

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

Second Evaluation Report to September 2015

Contents

EXECUTIVE SUMMARY	i
SECTION ONE: Background and context	1
SECTION TWO: Methodology	5
SECTION THREE: Meeting the national programme objectives	8
SECTION FOUR: Wider learnings and lines of enquiry	20
SECTION FIVE: Financial evaluation	30
SECTION SIX: What has enabled innovation and change?	33
SECTION SEVEN: What barriers and challenges have been faced?	36
SECTION EIGHT: Conclusions	40

EXECUTIVE SUMMARY

In October 2013, the Prime Minister announced a new £50 million Challenge Fund¹ 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, then covering 1,100 general practices and 7.5 million patients.² Each scheme chose its own specific objectives, innovations and ways of organising services. The timeline associated with implementing services funded by the the original allocation of £50 million was April 2014 to March 2015. Following this subsequent funding was made available by NHS England to enable pilots to continue with some of their initiatives for a longer timeframe. Many pilots are still delivering projects which were originally developed through their involvement in the Challenge Fund programme.

The independent national evaluation of the Challenge Fund (wave one³)

From April 2014 to September 2015 wave one pilots participated in the national evaluation of the Challenge Fund programme.

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 two online surveys
- 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

Data has been collected for all pilots as they have become operational with their initiatives. We are able to report findings across all of the key metrics. However, the level of detail available remains less comprehensive for a few pilots. It is important to bear in mind the assumptions and limitations listed on page 7 of this 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' service⁴.

About this second evaluation report

The first evaluation report was published in October 2015, which considered pilots' activity from April 2014 to May 2015. This second report provides a conclusion to the evaluation of the wave one pilot schemes and it assesses pilots' activity and initiatives from the start of the programme until the end of September 2015.⁵

1. As of November 2015, this programme has been referred to as the GP Access Fund (GPAF).

2. Over the course of implementation practice numbers grew to over 1,200 practices and the patient population covered by these practices grew to over 8 million.

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

4. 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'.

5. Please see page 7 for details of data used.

Key achievements

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 include⁶:

During the course of the PMCF programme for the 20 wave one pilot schemes over **8 million patients** have had access to a new or enhanced primary care service due to new projects or different approaches to service delivery.

At the peak of the programme **5 million patients** had access to a new or enhanced GP appointment service after core working hours during the week due to Challenge Fund investment. As at September 2015, **4.3 million** patients had access to one of these services⁷.

At the peak of the programme **5.4 million patients** had access to a new or enhanced GP appointment service at the weekend due to Challenge Fund investment⁸. **4.6 million patients** had access to these weekend services in September 2015.

Approximately **540,000** additional appointments have been provided in extended hours to patients across the pilot schemes up until September 2015.

Approximately **550,000** additional appointments have been provided in core hours to patients across the pilot schemes⁹ up until September 2015.

At November 2015, there had been a **reduction of 42,000** minor self-presenting attendances at A&E across the pilot schemes compared with the same period across previous years, representing a 14% reduction.

The range of initiatives that have been introduced across the pilot schemes



6 It is important to recognise that these figures reflect a point in time and pilot initiatives are ongoing.

7 Core hours: 8am – 6.30pm, Monday – Friday. This is in addition to extended services that were already available during the week prior to PMCF.

8 This is in addition to extended services that were already available at the weekend.

9 This is across 17 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 (over and above the hours that were previously being provided by GP practices prior to the introduction of PMCF). This second evaluation includes extended hours data across all 20 pilot schemes; the first evaluation report featured data for only 16 of the pilots as data was not available for four pilot schemes in time for publication.

Extended hours

From data collected to the end of September 2015, the number of additional appointments available during extended working hours across the whole Challenge Fund Programme was 540,000 across all practitioners.

From the time that the pilots went live with their initiatives until September 2015 an additional 85,000 extended hours have been offered. This change in additional hours represents an annual increase in hours of over 200% from their baseline position reported at June 2014. Of these additional 85,000 hours, around 80% have been provided by GPs. This translates into around 540,000 additional available appointments during extended hours, 480,000 of which were provided by GPs.

Schemes made initial estimates of the demand for additional appointments and based their supply on those. On average, there was an over-supply, with a mean utilisation of appointments of 71% compared to the baseline position of 80%. Initial over-supply was more evident at weekends, with lower demand on Saturday afternoons and Sundays in most schemes. Many subsequently reduced supply on Sundays, with some closing Sunday services altogether.

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 September 2015, a total of 104,000 additional hours have been provided, of which 35,000 have been provided by GPs. Also, as a consequence of introducing new modes of contact, the average number of available appointments per hour has increased by 7%. In total, an additional 550,000 available appointments have been made available, of which one third were provided by GPs¹⁰.

The Challenge Fund did not change the average utilisation of in hours appointments, which remained at 94%.

10. This reflects complete core hours data for 16 of the 20 pilot schemes. Data is not available for North West London, Barking & Dagenham and Havering & Redbridge, Slough; and Derbyshire & Nottinghamshire. It should also be noted that since the publication of the first evaluation report some pilots have re-submitted their entire datasets.

11. Note that the national GP Patient Survey does not specifically focus on PMCF and is more generally reflective of patients' experiences and satisfaction with primary care services.

2. To improve patient satisfaction

Patient experience and satisfaction

There has been little change in patients' levels of satisfaction and experience since the introduction of Challenge Fund initiatives¹¹. Patient satisfaction with appointment times at practices involved in the Challenge Fund has remained consistently high. 90% of patients that responded to the national GP patient surveys (published in June 2015 and January 2016)¹² considered that appointments are either very or fairly convenient and around 60% of patients are able to see their preferred GP.

Staff experience and satisfaction

An online survey has been undertaken for the purposes of the evaluation twice to assess the impact on satisfaction amongst staff involved in delivering Challenge Fund activities.¹³ 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 technology¹⁴

All of the pilots introduced extended hours services for their patients. In addition to this, the majority of pilots (15 out of 20) have increased the variety of modes by which patients can access an appointment by their GP or access their practice services. Over the course of the programme:

- Twelve pilots introduced telephone consultations or a GP led telephone triage service. Over 360 practices have offered this service to over 2.65 million patients.
- Across these pilots, the average percentage increase in telephone consultations and GP led telephone triage being offered in per week compared with the baseline was 10% during core working hours and 650% during extended working hours.
- Six pilots introduced video consultations as part of their PMCF activities. At the peak of the programme this service was being offered by 33 practices and available to nearly 290,000 patients. Currently four pilots are delivering video consultations, with 25 practices involved with a patient population of over 250,000.
- Seven pilots trialled GP e-consultations and/or online patient diagnostic tools (which include an e-consultation facility for patients who need them). These online-based consultations were offered by nearly 100 practices reaching a patient population of nearly 770,000.

12. These surveys cover the period July 2014 through to September 2015.

13. The staff survey has not been re-run since the first evaluation report was published in October 2015.

14. For more information and examples studies see the 'Using technology to improve access' showcase: <https://www.england.nhs.uk/wp-content/uploads/2015/03/pmcf-innv-shcse-2-tech.pdf>

- Five pilots developed texting services, providing this facility to nearly 1.6 million patients across 265 practices.
- Seven pilots have also introduced enhanced online access features, typically online registration and booking systems, as part of their pilot programmes. These services have either been enabled at more practices or pilots have made concerted efforts to increase take-up by patients. This activity has been undertaken by over 250 practices serving a patient population of nearly 1.7 million patients.

Introducing a wider range of practitioners¹⁵

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

- Eight pilots 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.¹⁶
- Five pilots integrated pharmacy into delivery of primary care services. There has been good buy-in from pharmacists and pilots have reported that these projects have been a success, helping to release GP time.
- Four of the pilots undertook 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 have delivered benefits, releasing GP time and achieving patient satisfaction.
- Six pilots 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 have worked well locally, releasing GP time and proving popular with patients.



15. For more information and examples see the 'Collaboration in delivery' showcase: <https://www.england.nhs.uk/wp-content/uploads/2015/05/pmcf-innov-showcase-five-collaboration-delivery.pdf>

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.

