federations to deliver services – for example Brent CCG has commissioned the 4 GP networks to deliver extended access “hubs” services, whilst the five inner London CCGs have let a range of out of hospital service contracts (including extended access) to federations in their areas. This approach gives federations income and common purpose – and it is expected that this will help to maintain organisational form and collaborative approaches to primary care delivery, leading to long term change.



#### Southwark

Finally, in **Southwark**, the CCG has allocated funding for activity for three years, and is committed to the long term viability of the extended access and increased collaborative working. This up-front CCG commitment has enabled the pilot team to develop the pilot and its new networks without the immediate pressure of demonstrating impact.

## Reducing demand elsewhere in the system

There has been a statistically significant reduction in minor self-presenting A&E attendances.

Wider system metrics for A&E minor attendances and emergency admissions have regularly been analysed. In addition to this, pilots were requested to submit out of hours contact data as part of their monthly data submissions.

### A&E attendances

Up to May 2015, comparing the weeks that pilot schemes have been live with the same period in the previous year, at an overall programme level, there has been a statistically significant reduction in minor self-presenting A&E attendances<sup>31</sup> by those patients registered to GP practices within Challenge Fund pilot schemes (see Figure 1).

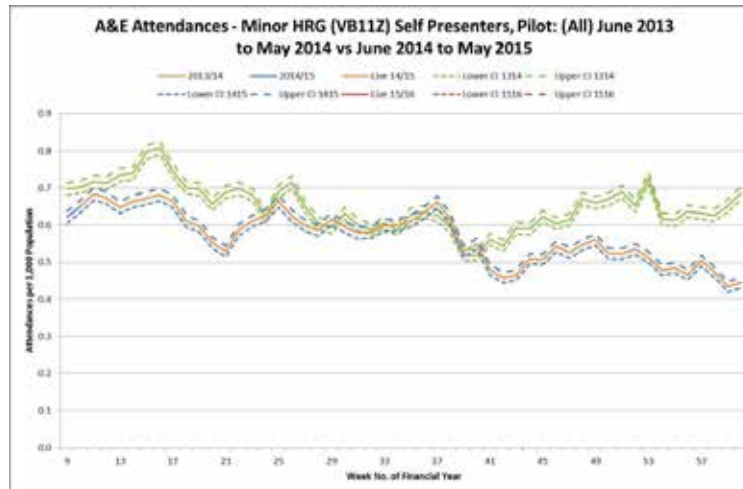


Figure 1: Profile of A&E Attendances 2014/15 versus 2013/14

Overall, this has translated into a reduction of 29,000 minor self-presenting A&E attendances equivalent to a reduction of 15% or 3.0 attendances per 1,000 registered patients<sup>32</sup>. In comparison, using the same data source, nationally there has been a reduction of 7% in minor self-presenting A&E attendances.

13 pilot schemes have shown a reduction in minor self-presenting A&E attendances with the most notable reductions experienced in **BHR, West Hertfordshire, North West London, Morecambe, and Brighton and Hove**. Seven pilot schemes have seen no reduction in minor self-presenting A&E attendances.

In terms of any defining characteristics between pilot schemes which may help explain why some pilot schemes have seen a reduction in the use of A&E departments, it is interesting to note that all four of the largest pilots achieved a positive impact compared with around 50% of both the small and medium size schemes. Identifying the key factors for this will be an area of further work over the coming months.

### Emergency admissions

Similar analysis as that above in relation to the change in emergency admissions to hospital has shown that up to May 2015, the overall programme rate of emergency admissions per population during the live weeks in 2014/15 has been greater than the profile of emergency admissions during the same period in 2013/14 (see Figure 2).

Only five pilot schemes have seen a reduction in emergency admissions during the same time in the preceding year; ranging from a reduction of 1% to over 7%. These pilot schemes are Southwark, Bury, Darlington, Brighton and Hove and Care UK. Most of these pilot schemes are medium sized schemes<sup>33</sup>.

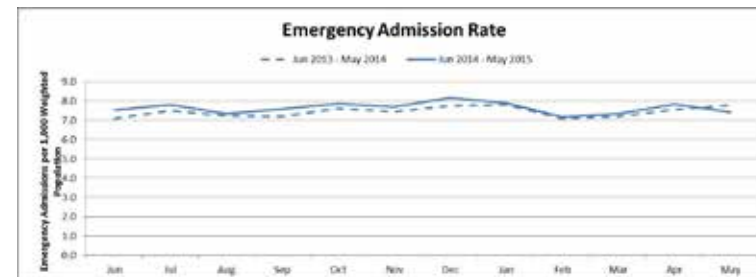


Figure 2: Profile of emergency admissions Between June 2013 and May 2014 compared with June 2014 and May 2015

Of the 20 pilot schemes, 13 have shown a statistical reduction in minor self-presenting A&E attendances.

Only five pilot schemes have shown a marginal reduction in emergency admissions compared to the same time in the preceding year

<sup>31</sup> These have been defined using HRG code VB11Z. Note also that data for 2015/16 may be subject to amendment through the financial year

<sup>32</sup> Note the issue of attribution detailed in the Assumptions and Limitations in Section Two.

<sup>33</sup> as above



Over 40% of respondents to the online staff survey considered that their Challenge Fund pilot was having either a very positive or positive impact for A&E and out of hours service but only 33% of respondents considered that there was a similar impact with regard to NHS 111 services. There is a correlation between the A&E data analysis and those pilots where the staff response has been more positive to the wider system impacts.

### Out of hours contacts

Contact data to support an assessment of the change in the Challenge Fund pilot schemes on local out of hours services has proved difficult to access for some pilot schemes. To date, data related to 15 out of the 20 pilot schemes has been assessed.

Assessing the overall trend in the number of contacts per 1,000 registered patients shows that there has been no discernible change in the use of this service and that the monthly profile is quite variable. This pattern is also evidenced within the majority of individual pilot schemes, with one or two exceptions e.g. Slough.

This may be a product of latent demand and the balance between urgent and bookable appointments being offered during extended working hours by the pilots.

### Findings from local data

Some pilots have undertaken local surveys with patients attending their extended hours services. Whilst findings from these surveys vary, some have shown that if the service had not been available, more than 50% of patients would have waited to see their own GP. The next largest proportion stated that they would have attended their local walk-in centre, urgent care centre or contacted their GP out of hours service. Only a small proportion of patients stated that they would have attended their local A&E department<sup>34</sup>. However, this evidence is not conclusive and one pilot (**BHR**) has reported that between 60-70% of patients using their hubs would have attended A&E if they had not been able to get an appointment at one of the hubs.

### Data Caveats

It is still quite early to be definitive about impacts and for many pilot schemes an impact on the wider system was not set as a primary objective. It would therefore be misleading to interpret those findings of less change as a failure of the pilot schemes.

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<sup>34</sup> These findings are reasonably consistent with the national findings of the GP Patient Survey.