Going forward the sustainability of specific pilot initiatives is dependent on negotiations with local CCGs. There is also likely to be work to do at local level with regard to influencing patient behaviours to encourage more flexible use of primary care services. Some of the wave one pilots dedicated resources to developing awareness-raising and patient outreach projects which provide good examples to follow and are recommended as a way in which to help stimulate behavioural change amongst patients themselves. However it is recognised that culture change amongst patients and the way they use services is a long term goal and will take far more time to realise than the Challenge Fund implementation timeframe.

16. For more information and examples see the 'Enhanced use of specialist nursing staff' showcase: <https://www.england.nhs.uk/wp-content/uploads/2015/12/pmcf-innv-shwcse-eight.pdf>

Reducing demand elsewhere in the system

Up to November 2015, at a programme level, there has been a statistically significant reduction in minor self-presenting attendances at A&E by those patients registered to Challenge Fund GP practices. Across the 20 pilot schemes, this has translated into a reduction of 42,000 minor self-presenting A&E attendances and represents a 14% reduction.¹⁷ Over the same time period, across England there has been a 4% 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, **Watford, North West London (NWL), Herefordshire, Morecambe, Care UK, Barking and Dagenham, Havering and Redbridge (BHR), and Brighton and Hove**. These 13 pilots have seen a combined reduction of 44,400 minor self-presenting A&E attendances (17% reduction).^{18 19} This suggests that most additional capacity served to meet previously unmet demands for GP appointments, some of which were being diverted to A&E.

There has been 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, Hambleton, Richmond and Whitby (HRW), Morecambe, Slough and Warrington**); the establishment of action learning sets (**Brighton and Hove, Warrington**); practice buddying (**Slough and Warrington**); and commissioning local evaluations (**Care UK, Devon, Cornwall and Isles of Scilly (DCIoS), Herefordshire and Morecambe**).

Throughout the programme, the national team at NHS England and NHS Improving Quality (NHS IQ)²⁰ have supported peer networking and knowledge exchange among pilot schemes. Some pilots have also undertaken their own dissemination activities. A nationally commissioned programme of training and coaching has also created a legacy of increased capabilities for change leadership.

Tackling health inequalities in the local health economy

Some pilot schemes (**Morecambe, Warrington and West Wakefield**)²¹ have targeted projects at hard-to-reach groups or areas of socio-economic deprivation. Another popular strategy was 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**).

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.

17. Please note the assumptions and limitations detailed in Section Two of the report.

18. Comparing the weeks that pilot schemes have gone live with the same period in the previous year.

19. Minor attendances have been defined as those attendances coded to HRG VB11Z. Statistical significance has been measured at 95% confidence levels.

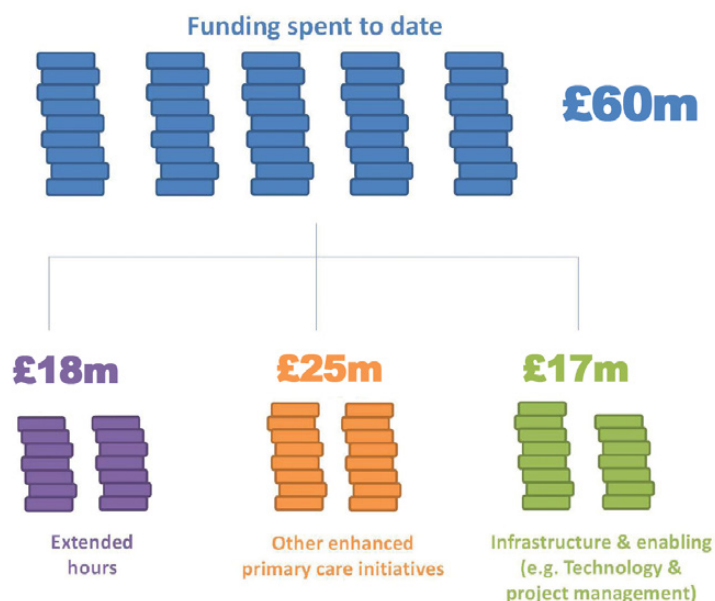
20. NHS IQ is now called NHS Sustainable Improvement Team (SIT).

21. For more information and examples see the 'Improving access for specific patient groups' showcase: <https://www.england.nhs.uk/wp-content/uploads/2016/01/pmcf-innv-shcse-nine-imprv-access.pdf>

Delivering value for money

Up until September 2015 pilot schemes had received a total of £60 million; comprised of both original PMCF funding, sustainability funding and also any local match funding. Of this, pilot schemes have indicated that they have spent a total of £18 million on extended access hours, £25 million on other initiatives and £17 million on enabling activities.

The cost per hour and the cost per appointment to support extended access is on average, the same as the cost per hour for routine core hours general practice.²²



Whilst there is a broad range across the pilot schemes the average cost per total additional extended hour was around £215.²³ 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 was typically around £34.

As detailed above, 13 of the pilot schemes have collectively seen a reduction in minor attendances at A&E from the date they went live with initiatives up to November 2015, the total reduction of which was 44,400. This would generate a reduction in annual expenditure for commissioners in this service of £1.9 million. This saving would need to be offset against the investment in primary care.

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.

22. Unit Cost of Health and Social Care, Personal Social Services Research Unit, 2015

23. The average figure of £215 is based on data from eleven of the pilot schemes (minimum cost per hour £102 and maximum cost per hour £399). There were some schemes for which the cost per hour was significantly higher but these were considered outliers and excluded from the above analysis.

Conclusions

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 lower.

Based on the evidence on current provision pilots are providing on average an additional 30 minutes per 1,000 registered patients. For example, for a pilot operating an extended hours hub which serves a 40,000 registered population then around 20 hours per week of extended hours provision would be about the norm in order to meet the levels of demand experienced in these pilots and to optimise utilisation.²⁴ Given reported lower 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, feedback from some pilots suggests that these might best be reserved for urgent care rather than pre-bookable slots.

On average, the annual cost per registered patient to support additional extended hours is £5.60. This represents a full cost covering all clinical staff time and overheads associated with setting up a new service; typically 50% of this cost can be attributed to GP time. The annual cost per hub serving 40,000 registered patients is therefore around £224,000.

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. 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. Beyond this, and as part of the GP Access Fund wave two evaluation there will be ongoing work 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 had fewer tangible benefits with issues around implementation. Where these have been implemented there has generally been a low take-up with one or two exceptions. These modes of consultation will continue to be looked at during the wave two evaluation.

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.²⁵

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 learnt along the way. Phasing delivery also helps to manage implementation risks and workload during the resource intensive set-up stage.²⁶

Scale and scope

The wave one pilots were 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. Experience from the 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. Consideration also needs to be given to co-terminosity with the CCG, with one or more federations / networks operating within this as locally appropriate.

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.

24. Given the uniqueness of its service model, this excludes Care UK.

25. For more information and examples see the 'Collaboration in delivery' showcase: <https://www.england.nhs.uk/wp-content/uploads/2015/05/pmcf-innov-showcase-five-collaboration-delivery.pdf>

26. For more information about mobilisation see the 'Pace of implementation' showcase: <https://www.england.nhs.uk/wp-content/uploads/2015/03/pmcf-innv-shcse-one-pace.pdf>

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 hub 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. As in this programme, a piloting approach may be required to identify the best fit for a given population.

Transformational change

The establishment of federations and networks and delivery via hub and spoke models 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.

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 procurement and CQC registration have been the most commonly cited process barriers. Acknowledging these issues, NHS England has established support for wave two pilot schemes 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 have been better placed to secure future funding.

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, 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

There were some issues raised around access inequalities 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 inequalities 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 in agreement 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 eighteen months in moving away from independent working to delivering services at scale through collaboration is added value in itself.

Wave two schemes

Following the success of the initial wave one pilot schemes, a further 37 schemes were selected to participate in the programme as part of a wave two development. In total across both waves, this represents 18 million registered patients. In supporting this second wave of schemes, NHS England took steps to learn the lessons from wave one and put in place the mechanisms to support schemes in overcoming some of the initial barriers in setting up their new services, including support from the Digital and Sustainable Improvement teams. delivering services at scale through collaboration is added value in itself. An evaluation report looking at the progress and impacts of these 37 wave two schemes will be published later in 2016.

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 and ageing population.²⁷ 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
- Changing public expectation in an increasingly 24 hour, 7 day society

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 and 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.²⁸

The NHS Five Year Forward View emphasised the importance of general practice at the heart of the NHS, and pointed to a need for care redesign and organisational change to release more of it. In April 2016, the General Practice Forward View was published with a focus on accelerating funding of primary care, expanding and supporting GP and wider primary care staff, reducing practice burdens and helping to release time, developing the primary care estate and investing in technology, and care redesign.²⁹



27. Five Year Forward View, NHS England, October 2014.

28. It's time to embrace seven day services, NHS England website, October 2013.

29. General Practice Forward View, NHS England, April 2016.

The Prime Minister's Challenge Fund (PMCF³⁰): 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 was 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, then covering 1,100 general practices and 7.5 million patients.³¹

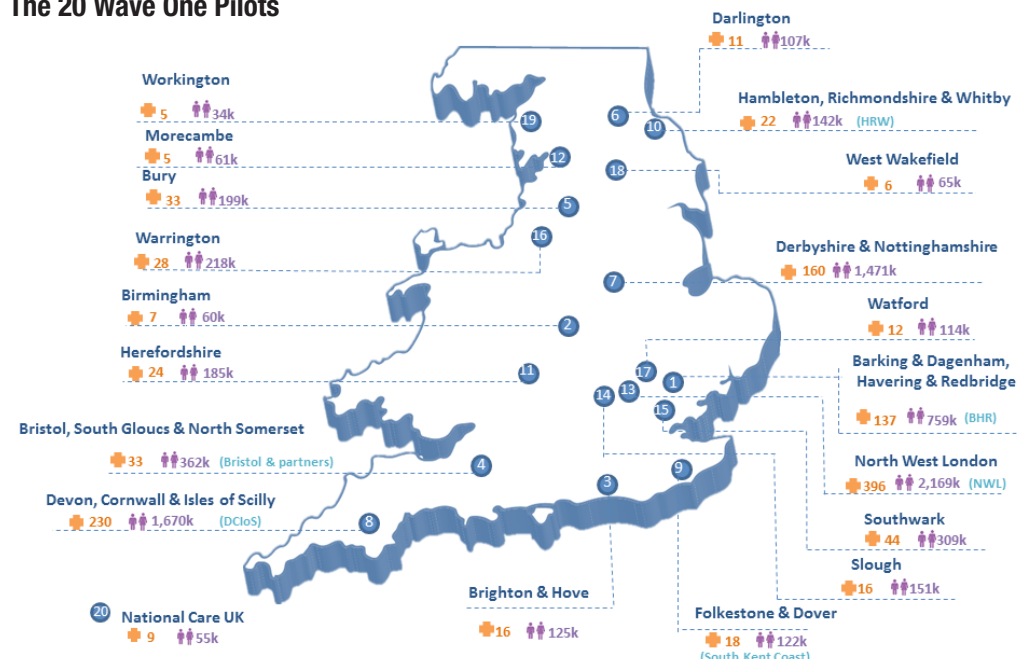
Pilots were selected based on their public and patient engagement; sustainability prospects; scale and ambition; leadership and commitment; links to local strategy; capacity for rapid implementation and their monitoring and evaluation plans.

Following the selection of the 20 pilots, 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. Integrated Primary Care Access	15. Extending Primary Care Access
2. Health United	9. Integrated South Kent Coast	16. The Primary Care Home
3. Extended Primary Integrated Care	10. Together as One Community	17. Transformational Innovations for Primary Care in West Hertfordshire
4. Co-operative in Bristol and South Gloucestershire	11. Improving Access, Supporting Primary Care Integrated Whole System Change	18. Moving Primary Care to a Population Wellbeing Approach
5. EasyGP 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	

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

31. Over the course of implementation practice numbers grew to over 1,200 practices and the patient population covered by these practices grew to over 8 million.

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	Barking & Dagenham and Havering & Birmingham	Brighton and Hove (EPIC)	Bristol, South Gloucestershire and Bury	Darlington	Derbyshire and Nottinghamshire	Devon, Cornwall and Isles of Scilly	Hambleton, Richmondshire, 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 (pharmacy, paramedic, physio etc)																
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, or other hospital interaction																
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																
Patient education / community signposting initiatives																
Facilitating learning and development																
Patient group consultations																

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 innovative 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, were 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 to:

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

About this second and final report

The wave one pilots have been delivering their plans over the last 18 months (up to the end of September 2015) during which time they have received additional funding through the Challenge Fund (see below). A first evaluation report was published in October 2015 providing initial analysis of the impacts and outcomes of the pilots' delivery of their plans. Following additional data collection, this second evaluation report sets out a final review of their progress, provides an updated position against the national metrics and assesses the extent to which the PMCF core programme objectives have been met. This report will be accompanied by 20 individual pilot summaries which review the individual PMCF programmes, and how they meet the national objectives, in more detail. This second evaluation includes extended hours data across all 20 pilot schemes; the first evaluation report featured data for only 16 of the pilots as data was not available for four pilot schemes in time for publication.

Local evaluation

Many pilot schemes have undertaken their own monitoring or 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 and began implementing their initiatives in April 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.

Part of this further funding was used by NHS England to support all wave one pilot schemes for a further period of time. This additional 'sustainability funding' was 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.

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.

Overview of approach

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
- 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.

32. 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' service³²

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.³³ 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.

33. 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 access out-of-hours data.

Notwithstanding these challenges, the national evaluation team has received data from all pilot schemes; the majority of which provide details up to the end of September 2015. For a few pilot schemes, the level of the detail is more limited. Also, for a few pilot schemes, revised baselines and ongoing monitoring data was received for this second report.

Qualitative evaluation

The evaluation has enabled the team to establish a detailed understanding of what pilots were seeking to achieve; explore the full range of activities and why these were 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 ten thematic innovation showcases as a way in which to spread learning. These showcases can be found on NHS England's website www.england.nhs.uk/ourwork/futurenhs/pm-ext-access/resources/.

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

The topics considered are:

- Delivering at pace
- Innovative use of technology
- Patient engagement
- Practice engagement
- Delivery at scale
- Collaborating with other providers
- Effective leadership
- Enhanced use of specialist nursing staff
- Tackling known health disparities
- Shifting modes of consultation

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 early on 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.³⁴

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



**Prime Minister's Challenge Fund (PMCF):
Improving Access to General Practice**

Innovation Showcase Series
Pace of Implementation
February 2015. Showcase One



**Prime Minister's Challenge Fund (PMCF):
Improving Access to General Practice**

Innovation Showcase Series
Using Technology to Improve Access
February 2015. Showcase Two

34. Prime Minister's Challenge Fund Wave Two: Learning from wave one, NHS England, December 2014 [hyperlink 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 certain initiatives.

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 overall programme level unless otherwise stated. Accompanying this main report are individual summaries 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.
 - 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 heterogeneity 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, there may be some inconsistencies in how hospitals record A&E attendances and some of the emergency admissions which may 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 summaries discussing local issues in more detail, which accompany this overall report.
- The findings presented in this evaluation report, and in the individual pilot summaries, 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.
 - Practice based metric data and data for out of hours up to the end of September 2015 has been used for this report. For A&E attendances, this is to November 2015, and emergency admissions, this is October 2015. Baseline data has been collected and then 'live' data during that time that schemes have been operational up to the end of September 2015. Therefore, there are different start dates across the schemes for which data has been collected.
 - For this report A&E attendance and emergency admission data has been sourced from Secondary Uses Service (SUS). Due to some data recording issues at the time of reporting the data for this report, there were concerns raised regarding the completeness of the Hospital Episode Statistics (HES).
 - For the patient survey this compares the findings of the last two national GP patient surveys (published in June 2015 and January 2016, covering the period July 2014 to September 2015) with previous survey findings. The staff survey was run in January and July 2015 and this presents no new update since the publication of the first evaluation report.
 - 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 September 2015.
 - 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.