*“Critical to the success of any programme or project is effective knowledge management - how you gather, create, organise, share, analyse and action knowledge”<sup>35</sup>*

NHS IQ

## Facilitating learning to better enable pilots to implement change

Sharing knowledge has been important at different stages throughout the lifecycle of the pilot schemes:

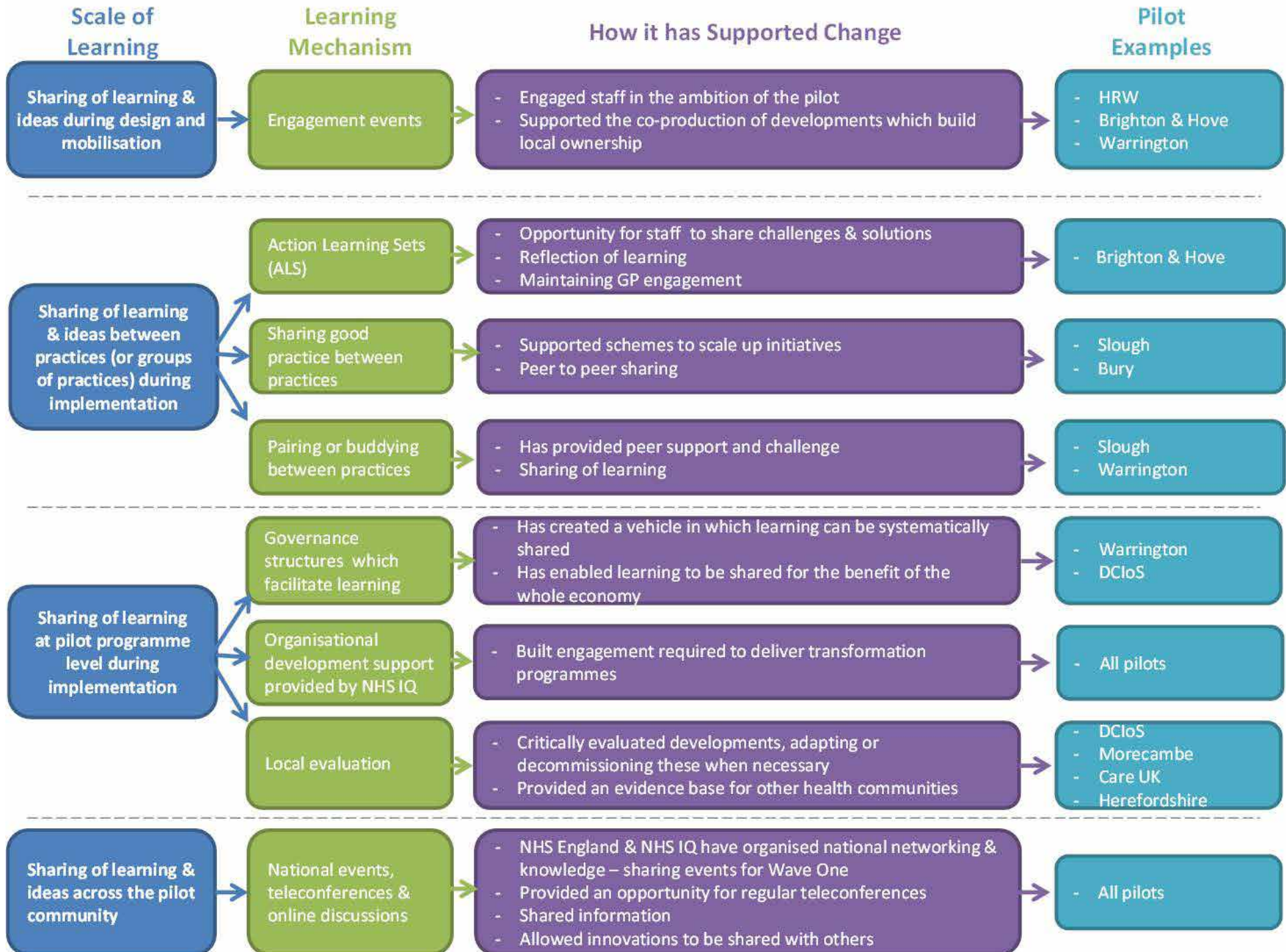
- **Initiation and mobilisation:** for many pilots there was a strong focus on the internal sharing of knowledge and ideas as they designed their programmes. This often included a wide range of primary care professionals including, clinical leads and GPs, practice staff, as well as input from local commissioners and providers.
- **Implementation:** throughout the delivery phase, several pilots established mechanisms to continue the process of learning between practices. In addition, some pilots have been participating in more external facing activities such as liaising with other pilot areas or third parties, as well as utilising the experience and expertise of NHS IQ.
- **Sustainability planning:** the focus in later stages of delivery has been on working with commissioners and undertaking local evaluations to understand the lessons from implementation.

There are many examples of pilot schemes sharing knowledge and learning between their own member practices and local PMCF programme partners. However whilst pilot schemes have been committed to sharing this knowledge internally, evidence of pilots sharing beyond their immediate health economy, are more limited. This may be because pilots are hesitant to share until they understand their local learning.

In addition to this, mechanisms have been established by the national programme and NHSIQ, which have supported exchange of knowledge and ideas and these are generally welcomed by the pilots. Every pilot engaged in this innovation support programme. NHS England recognised the need to share learning between wave one and wave two schemes and established a funded buddying programme to help facilitate this. The intention of this scheme is for self-nominated wave one schemes to share their experiences of challenges faced and learnings from progress to date. Pairings have been made either by geographical location or by matching of themes. Additionally, wave one representatives have led table sessions at national wave two events to encourage a culture of sharing learning. The programme offers to cover backfill costs and travel expenses for the wave one colleagues who are participating in this.



<sup>35</sup> <http://www.nhsiq.nhs.uk/capacity-capability/knowledge-and-intelligence.aspx>



## Tackling health inequalities in the local health economy

Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. Several of the pilot schemes have used the opportunity presented by the Challenge Fund to target projects at geographical areas or population groups where there are known health disparities. This page features some examples:



### Morecambe

In **Morecambe**, a minor ailments scheme is increasing access for patients from certain vulnerable groups (such as those who may be socio-economically deprived) to medications which they might otherwise have to source via a prescription from the GP. As well as ensuring that GP appointments are used appropriately, this initiative is supporting this patient cohort to seek medication earlier, before their condition potentially exacerbates.

### Warrington

In **Warrington**, as well as seeking to create equitable provision of primary care and access across all GP providers, paediatric ambulatory care and integrated services including social care are being prioritised in electoral wards of greatest economic deprivation

### West Wakefield

In **West Wakefield**, the 'HealthPod', a mobile health and social care outreach service has been established for deprived and hard to reach communities. The HealthPod provides health promotion advice, blood pressure tests and access to the Citizens Advice Bureau. As a mobile facility it can be moved to different locations to target the most remote communities. The pilot has reported that this service has managed to reach vulnerable communities such as Gypsy-Roma populations who would have otherwise struggled to access primary care.



## Children and young people



**Slough** has established a programme of health education with children in ten primary schools and the pilot is working with the local authority to develop this project further.

In **Herefordshire**, young people have been targeted via GP outreach interventions into education providers and a community facing app targeted to this audience. Anecdotally, this project is reported to have been successful with both young people and with schools/colleges.