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

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

Objective one: To provide additional hours of GP appointment time

Prior to the Challenge Fund initiative, there were some GP practices that were already offering patients appointments during extended working hours; 414 practices (34% of participating practices) were offering some form of extended access during the week and 204 practices (17% of participating practices) were offering some form of extended access at the weekend. The hours provided varied. 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. At its peak it is estimated that net of the baseline service prior to the start of the Challenge Fund initiative, 5 million more patients had 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. Currently, as at September 2015, 4.3 million patients have access to one of these services during weekdays and 4.6 million at the weekends.

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

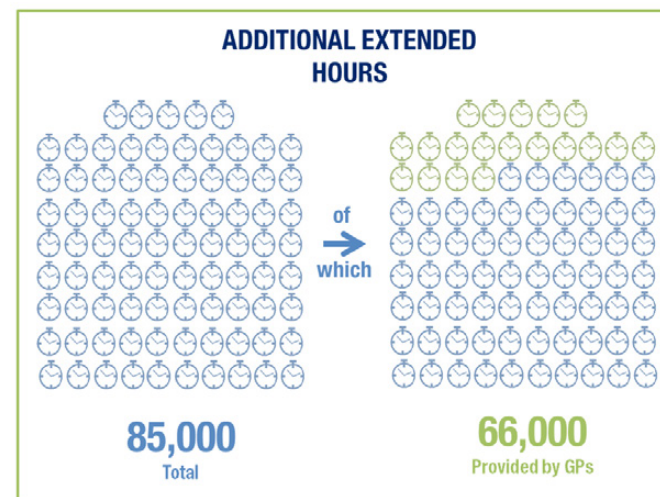
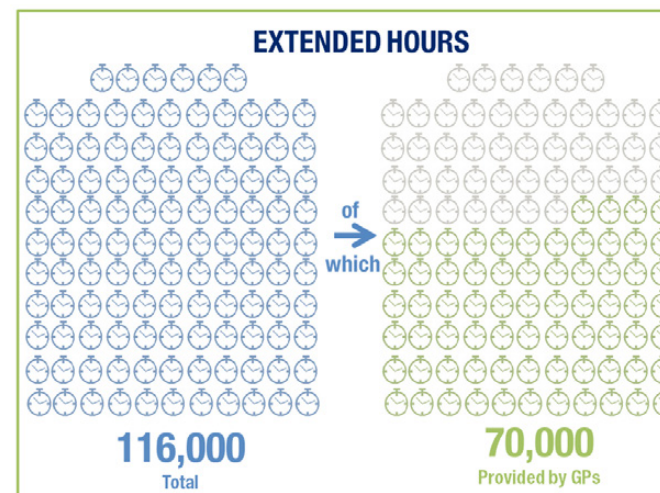
Hours and appointments

Across the pilot schemes, a total of 116,000 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 end of September 2015. Of this, 70,000 hours (60%) were provided by GPs. Net of the baseline, the additional extended hours being offered across all of the pilot schemes was 85,000 hours of which 66,000 were provided by GPs (78%).

The cumulative impact of additional core hours being provided over and above the baseline across all of the schemes up to end of September 2015 was 104,000 hours of which 35,000 (34%) 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 from the time that individual pilot schemes went operational with their initiatives up to the end of September 2015.

- Around 540,000 additional available appointments during non-core (extended working) hours of which 480,000 additional available appointments were provided by GPs. These additional appointments have varied in length depending on the models in operation locally.
- Around 550,000 additional available appointments during core working hours of which one third were provided by GPs.

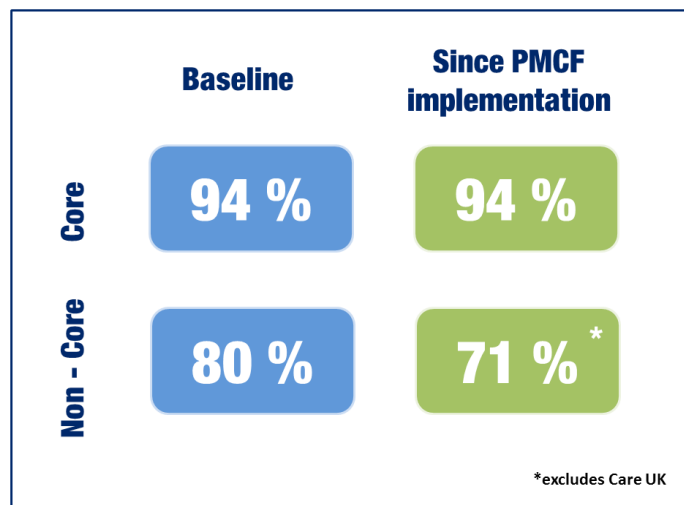


In total almost 1.1 million additional appointments have been made available (as at September 2015) over the course of the time that each wave one pilots have been live their initiatives.

Data caveats

It is important to note that:

- The analysis reflects the cumulative impact of the continued implementation of pilot schemes' extended working hours initiatives post June 2014 up to September 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.
- A reduction in available contacts may be due, for example, to longer appointment times being offered by the practice. Similarly a reduction in available hours may be due to recruitment and retention challenges.



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 to the end of September 2015, the average utilisation of available appointments during core working hours was 94% and 71% during extended working (non-core) hours. Given the sizeable increase in the number of available extended hours appointments compared with the baseline and schemes looking to match supply with demand, this represented a high level of use. There is a slight increase in core working hours.

This analysis may overstate utilisation slightly given that in some pilot schemes not all used contacts have an assigned pre-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 lower demand on Sundays has been evident nationwide with the vast majority of pilots highlighting this in their feedback including **Derbyshire and Nottinghamshire, Darlington, DCIoS, BHR, Care UK, 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. 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 reduced service over the course of programme, offering fewer hours and some ceasing provision on Sundays completely (e.g. **Brighton and Hove, DCIoS, Watford, HRW, Darlington, Birmingham**). In Darlington, for example, utilisation on Sunday

Through discontinuing or reducing the Sunday service, some pilots were able to reallocate resources to meet patient demand at other times of week. For example:

- **DCIoS:** funds were diverted to continue its Exeter Primary Care Saturday service over the winter.
- **BHR:** all three federations reduced the number of GPs employed on Sundays and moved this capacity to Mondays where the pilot was struggling to match demand.
- **Brighton and Hove:** following discontinuation of their Sunday services, resources were reinvested into the pilot's week night service where demand for both GPs and nurses was high.
- **HRW:** the pilot redirected funds to establish an online self-care platform (initially trialled at one practice, but with plans to now roll this out to a further eight practices) and a community pharmacy initiative (initially trialled at five practices, later extended to 21 practices).

It should be noted that a few pilots have reported that, despite a slower start, utilisation on Sundays has seen some increases. This is the case for **Herefordshire** and **Workington**, for example, which have both seen demand for Sunday slots grow steadily. In addition, others (e.g. **South Kent Coast**, **Southwark** and **West Wakefield**) have continued with a seven days a week service offer (even if hours on Sundays have been slightly reduced or flexed to suit local patterns of demand).

The wave one pilots have recognised that there are critical success factors with regard to provision and use of extended hours appointments, both during the week and at the weekend. These include securing GP buy-in, raising patient awareness and adequate receptionist training. 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 is perhaps a result of entrenched patient behaviours. These behaviours take longer to change and services need time to become more embedded. **Darlington**, for example, attributes a steady growth in demand for its Saturday services to word of mouth and patients having a good experience and being willing to try it again and tell their family and friends.

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 during the time that they have been operational with this service. 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 typical range for many schemes is between 0.5 and 0.65 although the rate per 1,000 population in **Bristol, North Somerset and South Gloucestershire** is 0.1 (reflecting weekend extended access). **Slough** and **Herefordshire** pilot schemes offer around 1.5 and 1.8 extended working hours per week per 1,000 registered practice population respectively.

Overall across the schemes, this analysis would suggest that a scheme with hubs covering 40,000 patients, should provide around 20-26 hours for extended access per week and for hubs covering 100,000 population, the provision of 50-65 hours for extended access per week. However, this does not factor in utilisation which has shown that, to date, 71% of extended working hours contacts are being utilised. If this was factored, then the suggested number of hours per week for extended access would be less.