In **NEW Devon**, a children's walk in clinic has been introduced at a practice situated in an urban deprived area. Staffed by a triage practitioner nurse, its opening hours allowed parents to attend after school. The pilot reports that this has improved speed of access for this patient cohort and has offered a more effective approach than telephone assessment.

Other pilot schemes, whilst not addressing health inequalities explicitly, have used Challenge Fund investment to target specific patient groups which are known to be existing high users of primary care services or patient groups who are less engaged with general practice. Some examples are provided below and further detail is provided in the individual pilot reports.

The impact of these developments is yet to be proven and given that they are very area-specific or discrete in their coverage, there is little collective learning that can be disseminated at this stage. More work will be done with these pilots over the next few months to gather evidence on these initiatives.

## Older people and those with long term conditions

**Darlington**, the frail elderly population have been targeted through proactive management to assessments and care planning, undertaken by a new MDT support team.

Within **Torbay and South Devon**, a Proactive Care Team (PACT) has been established which is a multi-agency initiative. This MDT team provides proactive, preventative support to patients identified as being at risk of admission to hospital, and is improving discharge planning for patients in community and acute hospitals to enhance patient flow.

In **Workington**, there has been a focus to standardise care for patients with certain long term conditions. This is being achieved through the recruitment of specialist nurses and the implementation of the 'Year of Care' approach.



## Identifying models that can be replicated in similar health economies elsewhere

### Replicating hub and spoke models

The main model which has been highlighted as having the potential to be replicable across different health economies is in providing extended hours appointments through a number of designated hubs, rather than at all practices. Whilst there is variation in the detail, common features of an effective hub and spoke model include:

- Patients from all member practices can access extended hours appointments and wider services from the hub.
- GPs providing the service have read and write access to patient records.
- Phone systems may also be diverted during extended hours to promote use.
- Modelling has been an important feature in determining the capacity and location of hubs.

### Replicable interventions

Some are already rolling out initiatives beyond the pilot scheme boundary. For example, in **Morecambe**, conversations are underway with the CCG about the replication of their 8am - 8pm '828' GP telephone triage service across the CCG footprint. In addition, both Morecambe and Workington have been trialling local responses to the NWAS (North West Ambulance Service) Pathfinder Scheme which aims to deflect patients away from A&E by providing support and access to the patients care record to paramedics. This learning is being applied to other areas applying the Pathfinder across Cumbria and Lancashire.

Other pilots have highlighted initiatives which have the potential to be replicated across different health economies. For example:

- GP group consultations where a GP will typically see 15 patients with similar needs together i.e. diabetes patients. This approach has been implemented in **Slough**.
- Multi-disciplinary primary or community nursing teams based around groups or clusters of GP practices. Teams are targeted to specific patient cohorts or nursing homes and focus on delivering proactive care. This is being implemented in **DCIoS** and **Warrington**.
- The proactive management of complex patients through multi-disciplinary assessments and care plans. This is being implemented in **Morecambe** and **Warrington**.
- Educational support sessions which are group sessions focused on certain long term conditions such as diabetes. This has been implemented in the EPiC pilot in **Brighton and Hove**.
- The implementation of a Community Specialist Paramedic who reviews patients in A&E to determine whether they could have been more appropriately treated in Primary Care Centre. This has been implemented in **Workington**.

Deriving maximum benefit and value from the Challenge Fund is reliant on the transferability of learning and effective service models to other local health economies.

The hub and spoke delivery model is regarded as a replicable model

Detailed evaluation of the replicability of these initiatives and those models which are indicating success will be undertaken over the next three months, although pilot schemes themselves are already reflecting on this.

### Conditions for success

Whilst detailed evaluation of the potential for replicability will continue to be undertaken as pilot schemes further develop, it is already apparent that for transferability to be achieved effectively, there are a number of contextual factors which must be carefully assessed by organisations looking to replicate others' service models locally. Early findings suggest these include:

The geographic profile and transport infrastructure of a locality is important in terms of the replicability of the model. In some areas, the use of hubs to provide extended access appointments may not be suitable if patients are required to travel long distances to access these sites. **DCIoS** found this to be an issue. Similarly infrastructure such as broadband connectivity is not of the same standard across the country and this needs to be reflected upon when seeking to copy across schemes which rely on mobile working.



Geography  
& context

Local ownership is essential. Models need to be tailored to local context and pathways through stakeholder input and from design through to implementation. Key stakeholders will include patients and GP practice staff, as well as commissioners and other providers in the local health and care system.



Stakeholder  
engagement

Pilot schemes have commented that they consider models would be replicable in "similar sized" health economies although some have also commented that they consider these to be 'scalable' with the appropriate programme management support. For example some have indicated that a sufficient critical mass is required to sustain extended hours service model. A scale which is able to justify the affordability of roles such as extended hours operations managers is required.



Size of health  
economy

The relationships and culture between system partners is also likely to impact the ability of areas to replicate successful models. Commissioner involvement has also been an important feature of the pilots in **West Wakefield, Bristol, NWL, Warrington** and other pilots. In many pilots, PMCF developments have built on a long history of collaboration and engagement and this may be an important prerequisite in successfully replicating one of the Challenge Fund service models.



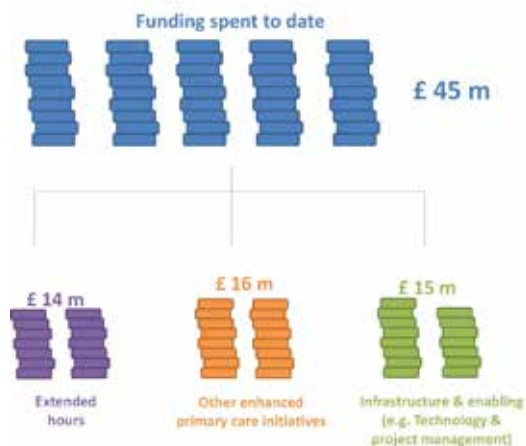
Building on existing  
relationships

Demonstrating value for money and a return on investment is a key requisite for the sustainability of any new initiative.

Overall, pilot schemes have indicated that they have spent a total of £45 million up to the end of March 2015 as part of their original Challenge Fund and matched funding. Beyond this, pilot schemes have identified a further £3.7 million funding as part of their ongoing sustainability for a further 6 months. Of the original funds spent to date, almost £14 million (31%) has been identified as funding for extended access schemes (£10 million on staffing costs and £4 million on non-staff costs including, for some pilots, one-off technology costs) with a further £16 million (36%) used to support other clinical initiatives being implemented by the pilot schemes. The remaining £15 million (33%) has been used to support infrastructure and enabling activities such as technology developments and programme management.

### Extended access

As set out in Objective 1, extrapolating the metric data to include all pilot schemes, then potentially an additional 70,000 hours and 400,000 appointments had been provided through extended access hours up to May 2015. If we assumed that the additional estimated extended hours across all pilot schemes up to March 2015 were funded through the Challenge Fund monies spent on extended access up to the end of March 2015, then the average cost per extended hour is £233 and the cost per available appointment is £43.



However, given the limitations with some of the activity metric data, in terms of refining the assessment on the value for money of extended access services, the analysis can only be properly conducted using a subset of the pilot schemes. Further caveats to this assessment also centre on the need for further clarity from some pilot schemes of the extent to which funds up to the end of March 2015 were all spent or whether some of this original funding has been vired and used in combination with the further funding for sustainability post March 2015.

Analysing schemes with complete and clear data, the cost per additional hour to support extended hours working within a hub and spoke model is typically in the range of £200 - £280 of which the hourly cost of the GP may represent 50% or more of this. The remainder of the cost is accounted for by other staff, overheads and other supporting activity costs, including premises and technology. It is important to note that depending on how pilot schemes have recorded their metric data some of the cost per hour of 'Other' staff may include GP staff time. The average cost per available appointment in extended hours is typically in the range of £30 to £50.

On the assumption that this analysis provides a reasonable estimate then, even given that this work is undertaken during unsocial hours, the cost per hour and appointment to support extended access is more expensive compared with the average GP hourly rate<sup>36</sup> but not out of line with the cost of locum GPs. This is likely to be expected for a pilot scheme with economies of scale, such as permanent contracts, only making an impact over a longer time period. The value for money is further negatively influenced when utilisation of the extended access service is factored in. A number of respondents to the staff survey have drawn a similar conclusion and questioned the cost effectiveness and value for money of extended hours access; particularly at the weekend, most notably Sundays.

In comparison with Out of Hours<sup>37</sup> the cost per additional appointment used during extended hours is less expensive.

<sup>36</sup> Based on average GP salary cost only. This assumes an average salary of £92,900 and is taken from GP Earnings and Expenses 2012/13, Health and Social Care Information Centre, September 2014. A 46 week working year and a 40 hour working week are also assumed.

<sup>37</sup> Out of hours GP services in England, National Audit Office, September 2014.

In **Brighton & Hove** introducing more telephone contacts resulted in an average monthly increase in hours and appointments during core working hours of 8% and 17% respectively.

However, there is variation across the pilot schemes and more work is required to tease out the subtleties of individual pilot scheme data returns to ensure that we can match more closely the profile of financial spend with the metric analysis. This will then provide a more accurate assessment of the cost effectiveness of providing extended access services.

### New modes of contact

As a product of some of the other supporting activities being implemented and, in particular, the introduction of new modes of contacts and new staff practitioner types, pilot schemes have been successful in reducing the length of the appointment time. In particular, many pilot schemes have been piloting advanced nursing and other clinical support staff appointments, and telephone and online consultations. At an overall level, the number of available appointments per core working hour has increased by 6% and during extended working hours by 33% .

In **Birmingham**. The mode of contact by telephone during core working hours has changed from 38% in the baseline to around 60%.

In relation to alternative staff practitioners to free up GP staff time which the Challenge Fund initiative has supported includes:

- **Bristol, North Somerset and South Gloucestershire** pilot scheme which up to March 2015 has invested £477,000 in its channel shift initiative to divert work from GPs to appropriately qualified clinical staff such as nurses and allied health professionals. Fifty per cent of available hours are supported by these staff who have provided around 460,000 available contacts between August 2014 and March 2015.
- **Brighton & Hove** pilot scheme where the investment of £43,000 to date has supported an additional 1,500 hours of pharmacist time; an average cost per hour of £29.
- Social prescribing at the **West Wakefield** pilot scheme. Since going live, this scheme has provided almost 3,600 additional hours at the end of March 2015. This scheme provides health and social care advice and is designed as an outreach service for deprived and hard to reach communities. The cost of this initiative has been almost £80,000, an average cost of £22 per hour.
- **South Kent Coast** pilot scheme's investment of £135,000 in paramedic practitioners and releasing GP time.

Typically, the use of these alternative clinical practitioners to support primary care services cost less than the cost of the GP's time; typically 50% of an average GP salary. Hence, on the assumption that these clinical practitioners are providing a direct substitution of services which would have traditionally been provided by a GP and are achieving similar outcomes, then this represents a significant cost saving.

**NWL, Southwark and Warrington** have used PMCF resources to establish sustainable models for future delivery

In relation to new modes of patient contacts, a number of pilot schemes have implemented telephone triage and consultation and online appointment services. These telephone appointments typically are half the length of face to face consultations and hence for every face to face consultation a GP could have undertaken two telephone consultations. This has therefore helped to support the growing demand for access to primary care services; either unmet need or latent demand. However, it is acknowledged that some consultations cannot be dealt with entirely over the phone. In terms of assessing the return on investment in the telephony systems being implemented by pilot schemes, it is possible to assess the extra patient consultations being offered or used by telephone which, if not available, would have required a face to face appointment, and hence a saving in GP time<sup>38</sup> against the investment in technology being made.

### Examples of these include:

Pilot	Investment in Technology	Additional Telephone Appointments	Return on Investment
Brighton & Hove (telephone based triage)	£186,000	More than 77,000 additional used telephone appointments	Assuming a saving of 6,400 hours of GP face to face time with patients to date, this has achieved an opportunity cost saving of £324,000. This has more than offset the cost of the investment in new technology
Herefordshire	£48,000	23,000 additional telephone appointments have been provided to patients during core working hours	Assuming a saving of 1,900 hours of GP face to face time with patients to date, this has achieved an opportunity cost saving of £97,000; more than offsetting its investment in new technology
Birmingham	£222,000 <sup>39</sup>	26,000 core hour telephone appointments have been made available	Assuming a saving of 13,000 face-to-face consultations, the saving in GP time to date is £108,000. Running this scheme for a further 7 months would result in a positive return on investment
Morecambe (telephone based triage)	£30,000	10,600 telephone appointments available during extended working hours	Assuming a saving of 880 hours of GP face to face time with patients to date, this has achieved an opportunity cost saving of £45,000; again more than offsetting its investment

<sup>38</sup> Based on average GP salary cost only. This assumes an average salary of £92,900 and is taken from GP Earnings and Expenses 2012/13, Health and Social Care Information Centre, September 2014. A 46 week working year and a 40 working week are also assumed.

<sup>39</sup> This represents a total spend in technology and may overstate the expenditure in telephony infrastructure.



This is an encouraging outcome to date.

Further work is required to understand the impact of these new ways of consulting, including issues of continuity, equality and supply induced utilisation.

### **Impact on the wider system**

As was highlighted in Objective 2, across all pilot schemes a reduction of 29,500 minor self-presenting A&E attendances had been observed up to the end of May 2015. Notwithstanding the complexity of attributing cause and effect between the Challenge Fund Programme and the reduction in A&E attendances, it nonetheless represents an impact on A&E Departments both in terms of staffing and financial resources.