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. The GP Patient Survey indicates there is unmet need currently but this varies across the country and between practices. 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 so that they match with when demand is most evident locally.

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 and January 2016 represent the time period during which the pilot schemes have been up and running (July 2014 to September 2015).³⁵

Findings from the national GP Patient Survey

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. This shows that there has been little change in patients' levels of satisfaction and experience. 75% 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.

When comparing the survey results published in January 2016 with those reported at the same time in the previous year, notable exceptions to the overall programme trend include:

- A 3% increase in patients rating the convenience of appointments as very or fairly convenient across the **West Wakefield** pilot scheme.
- A 4% and 3% increase respectively across the **Bury** and **South Kent Coast** pilot schemes of patients rating their experience of making an appointment.
- A 7% increase in the proportion of patients satisfied with the opening hours of GP surgeries at the **Morecambe** scheme. However, there has also been a 7% and 9% drop in this satisfaction rating across the **Workington** and **Birmingham** schemes.
- A 3% increase in a positive response to GP surgeries being open at times that are convenient for patients at the **Slough** pilot scheme.
- An 8% reduction in patients rating their overall experience of GP surgery as very good across the **Birmingham** pilot scheme.

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, with reference to extended hours services:

- In **Bristol**, 100% of those surveyed would recommend the service to their family and friends.
- In **Southwark**, the Friends and Family test highlighted a 95% patient satisfaction rate.
- In **Slough** 97% are very satisfied or satisfied with the extended hours service.
- In **Herefordshire** 71% of patients using the Healthcare Hub described this as excellent or very good when rating the speed of being seen by a clinician and 76% said they were likely or extremely likely to recommend the Healthcare Hub to family and friends.'

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. In Southwark, the pilot is working with locality public and patient groups (PPGs) to identify ways in which patients can be engaged in its local evaluation framework.

Findings from the staff survey

Findings from the two staff surveys³⁶ have identified that 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.

"I think it's great that this surgery is open on a Saturday. It means if work is really busy I can still visit the GP if I need to without stress. Brilliant service" Extended hours service patient, Brighton and Hove.

"Excellent service – no waiting, very convenient for emergencies that do not require a trip to A&E." Weekend service, Bristol and partners.

35. Note that the national GP Patient Survey does not specifically focus on PMCF and is more generally reflective of patients' experience and satisfaction with primary care services. The survey findings cover the period July 2014 to September 2015.

36. The staff surveys were run in Jan 2015 and July 2015. The staff survey has not been re-run since the first evaluation report.

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 has been run twice, facilitated by the evaluation team.³⁷

Almost 1,000 responses were received to these two 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 has undertaken its own members survey in September 2015 to assess future direction and next steps.

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. 14% of respondents were either dissatisfied 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 **Watford**; 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 selected locations are accessible for patients with good transport and parking.
- 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.
- Consider how to improve core hours access as well as extending hours.

³⁷ The staff surveys were run in Jan 2015 and July 2015. The staff survey has not been re-run since the first evaluation report.

Objective three: Increasing the range of contact modes

Using technology³⁸

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 3% were home based appointments.³⁹
- Extended hours: 85% of appointments were face-to-face and 15% were telephone consultations.

The introduction or expansion of telephone access has been a popular component of the wave one pilot programmes, with 12 of the pilots introducing schemes to introduce or expand this type of access. PMCF has increased the scale of provision considerably, supporting the development of telephone consultation facilities⁴⁰ at over 360 practices (serving nearly 2.7 million patients).

During the time that pilots have gone live with their initiatives, the overall profile of patient appointments during core hours has changed with 76% of available appointments as face-to-face clinic appointments and 21% as telephone appointments. The change to the contact profile during extended working (non-core hours), has been more pronounced with:

- 61% face-to-face clinic appointments.
- 39% telephone appointments.

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

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

38. For more information and examples see the 'Using technology to enhance access' showcase: <https://www.england.nhs.uk/wp-content/uploads/2015/03/pmc-f-innv-shcse-2-tech.pdf>

39. 1% use "other".

40. The pilots have introduced a range of telephone models by different names (e.g. telephone consultations; telephone triage; call centres).

Birmingham

In **Birmingham** the provision of telephone based consultations was a major part of its offer; it established a central telephony hub which booked 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 took 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 57% of appointments are now over the telephone compared to Birmingham's baseline position of 37%. This change in mode of consultation has released capacity to undertake additional appointments.

GPs reported increased capacity and greater control over their own workloads, as a direct result of the telephony offer. Local data from practices which participated in the pilot reported 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.

Brighton and Hove

In **Brighton and Hove** local data suggested that the majority of practices implementing telephone consultations noticed some positive impacts, particularly in terms of GP time with some GPs reporting that they had increased productivity and saved up to one hour a day in seeing the same number of patients. In addition, this model has helped to shift the profile of GP appointments so that now 32% of core hours appointments are over the telephone, compared to a baseline of 20%. The pilot found that the success of its telephone model has been dependent on how GPs use it; some have been reluctant to deal with patients entirely over the phone and ask patients to visit the surgery anyway.

The proportion of telephone appointments in non-core hours has grown.

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, which has been rolled out to five other practices with another six taking steps to implement it. 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 records a high 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

Care UK has seen some significant shifts towards telephone consultations in its contact profile in both core hours (from 14% to 38%) and extended hours (from 27% to 83%). 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. 91% 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 and four are currently offering this service. At its peak 33 practices were piloting this contact mode with potential access for nearly 290,000 patients; the current number of practices offering this service is now 25, providing 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 did not prove to be popular with patients. The pilot felt that intensive marketing would be required to increase take-up of this offer.

Video consultations have been challenging to implement.

DCIoS trialled, and has since discontinued, video appointments in Devon at two practices. Patients were offered the choice of a Skype appointment during Monday evening slots. 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

Seven pilots introduced either online patient diagnostic tools and/or e-consultation facilities as part of their PMCF programmes. These include self-help content, signposting options, symptom checkers, access to 111 clinicians and ultimately the ability to consult remotely with a GP via e-consultations.

These tools have been met with a mixed reception by both GPs and patients. In **Bristol** 13 practices introduced an online, self-diagnostic tool and, despite some technological set up issues, the trial was seen as a success.

Recent local data from **Bristol and partners'** patient satisfaction survey suggests that 81% of users were either satisfied or very satisfied with the service. 95% agreed or strongly agreed that the website was easy to use and 82% of users were likely to recommend the online consultation service to others. Further, local data suggested that 60% of users would have requested a GP face-to-face discussion of the online tool had not been available, whilst 20% would have sought a telephone discussion.

"Very efficient, easy to use and has helped my problem without the need of having to book time of work for a face-to-face appointment"

Online tool patient

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. Collectively 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 over 2000 on-line consultations up to the end of September 2015 during core and extended working hours.

Seven practices have also enabled new online access features, typically online registration and booking systems and encouraging patient take-up 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**.

Introducing a wider range of practitioners⁴¹

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 staff⁴²



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 which can be directed into other activities.

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 Herefordshire has secured further funding from the CCG to continue it.

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. In the majority of cases these initiatives have demonstrated success. In Erewash (in **Derbyshire and Nottinghamshire**), local data across the first nine months of 2015/16 suggested that its ANP care home work stream resulted in the avoidance of 417 unplanned admissions as well as freeing up GP time. In **Brighton and Hove**, data shows that an additional 3,700 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**, IT restrictions meant that the link nurse was unable to input directly to primary care records, meaning the project had to be flexed accordingly.

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

"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

There have been several hurdles to overcome in order to introduce wider roles for nurses.

41. For more information and examples see the 'Collaboration in delivery' showcase: <https://www.england.nhs.uk/wp-content/uploads/2015/05/pmcf-innov-showcase-five-collaboration-delivery.pdf>

42. For more information and examples see the 'Enhanced use of specialist nursing' showcase: <https://www.england.nhs.uk/wp-content/uploads/2015/12/pmcf-innv-shwcse-eight.pdf>

Pharmacy

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 134 pharmacies made 8000 consultations, saving nearly 3,000 GP appointments, nearly 2,000 OOH appointments and 200 A&E appointments over its first five months of operation. 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 GP

HRW introduced the use of clinical pharmacists to support primary care in the community in five of its practices. Each practice was given autonomy as to how they used these pharmacists; most used them for home visits to help ensure that patients follow their medication advice. Local data suggested that nearly 140 patients benefited from this service; each receiving around five interventions. The five practices that participated in the pilot provided positive feedback, which led to wider interest from across HRW's practice population. As a result the initiative was extended to 21 practices and in total 219 patients have taken part in medications reviews, which have resulted in 535 interventions. Local data suggests that there has been a 21% reduction in both GP and practice nurse appointments for relevant patients over the three months post review compared to the three previous months.

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 conditions. This was shown to be a success, with local data showing that utilisation rates remained consistently high for these services (averaging between 80-100%). Patient feedback for these services was also good. However, the community pharmacy element of this work stream was a significant challenge. Whilst there was good buy-in from local pharmacists and good local satisfaction data from patients who have used the service, utilisation of pre-bookable appointments in pharmacies was typically less than 5%. Practices reported that it was often more natural for telephone consultations to be completed by the GP rather than to refer the patient on to the pharmacy.

Working with care homes



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

Service user community navigation

Recognising that older people are a key GP patient group, four pilots undertook targeted activity with nursing and care homes. In **Workington** a specific frail and elderly multi-disciplinary team was established to improve the case management of people aged over 75 at risk of admission and provide support to care homes. Local data suggests that this initiative has been a success. For example, there has been a reduction in the number of non-elective admissions of over 75s in Workington and a reduction in the number of admissions from care homes.

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 was 100% positive and more carers felt confident in testing for key conditions.

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

GP

Voluntary sector / Community navigation



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. Over the course of the pilots, 18 'community navigators' were recruited 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. The success of this workstream led to it securing continuation funding from the CCG.

Working with the voluntary sector did bring 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 were overcome through effective partnership working and through including the voluntary organisations on the programme board. At a GP level, the initiative worked best where practices are inclusive, fully involving their volunteers and ensuring they are visible.

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

Community Navigator

West Wakefield undertook in-practice activities to encourage patients to access wider self-care and community resources. It trained 73 practice staff as Care Navigators so that they could 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 West Wakefield's Care Navigation service has managed over 6,300 referrals (over 400 per month), of which only 26 were then referred to a GP. The service has also been popular with patients. Local survey data suggests that 62% of patients using the in-practice Care Navigation kiosks are extremely likely to recommend the service whilst 18% are likely to recommend it.

A&E

Aware of both national and local agendas to reduce pressure in the A&E system, some pilots experimented with closer working with A&E providers.

Morecambe and **Workington** have trialled 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.

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 via an 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 was some 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 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

South Kent 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 have been referring cases to the service and the paramedic reports back with details of any treatment and medication given. Local data estimates between August 2014 and December 2015 1,500 hours of GP times has been released (this is based on the Folkestone hub being operational over the whole period and the Dover hub providing the service from March 2015). This pilot 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 called Physio First, which provided patients in West Wakefield with access to a front line physiotherapy service in the practices without the need for a GP appointment first. The pilot's trained Care Navigators and receptionist staff referred patients directly to the physiotherapist, following a set of referral criteria. The service was designed to save GP time and provide patients with quicker access to the service they needed. The physiotherapists had access to patient records via SystemOne, and so could either refer patients for a follow up appointment or to the GP. The Physio First service was initially implemented in two practices in October 2014 in order to trial the service. Following successful implementation, it was then rolled out to the remaining practices in early 2015. The vast majority of the presenting conditions were lower back pains, followed by knee pain and shoulder pain.

Between December 2014 and September 2015, there were 1,300 used appointments with the physiotherapist (a monthly average of around 130 appointments). These appointments were available for patients to receive a brief assessment, advice and signposting for musculoskeletal problems without having to see the GP first. Overall utilisation of physiotherapist appointments was 70%. The pilot estimates that approximately 75% of patients seen through Physio First were then able to successfully manage their own care.



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

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.⁴³

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.

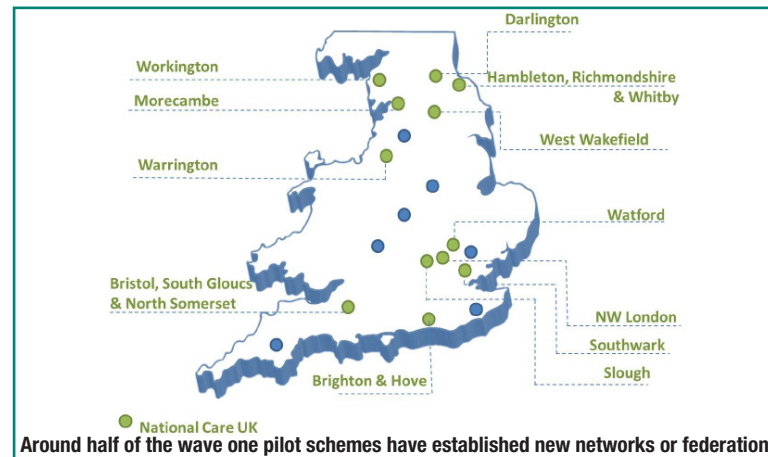
This change in ways of working has been characterised in several ways. Most common has been the development of new networks, federations and legal entities. For example federations are now present in **Bristol, Darlington, Workington** and **West Wakefield** as a result of PMCF involvement, whilst **Brighton 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

“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**

43. ‘Much of the data and findings in this chapter remain consistent with the first evaluation report.



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

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 two million patients. For **West Wakefield** and **Birmingham** PMCF helped create a platform for securing Vanguard status.

The formal establishment of federations and networks over 18 months 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**.

“Delivering PMCF weekend access has brought us together as practices and has made the Federation ‘real’ for the first time”.

GP, DCIoS

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.

Some practices have struggled to move away from an independent mindset 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 Health1000⁴⁴ 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 mindset 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 (22% of respondents disagreed). 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.

The **Bristol, North Somerset and South Gloucestershire** pilot directly involves all 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 and 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.

44. 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.



NWL⁴⁵

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 four 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 upfront CCG commitment has enabled the pilot team to develop the pilot and its new networks without the immediate pressure of demonstrating impact.

45. For more information about NWL's multi-CCG pilot see the 'Very large scale pilots' showcase: <https://www.england.nhs.uk/wp-content/uploads/2015/03/PMCF-Innovation-Showcase-Six-Scale.pdf>

Reducing demand elsewhere in the system

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

Wider system metrics for minor A&E 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

As at November 2015, comparing the weeks that pilot schemes have been live with the same period in the preceeding 12 months, at an overall programme level, there has been a statistically significant reduction (at a 95% confidence level) in minor self-presenting attendances⁴⁶ by those patients registered to GP practices within Challenge Fund pilot schemes (see Figure 1).

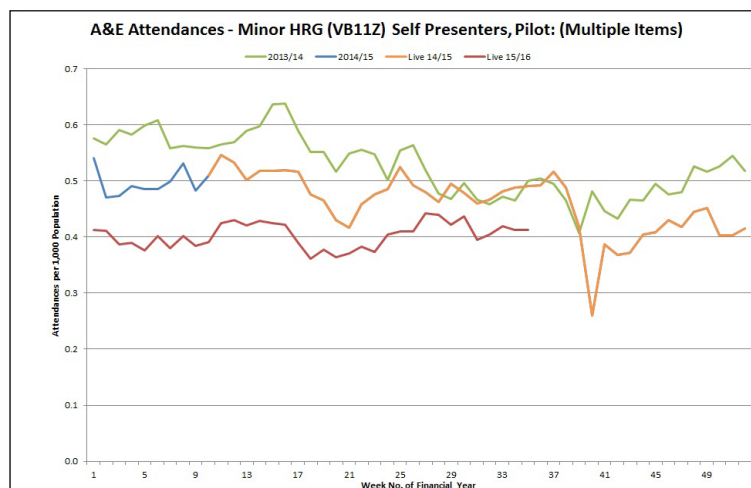


Figure 1: Profile of A&E attendances before and during the implementation of PMCF initiatives

Overall, this has translated into a reduction of 42,000 minor self-presenting attendances equivalent to a reduction of 14%⁴⁷. In comparison, using the same data source, nationally there has been a reduction of 4% in minor self-presenting attendances.