Focussing on those 13 pilot schemes with a reduction in minor A&E attendances observed during the time that each pilot scheme has gone live with implementing its initiatives compared with the same time period in the previous year, the overall reduction is 34,000 attendances. Assuming that these levels of reduction continue to be observed within each of these pilot schemes, then extrapolation for a full financial year would yield an overall reduction in minor A&E attendances of 56,000. In terms of financial savings, this would generate a reduction in expenditure for commissioners of £3.2 million. This saving would, of course, need to be offset against the investment in primary care. Whilst further work and data points are needed to justify this estimate and understand better the key factors influencing the effectiveness of different models of care on the use of A&E services, for simple illustrative purposes only at this stage, if this change was seen at a national level then the savings could be between £17 million to £24 million. As above, savings would be offset against the investment in primary care.

For emergency admissions and out of hours, to date there has been no observed change at a programme level. For the former, this may not be entirely unexpected.

# SECTION SIX: What has enabled innovation and change?

Pilots have highlighted some key conditions for success that have enabled them to introduce innovation and change. There has been considerable consensus around the factors which have been instrumental to their achievements. Other local health economies seeking to introduce collaborative working would do well to consider these enablers as they design and implement their own primary care programmes.

## Pre-existing relationships

The importance of building on existing relationships has been stressed by many of the pilots; these relationships provide a useful platform from which to build more formalised collaborative working.

For example, **Brighton and Hove**, the pilot is managed by the Brighton and Hove Integrated Care Service (BICS), a pre-existing organisation with experience in delivering primary care. In addition, the networks formed as part of this pilot were determined by practices with a history of working collaboratively. In **West Wakefield**, the six GP practices have a track record of working together on their Health Care Integration Board, which has been in place for two years. This provided a strong platform for creating a federation of GPs that ultimately supported the pilot's delivery of extended access to primary care and supported its successful application to be a Vanguard site.

## Effective leadership and project management

The importance of specific individuals in developing buy-in and recognition has been key. Articulation of a clear vision allows buy-in at all levels. In terms of project management, making additional dedicated resource available and using the different skills in teams appropriately have been crucial elements.

In both **Darlington and Watford** specific individuals leading the pilots were seen as pivotal in developing recognition and buy-in locally. **Morecambe** ensured that implementation was supported by a small project team with defined roles. As the project manager led on actions which did not require clinical input, decisions could be made in a timely manner and momentum was maintained. This allowed the service to be rapidly designed and implemented, with the 8am - 8pm service live from August 2014.

## Remaining flexible to change

As is to be expected with a programme focused on piloting innovative primary care approaches there have been unanticipated challenges. In order to succeed, pilots have had to be responsive to emerging lessons, adapt to patterns of demand and supply, and overcome process delays. Demonstrating this flexibility has been essential in order to provide solutions which are aligned to the needs of the local health economy.

Where significant service changes have been deemed necessary to maximise the efficient use of resources, pilots have consulted with NHS England.

An enabler cited by many pilots is the importance of remaining open to change



Effective leadership and project management have been central to successful implementation and managing risks.

A clear vision that allows for staff to understand and buy in to the goals of the change is important.

**Morecambe:** funding has been diverted away from the weekend X-Ray service (due to low patient demand) and app (as an appropriate app platform to meet the pilot's scope could not be found). Instead, this portion of funding has been used to fund the Community Deep Vein Thrombosis service, the minor ailments scheme, as well as additional investment for Florence, a self-management app for registered patients with long term conditions.

**West Wakefield:** whilst many GPs were positive about implementing video consultations, there were not enough resources locally for GPs to staff this. Responding to this challenge, the pilot is trialling the service with nurse consultations, making the most of available resources and utilising a multi-disciplinary model, rather than abandoning the initiative.



## Phased implementation

Phased implementation, whereby mobilisation is split up into more manageable stages and staggered over a stretch of weeks or months, has seen a number of benefits. These include the opportunity to share learning between each stage of implementation, increased efficiencies in later stages of implementation, the facility to adapt to the changing needs of the local pilot.

Consultation and engagement with member practices, both early on and throughout, has been critical in shaping pilots and developing buy-in.

In **Warrington**, for example, practices have had the flexibility to focus on projects which are most relevant to them and their local population. For example, the Central West cluster has focused care co-ordination on their elderly population and household population, whereas the paediatric ambulatory care project is being developed by the Central North cluster. Projects are designed and tested ahead of rolling out throughout the clusters more widely. This approach also allows for evaluation and learning to be embedded.

More than half of pilots anticipated change to their initial plans and subsequently chose to adopt a 'phased approach' to delivery

The phased approaches to implementation in **Brighton and Hove** and **Care UK** were intentional. The pilots considered that implementing extended access across all practices at once would have been too much of a risk. Care UK invested considerable effort in recording lessons learnt, logging conversations at the central hub and auditing each process for future reference. Whilst this effort was labour intensive at the start of the project, it enabled initiatives such as enhanced WebGP and interactive texting to be brought forward ahead of schedule. In Brighton and Hove's case, the phased approach meant that those practices going live later could learn from the lessons of the faster starters, increasing efficiency in their own implementation.



## Engaging with practices

### Engagement during mobilisation

Many pilots undertook extensive practice engagement at the start of their schemes. For very large pilots this was quite a challenge due to their coverage. In **NHS NWL**, the pilot's central transformation team visited each practice at the outset, to explain the aims and objectives of the PMCF and listen to questions and concerns. A dedicated project manager has been assigned to each CCG allowing relationships and buy-in to develop through a single point of contact. **Workington's** experience of early engagement to capture staff and patients' local knowledge to inform primary care projects benefited them. The pilot ran an event for all staff, both clinical and non-clinical, to outline the programme and staff suggested ideas for initiatives; it was a bottom-up development process. For **Southwark**, engagement with

both clinical and non-clinical practice staff has been central to successful implementation; receptionists are particularly critical as they are often involved in booking patients into new appointment slots or services.

### Ongoing engagement

Beyond initial implementation, some pilots put in considerable effort to maintain regular channels of communication between the project leadership and practice staff. **Warrington** and **Brighton and Hove** both circulate a newsletter. Brighton and Hove has also developed two 'action learning sets', with bi-monthly meetings to provide the opportunity for practice staff to share challenges and solutions. These sessions have allowed the programme to be more agile and responsive to concerns, injecting flexibility and also keeping GPs on board.

## Engaging with patients

Patient engagement has been achieved in various ways across the pilots. Some pilots have focused on this more than others and it has been less of a consistent feature than practice engagement.

**Slough** has implemented a number of initiatives surrounding patient engagement and communication. The pilot has set up a Patient Representative Group (PRG) as part of pilot governance, which comprises patient representatives from across Slough's practices and is the primary channel to engage and communicate with patients. Slough has engaged the local authority and voluntary sector to help reach wider groups of people. This enabled views of those from wider age groups and those who are not part of the PRG, to be captured. In addition to this, two waves of patient surveys have been undertaken to capture real-time patient feedback (October and December 2014). The pilot also has a number of patient-led projects which involve patients and front-line staff in the co-design, such as:

- The 'Simple Words' project, which sets out to improve communications between GPs and patients.
- Self-help groups focused on peer support and self-management.
- Action learning groups which focus on patient representative experience and in developing personal leadership skills.
- A wellbeing programme involving voluntary patient navigators, supporting an online sign-posting portal to local sources of information and support.

Slough considers that successful patient engagement has helped to secure a high take up of the extended access appointments by securing patient buy-in and raising awareness of the pilot across Slough. Clinicians have also benefitted from learning about patient experiences of primary care and that this is leading to service improvements at practices.



Engaging with patients is an essential part of developing buy-in maximising utilisation and gathering feedback to inform ongoing improvement.

**Brighton and Hove** created a 'Citizen's Board' to gather patient and community viewpoints on programme development and implementation. The Citizen's Board holds the programme to account and has provided useful input around communication and how to tackle low utilisation issues. **Care UK** has put in place a number of channels to capture patient views (such as a complaints options on the Care UK website, paper comment slips in practices and text surveys to those who have used the extended hours service). The outputs of these feedback channels have informed delivery of the service, and supported business cases to amend delivery to better suit the needs of patients.

It is recognised that changing patient behaviours, however, does take time and this will not be achieved after a year of implementation.

### Close working with the CCG

The involvement of commissioners in PMCF pilot working is essential for adopting sustainable and more dynamic primary care provision. Those pilots which have secured funding to maintain their initiatives beyond the lifetime of PMCF have cited working closely with their CCG as one of the key enablers.

In **Warrington** both the CCG and Local Authority Commissioners have a place on the CIC Board. Aligned to this, the cluster based model is reflected in the commissioning intentions of these organisations.

In **Bristol**, the current Consortium directly involves the CCGs in all three areas (Bristol, North Somerset and South Gloucestershire). The team considers it a good sign that CCGs want to collaborate with One Care and a sign of recognition that this project is part of the solution, not a new problem to overcome. Involvement of the CCG throughout the design and implementation phases of the project has meant that sustainability was a key consideration from the onset.

**West Wakefield** has stated that regular contact with the CCG fostered a strong working relationship and provided a forum to have open and constructive discussions about pilot design and delivery; this ultimately led to faster mobilisation when implementing schemes and better outcomes. The pilot went live with extended hours across all practices in November 2014.

A number of pilots (such as **Slough, NWL, Southwark and Derbyshire and Nottinghamshire**) have reported that close alignment between PMCF objectives and the wider CCG strategies have provided impetus for the delivery of the project. In the case of NWL, its PMCF model was designed to

specifically align with existing initiatives taking place within the eight CCGs in the pilot area (Whole Systems Integrated Care and Shaping a Healthier Future). In Southwark, the alignment with its urgent care commissioning strategy and, particularly, the primary and community care strategy provided momentum and a context for championing improvements to GP and primary care as practices have seen this as part of a much wider context. Similarly Kernow CCG in **DCIoS** used its share of PMCF investment to support its wider objectives on urgent care and transformational change. This gave PMCF credibility and momentum early on and has also helped to ensure the legacy and sustainability of PMCF.

### Use of existing resources and infrastructure

Using existing resources and infrastructure to deliver PMCF services has helped pilots to reduce the amount of time and investment needed to implement new services.

The most common use of existing resources is GP surgery locations to facilitate extended hours and additional interventions. Nine pilots are utilising GP surgeries to host PMCF initiatives. Other pilots are using hospitals, out of hours facilities and walk in centres.



It is not necessary to reinvent the wheel. Take opportunities to build on existing success.



Alignment with and buy-in from CCGs as a key enabler to the success and progress of PMCF schemes

#### Care UK

**Care UK** has utilised its existing NHS 111 central telephony infrastructure to offer clinical telephone treatment beyond 8am-8pm to registered patients. Many of the call handlers employed by the pilot already had prior experience of this type of offer through 111 and the pilot was able to use its existing 111 call centre location.

Care UK national pilot

8 practices

45,000 patient population

#### Morecambe

The **Morecambe** pilot implemented a community Deep Vein Thrombosis (DVT) service by utilising clinical expertise and availability of the existing same day service (SDS) team. PMCF funding was used to procure testing equipment needed to diagnose DVT. By utilising this existing resource the pilot has been able to provide patients with access to care in a more convenient location.

Morecambe

5 practices

61,000 patient population

# SECTION SEVEN: What barriers and challenges have been faced?

7

Pilots have experienced barriers in the implementation of their Challenge Fund initiatives. Again there has been considerable agreement over which issues have been most challenging.

## GP capacity

There have been issues in terms of GPs lacking the capacity to deliver additional services and GPs being reluctant to deliver additional sessions outside of core hours. Two pilots reported both GP capacity and GP willingness to participate constraints; an additional eight pilots recorded GP reluctance to staff extended hours, with Friday evening and weekend appointments fairing the worst.

Some pilots have sought to overcome these challenges by offering a financial incentive to deliver extended hours services. Both **Darlington** and **Morecambe** pilots offered financial incentives in the form of slightly higher rates of pay for weekend sessions; Morecambe also attempted to attract GPs by limiting appointments delivered at the weekend to patients from the GPs' own practices.

Some pilots cite that GPs simply do not have the capacity to deliver PMCF services. For example **Bristol and partners** reported difficulties implementing additional hours of GP time particularly at weekends, with GPs feeding back that they already work long hours. **Bury** has found resourcing GPs during weekday evening sessions to be a challenge. The pilot reports that this has been due to the inconvenience for GPs of having to travel to a different location to deliver the service after work and because many GPs have other commitments such as practice management, CCG meetings and professional development. It has sought to address this by offering financial incentives, contacting GPs working in neighbouring CCGs, and writing to local GPs who do not currently deliver extended working hours to promote the service.

## Recruitment

The challenge that many pilots have experienced around recruitment is linked to capacity issues.

**Warrington** has found recruiting GPs to be a key challenge; as has **DCIoS**, which knew that filling GP posts was problematic prior to PMCF. Therefore, it developed projects which involved the use of other health practitioners (such as nurses and occupational therapists).

Perhaps even more than GPs, attracting nurses, particularly ANPs and other nursing staff has proved to be very challenging. A critical shortage of ANPs, limited timeframes within the lifetime of the pilots to train ANPs and temporary contracts have meant that several pilots (such as **Brighton and Hove, Care UK, Morecambe** and **Derbyshire and Nottinghamshire**) have struggled to recruit sufficient numbers. **Slough**, and other pilots have struggled to recruit other specialist nurses and healthcare assistants.

Nottingham North East CCG in the **Derbyshire and Nottinghamshire** pilot report that they were unable to fully implement their pilot due to limited ANP capacity to support their proposed hub. **Morecambe** also reported difficulty in employing nursing staff for its specialist cancer nursing team and as a result, had to decommission the initiative and divert funding into other areas.

The issue around short-term contracts associated with the pilot schemes are likely to have exacerbated the recruitment challenges experienced in delivering PMCF initiatives. Whilst this issue may affect wave two Challenge Fund schemes, it may not be as problematic if ANP use becomes commissioned as a long-term approach.

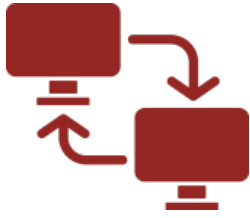


At least seven pilots cite difficulty in recruiting ANPs or specialist nurses



A number of pilots have experienced difficulties sourcing the GP capacity needed to deliver their PMCF services

The use of locum doctors to fill gaps in GP shortages has been recorded in six of the 20 pilots.