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

47. Note the issue of attribution detailed in the assumptions and limitations in Section Two.

Thirteen pilot schemes have shown a reduction in minor self-presenting emergency attendances with the most notable reductions experienced in **Watford** (47% reduction), **North West London** (33% reduction), **Morecambe** (29% reduction), **Herefordshire** (27% reduction), **Care UK** (13% reduction), **Brighton and Hove** (11% reduction) and **BHR** (7% reduction). All other pilot schemes have seen no reduction in minor self-presenting A&E attendances.

Emergency admissions

Similar analysis as that above in relation to the change in emergency admissions to hospital has shown that up to October 2015, the overall programme rate of emergency admissions per population during the live weeks has been similar to the profile of emergency admissions during the same period in the preceding years (see Figure 2).

Only six pilot schemes have seen a reduction in emergency admissions during the same time in the preceding years; averaging a reduction between 1% to 3%. These pilot schemes are **BHR, Bury, Warrington, Workington, Brighton and Hove** and **Care UK**. Most of these pilot schemes are medium sized schemes⁴⁸.

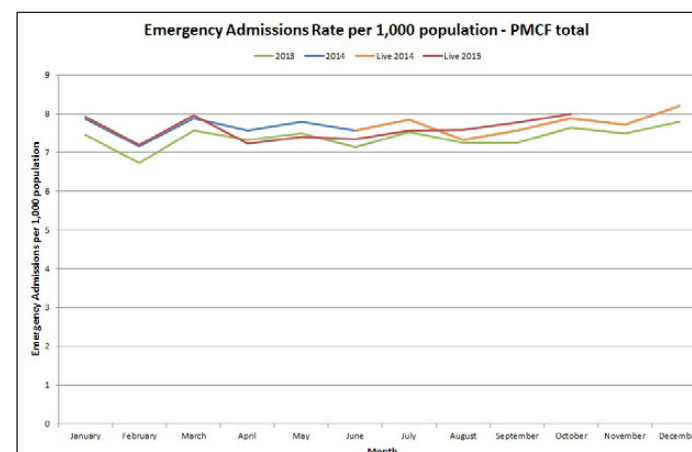


Figure 2: Profile of emergency admissions before and during the PMCF initiatives

48. Note the issue of attribution detailed in the assumptions and limitations in Section Two.

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

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

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. However data related to all but one pilot scheme 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 (**Slough, Herefordshire** and **Morecambe**) e.g. **Slough** which has seen an average reduction of approximately two contacts per 1,000 population per month; a 15% reduction against the baseline.

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.⁴⁹ However, this evidence is variable 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.

Finally

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.



49. These findings are reasonably consistent with the national findings of the GP Patient Survey.

Facilitating learning to better enable pilots to implement change

“Critical to the success of any programme or project is effective knowledge management - how you gather, create, organise, share, analyse and action knowledge”.⁵⁰

NHS IQ

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

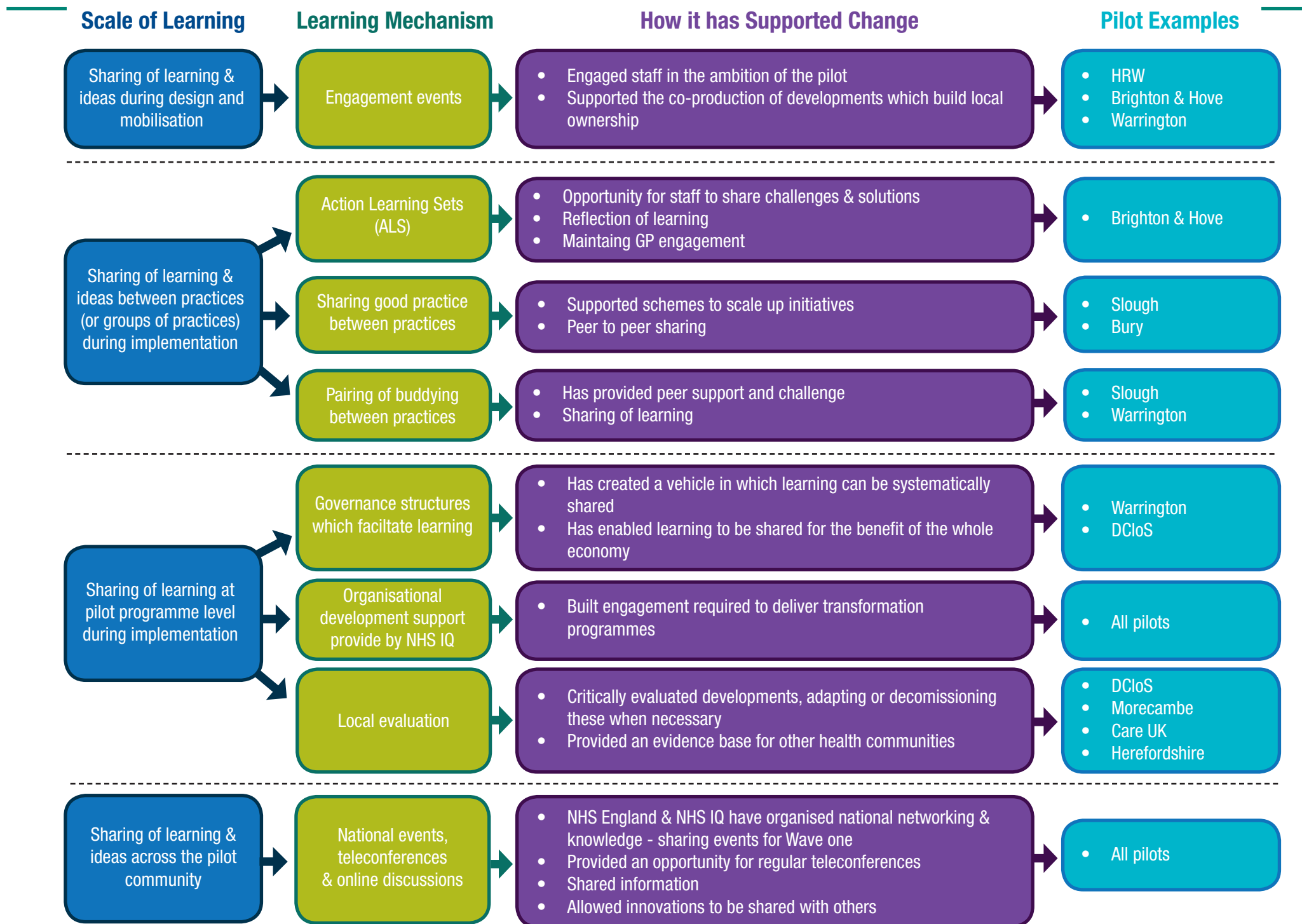
- **Initiation and mobilisation:** for many pilots there was a strong focus on the internal sharing of knowledge and ideas as they designed their programmes. This often involved a wide range of primary care professionals including: clinical leads, GPs, practice staff, as well as input from local commissioners and providers.
- **Implementation:** throughout the delivery phase, several pilots established mechanisms to continue the process of learning between practices.
- **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 and may also reflect demands on their time.

In addition to this, mechanisms have been established by the national programme and NHS IQ, which have supported exchange of knowledge and ideas and these are generally welcomed by the pilots. Every pilot engaged in this innovation support programme, which included face-to-face networking events with expert input, regular facilitated webinars and a dedicated online discussion forum. 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.



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



Tackling health inequalities in the local health economy⁵¹

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 increased 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 were used appropriately, this initiative supported 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 was established for deprived and hard to reach communities. The HealthPod was designed to provide 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 established a programme of health education with children in ten primary schools, co-designed by the lead GP and teachers. The programme engaged approximately 300 children. The programme received positive feedback from both families and children. Local data suggests that parents and children became more aware of the services available in the community to help with a range of illnesses. Teachers also confirmed that they found children to be more aware of NHS services.