## IT systems

As a result of the IT challenges NHS England has introduced a specific programme of support for wave two pilots.

### Interoperability

There are numerous IT service providers that practices and other health providers can use to record appointments and patient records (EMIS Web, SystemOne, INPS Vision, Adastral and Microtest to name a few). Creating a solution that allows IT interoperability across these varying systems, so that GPs, clinicians and receptionist staff can access and update patient notes, has proven particularly challenging to the wave one pilots.

Some pilots (**HRW** and **Watford**) trialled a Medical Interoperability Gateway (MIG) between systems. This forms a bridge between two systems. However, the MIG can only provide access to a limited amount of patient data, so is not necessarily a sustainable solution.

Both Erewash CCG in **Derbyshire and Nottinghamshire** and **BHR** encountered issues with sharing patient records. As a medium term solution these pilots resorted to using Adastral, which facilitates automatic forwarding of details and notes from an extended access appointment to the patient's practice for addition to the patient's record, rather than allowing the extended hours GP to access or amend patient records directly.

### Limitations of IT providers

In some cases the limited flexibility of the IT providers has restricted PMCF related initiatives.

#### Workington

Currently all five practices in **Workington** use INPS Vision. This system prevents nurses working in Workington using a single tablet iPad that works across all five practices; instead, they would need a tablet per practice and the costs of this are deemed prohibitive. Nurses are therefore required to complete their visits, take manual notes and return to the office to transfer them onto the system, which is not as efficient. Also poor or no wireless internet connection in local care homes meant that the frail elderly assessment team and care homes nurses were unable to utilise mobile working technology, and had to return to their practice to write up their patient notes.

Configuring usable and reliable IT systems to support joint primary care initiatives and shared working arrangements has been one of the primary barriers facing pilots.

11 out of 20 pilots had practices using different IT systems

#### Bury

**Bury** highlighted limited IT provider capacity to prioritise their development, highlighting that GPs in extended working hours cannot print prescriptions electronically which is limiting the pilots' ability to reach full capacity of appointments.



#### Herefordshire

In **Herefordshire**, a pitfall was encountered because of limited broadband capacity in local care homes, which prevented the implementation of remote appointments with GPs via videolink.



#### Watford

**Watford** originally commissioned BT to deliver its telemedicine solution however it emerged that they were unable to meet requirements and the pilot had to procure an alternative provider. This caused considerable delays to the project.





## Contractual, procurement and legal issues

### Indemnity insurance

There has been a lack of understanding about the difference between out-of-hours services and extended access and there is a current lack of suitable insurance products to cover new ways of working. Issues with indemnity insurance have led not only to increased costs but also to delays or the need to scale back original plans. For **Brighton and Hove** the considerable unforeseen cost prevented them pursuing other initiatives; for example, they wanted to target patients who were house bound by involving paramedics, but indemnity insurance challenges prevented this. **HRW** had hoped to utilise nurses more in staffing PMCF services but the prohibitive cost of indemnity insurance meant that this has not been possible. It has also meant that certain nurse-provided services cannot be offered in extended hours services (e.g. ear syringing, taking blood).

Other pilots have been able to overcome insurance issues; **Workington** was advised by their provider that individual indemnity cover would be quicker to obtain than the cheaper group scheme. As such the pilot secured individual indemnity cover initially and intends to transfer to the cheaper group scheme and receive a reimbursement for the costs in the near future. In **Slough** the pilot came to an agreement with the insurance provider and an annual charge was agreed to enable nurses to see patients from different practices.

### Care Quality Commission registration

The need for Care Quality Commission (CQC) registration for hubs and federations was an unexpected additional cost and has acted as a barrier to implementation for some pilots. In **Herefordshire** the host site for the hub already had CQC registration, however, because patients from other practices needed to access the hub for treatment, it was necessary to seek CQC registration again as a separate additional practice. Rushcliffe CCG in **Derbyshire and Nottinghamshire** reported that its main barrier was obtaining CQC registration; as a result their hub opened two months later than planned. **Southwark** struggled to acquire CQC registration within the timeframe required and had to escalate the issue to NHS England for support. Recent guidance has since been developed.

### Information governance (IG)

It is recognised by NHS England that the legal framework governing the use of personal confidential data in health care is complex. It includes the NHS Act 2006, the Health and Social Care Act 2012, the Data Protection Act, and the Human Rights Act. The law is intended to allow personal data to be shared between those offering care directly to patients but it protects patients'

confidentiality when data about them are used for other purposes. As a result, some of the pilots have encountered considerable issues in this area.

**Warrington and Herefordshire** are two examples of pilots which have come up against complex legal inter-practice agreements to enable cluster-based working across practice boundaries. In **Warrington's** case, both legal and data sharing agreements have had to incorporate clauses which reflect that care delivered will incorporate both reactive primary care but also proactive care.

Although the physical development of the data sharing agreement in **Herefordshire** was completed over two months, getting to a point where the practices were in a position to sign up to the agreement took significantly longer. The biggest delays were caused by:

- Waiting for the IG and legal reviews of the data sharing agreement to be completed and the final version to be available for signing.
- Waiting for all 24 practices to be IG Level 2 compliant before they could legally sign the Data Sharing Agreement.

## Collection of data

As mentioned above practices involved in the wave one pilot programme use various different clinical systems. This fragmentation and lack of consistency has had an impact on the collection and accuracy of data and the monitoring of trends. **Bristol and partners** have reported that requests for information have at times been confusing and the sheer volume of requests has meant that the pilot team are often too busy to manage these effectively.

A few pilots (such as **Brighton and Hove, Bury and Southwark**) have found the data monitoring process to be burdensome and resource intensive. Brighton and Hove has recognised that the task of extracting the relevant data and the capacity required was underestimated and that even the most experienced practice managers struggled with this aspect of the project.

Several pilots have stated that additional central support from NHS England would have been beneficial as well as best practice on collection methods. For wave two, in acknowledgement of these challenges, NHS England are looking to develop a more systematic data extraction system to help pilots.

Many pilots have sought NHS England central support to help overcome CQC registration delays

Herefordshire found there to be significant value in commissioning an independent IG consultant to develop a data sharing agreement.



Some pilots had to employ dedicated resource to support member practices in gathering the data required for evaluation

Most pilots have encountered contractual, procurement or legal issues in establishing their primary care models.

At least half of the pilots encountered difficulties securing affordable indemnity insurance for professionals delivering extended hours services.

## Conclusions to date

### Extended hours

Collectively the pilots have been successful at providing additional appointment GP time as well as providing more hours for patients to access other clinicians. The feedback from across the wave one pilots is clear in that some extended hours slots have proved more successful than others. Whereas weekday slots have been well-utilised, patient demand for routine appointments on Sundays has been very low.

Over half of the pilots have reported very low utilisation on Sundays

Based on the evidence on current provision and utilisation of extended hours it is suggested that 41-51 total extended hours per week are required per 100,000 registered population in order to meet the levels of demand experienced in these pilots; of these 30-37 hours should be GP hours. Given reported low utilisation on Sundays in most locations, additional hours are most likely to be well utilised if provided during the week or on Saturdays (particularly Saturday mornings). Furthermore, where pilots do choose to make some appointment hours available at the weekend, evidence to date suggests that these might best be reserved for urgent care rather than pre-bookable slots

### Contact modes

The Challenge Fund has considerably increased the number of patients who have a choice of modes by which they can contact and have an appointment with their GP. To date telephone-based GP consultation models have proved most popular and successful. There is growing evidence to suggest that investment in telephony infrastructure can be cost effective due to the GP time savings that are being achieved. More work needs to be done to understand the appropriate pilot scale and model that will realise most savings (i.e. a central call centre or individual practice telephone systems) and also deliver optimum patient and staff satisfaction, particularly in view of the importance of continuity of care for some patients.

Other non-traditional modes of contact (for example video or e-consultations) have yet to prove any significant benefits and have had low patient take-up; this will continue to be monitored.

### Collaboration and skills mix

Integration of other practitioners into primary care provision has been successful in almost all cases. Joint working with ANPs, pharmacists, the voluntary sector, care homes, physiotherapists and paramedics has released local GP capacity and more appropriately matched the needs of patients with practitioners. Collaboration has proved most effective when established working relationships have been built upon, engagement happens early on and there is buy-in from GPs and provider partners to a shared vision. Practices report that it is also often necessary to redesign care processes or other staff's working patterns to gain the full benefit of new roles.

### Mobilisation and implementation

Effective mobilisation and implementation rely on a variety of factors. Most notably they require clinical leadership to secure and maintain GP buy-in; dedicated project management to drive change forward; sustained practice and patient engagement to ensure initiatives are positively received; and utilisation of existing resources (such as premises, staff and infrastructure) to minimise set-up and recruitment challenges. Successful pilot delivery teams need to be agile and responsive, adapting to lessons learned along the way. Phasing delivery also helps to manage implementation risks and workload during the resource intensive set-up stage.

### Scale and scope

The wave one pilots are very different in terms of their size and coverage. From the analysis undertaken to date there does not seem to be a 'perfect size' but size is a factor in achieving different outcomes. For example evidence suggests that smaller pilots are quicker to mobilise and find it easier to engage and maintain exposure with both practices and patients. However, larger pilots have the benefits of economies of scale and are perhaps better placed to achieve system-wide change. Wave one pilots suggest that federations will be most successful when they are 'naturally-forming', based on pre-existing relationships rather than being driven only by size.



Also relevant to consider are the different approaches adopted. All pilots have been ambitious. However, some have focused their attention on a relatively discrete set of objectives or deliverables, whilst others have chosen to trial a wide menu of projects simultaneously. A very broad scope of work can in itself act as a barrier to rapid progress.

### **Understanding the local context and demand**

Understanding the pattern of demand locally is important in order to provide the most relevant and value for money service for patients. The size of the local health economy, maturity of partner relationships, geographic profile and transport infrastructure are all key factors. An urban solution may not be appropriate for a rural local health economy for example. For any localities seeking to replicate wave one pilot models it will be critical to ensure that initiatives are locally tailored, bearing in mind these contextual factors.

### **Transformational change**

The establishment of federations and networks and delivery via hub and spoke models marks a culture change in primary care and in most pilot areas provides or fortifies the platform for transformational change. Where there is clear alignment with other CCG strategies (such as urgent care, integration with social care or reconfiguration of acute provision) the contribution of these developments is maximised. This change programme has also prompted federations to build their capabilities in leadership, management, service redesign and business intelligence, providing a more solid foundation for future service transformation.

### **Learning and sharing knowledge**

Sharing knowledge and lessons among participating practices has occurred at pilot level, with feedback loops and learning mechanisms established locally by the majority of pilots.

Sharing between pilots and with the rest of the NHS has been facilitated by the national programme, with a few pilots undertaking their own dissemination as well. New lessons continue to emerge from wave one pilots' experience and it is important to retain flexibility in programme delivery in order to respond to them. It also remains imperative that this learning is constructively collated and shared with the wider primary care community to ensure that others are able to direct efforts into effective and proven initiatives.

### **Challenges**

The achievements that pilots have made have not been without challenges. Many of these challenges have been process related and have caused mobilisation delays and had cost implications. IT interoperability, information governance, securing indemnity insurance and CQC registration are the most commonly cited process barriers. Acknowledging these issues, NHS England has established support for wave two pilots to ease and expedite mobilisation of their programmes and minimise duplication of effort in resolving common problems.

### **Sustainability**

In order to sustain those initiatives that are demonstrating positive impacts, CCG support and buy-in is critical. Pilot programmes which are co-designed by CCGs or have engaged commissioners throughout implementation are better placed to secure future funding. This is especially the case given that the timescales of pilot delivery and commissioner planning have not necessarily aligned. As pilots were not able to demonstrate impacts early enough to influence spending decisions; close working with commissioners as well as undertaking locally appropriate evaluation makes it easier to reassure them of anticipated benefits.

### **Capacity in the system**

Wave one pilots did experience some capacity issues, which often manifested as difficulties in recruiting or competing with OOH providers for GP time. The short term nature of the contracts of the pilot schemes also contributed to this. There remains some concerns around the availability of ANPs in particular, which are likely to be exacerbated as more local health economies press ahead with seven day services and introduce skills mix. Similarly, to date some pilots have relied on incentivising GPs to resource PMCF initiatives and this may not be sustainable in the long term. These are issues likely to face all local health economies progressing towards extended access service models.

### **Equality of access**

Some wave one pilots have reported inequalities to access whereby patients whose practice is a hub have benefitted more from extended access initiatives than those whose practice is not. Rotation of hubs can be a way of overcoming this issue, although it may create other logistical issues. In addition, by the very nature of a pilot programme, there is potential to create some access inequities within local health economies because patients' access to new and enhanced services is dependent on whether their practice is a member of the pilot scheme or not. This issue could arise where not all practices within a CCG are participating in a pilot. However, this latter issue is unlikely to be a long term problem given the national agenda and move towards extended hours countrywide.

### **Benefits of working together**

The hub and spoke models and federated delivery enable practices to deliver a wider range of services to patients over more hours in the week. Large and small pilots have also highlighted some wider benefits that can be achieved through collaboration. For example, working together has made it possible to share new specialist staff or resources and has created a 'critical mass' enabling them to negotiate better deals, attract additional support or assist in recruitment. However, as more federations are established nationwide in response to the Challenge Fund and the seven day services agenda, any competitive advantage, particularly with regard to recruitment, might be short-lived.

### **Added value**

The Challenge Fund has provided a much-welcomed injection of investment into the primary care sector. This additional funding has provided the resource for local health economies to press ahead with collaborative working, create federations and extend patient access to GPs and other practitioners. Pilots are largely unanimous in their view that they could not have progressed with their agendas at the same pace if Challenge Fund resources had not been available. The considerable success achieved over the last year in moving away from independent working to delivering services at scale through joint working is added value in itself, even if some of the wider impacts and system outcomes are not yet fully tangible or measurable.