Following the PMCF funded activity, the CCG has sought to further its work with primary schools. This has included the CCG meeting with St Mary's University in December 2015 to explore opportunities in collaborative healthcare teaching. The CCG intends to deliver a programme in 2016 to approximately 150 children in a primary school setting. Themes likely to be within the scope of the project include:

- Self-care for those with long term conditions
- Impact of smoking on parents and children in relation to pneumonia
- Uptake of immunisations
- Parental uptake of cancer screening
- Diet and healthy eating and physical activity (not replicating Change4Life).

In **Herefordshire**, young people were 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 was 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 improved speed of access for this patient cohort and has offered a more effective approach than telephone assessment. The surgery has maintained the service and have built it into their permanent way of working.

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.

51. For more information and examples see the 'Improving access for specific patient groups' showcase: <https://www.england.nhs.uk/wp-content/uploads/2016/01/pmcf-innv-shcse-nine-imprv-access.pdf>

In **Darlington** the frail elderly population were targeted through proactive management, assessments and care planning. This was undertaken by a multidisciplinary support team.

Within **Torbay and South Devon**, a Proactive Care Team (PACT) was established. This MDT has provided proactive, preventative support to patients identified as being at risk of admission to hospital, 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 has been achieved through the recruitment of specialist nurses and the implementation of the 'Year of Care' approach.



It is acknowledged that extrapolating data to understand whether an initiative has helped to tackle health inequalities locally is complex. There are other influencing factors and many of the initiatives developed to tackle certain patient cohorts ran for a relatively short period of time. More data would be required to support further analysis of outcomes. This will be looked at further during the evaluation of the wave two GP Access schemes.

Identifying models that can be replicated in similar health economies elsewhere

Replicating at scale access 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 and post-launch adjustments have been an important feature in determining the capacity and location of hubs.

Other replicable interventions

Some pilots are already rolling out initiatives beyond the pilot scheme boundary. For example, in **Morecambe**, two additional practices have already joined the extended hours service and it is envisaged that its 8am - 8pm '828' GP telephone triage model will be rolled out across the whole CCG footprint.

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 has been implemented in **DCIoS** and **Warrington**.
- The proactive management of complex patients through multi-disciplinary assessments and care plans. This has been 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**.

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.

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. The range of factors which need to be considered are summarised below. Particularly critical is the local geographical context i.e. is an area rural or urban and how are patients distributed across the locality. In addition the existing infrastructure which is already in place to support services is a vital consideration; transport connections and broadband, for example, are key dependencies when looking at replicability of an extended access model.

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 or if transport links are inconvenient. **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 the extended hours service model. A number of schemes have demonstrated success through creating a shared management and IT infrastructure.



Size of health economy

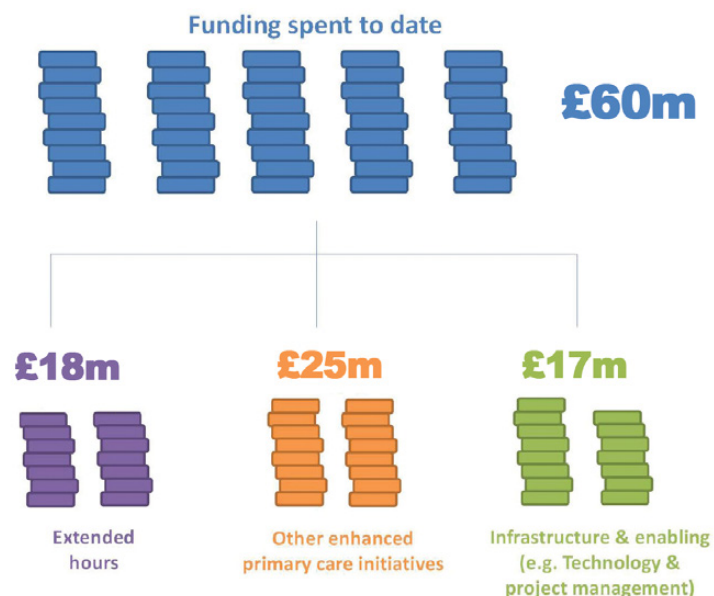
The relationships and culture between system partners is also likely to impact the ability of areas to replicate successful models. Commissioner involvement has also been an important feature of the pilots in **West Wakefield, Bristol, NWL, Warrington** and other pilots. In many pilots, PMCF developments 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.

Up to September 2015, pilot schemes have indicated a total spend of £60 million as part of their original and sustainability Challenge Fund monies and matched funding. Of this, schemes spent a total of £18 million (30%) on extended access schemes with further £25 million (42%) used to support other clinical initiatives that have been implemented. The remaining £17 million (28%) was used to support infrastructure and enabling activities such as technology developments and programme management.



Extended access

As set out in Objective one, an estimated 85,000 hours and 540,000 appointments had been provided through extended access hours up to September 2015. Therefore the average cost per extended hour was £211 and the cost per available appointment was £33.

However, this analysis does not take account of the **NWL** pilot where the funding for extended hours has come directly from the CCGs and not as part of the the Challenge Fund.

Excluding **NWL** and others such as **Care UK** (where the model for providing extended hours is very different or where the apportionment of costs attributed to extended access appears excessively high compared with what is being provided)⁵², the average cost per additional extended hour within a 'typical' hub and spoke model was around £215. Of this £215, the hourly cost of the GP may represent 50% or more.⁵³

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 was typically in the range of £34.

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, on average **the same cost as** routine core hours general practice care as defined by the Personal Social Services Research Unit (PSSRU) with a 12 minute GP consultation costing £37.⁵⁴ It was cheaper than the average cost of GP out of hours care.⁵⁵

The average annual cost per registered patient for extended hours provision was around £5.60. This represents the full cost of setting up a new service including staff costs and overheads.

52. For four pilot schemes the estimated cost per additional extended hour is in excess of £400.

53. Across these pilot schemes the minimum cost per was £102 and the maximum cost £399.

54. Unit costs of Health and Social Care 2015, Personal Social Services Research Unit.

55. 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 appointments of 16%.

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 7% and during extended working hours by 8%.

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 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. 50% of available core hours are supported by these staff who have provided around 690,000 available contacts between July 2014 and September 2015.
- **Brighton and Hove** pilot scheme where the investment of £43,000 has supported an additional 2,400 hours of pharmacist time; an average cost per hour of £18.
- Social prescribing at the **West Wakefield** pilot scheme. Since going live, this scheme has provided almost 7,300 additional hours at the end of September 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 £140,000, an average cost of £19 per hour.
- **South Kent Coast** pilot scheme's investment of £444,000 in paramedic practitioners and releasing GP time.

The use of these alternative clinical practitioners to support primary care services cost less than the GP's time; typically 50% or less of an average GP salary cost per hour. 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 releases GP capacity and represents a cost effective alternative. As an illustration, the typical salary cost per hour of a salaried GP is around £51. Therefore, based on this, the opportunity salary cost saving in Brighton and Hove to date would have been equivalent to £77,000 and for West Wakefield £225,000.⁵⁶

In **Birmingham** The mode of contact by telephone during core working hours has changed from 37% at the baseline to around 57%.

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.

It is recognised that for some schemes introducing more telephone consultations has not incurred any additional investment in technology. However, in terms of assessing the return on investment for those pilot schemes who have introduced new telephony systems both in hours and during extended hours to support the service, 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 against the investment in technology being made.

Examples of these include:

Pilot	Investment in Technology	Additional Telephone Appointments	Return on Investment
Brighton and Hove (telephone based triage)	£186,000	More than 102,000 additional available telephone appointments	Assuming a saving of 8,500 hours of GP face to face time with patients to date, this would have achieved an opportunity cost saving of £430,000 and more than offset the cost of the investment in new technology
Birmingham	£222,000 ⁵⁷	42,700 core hour telephone appointments have been made available	Assuming a saving of 21,350 face-to-face consultations, the saving in GP time to date would have been £180,000. Running this scheme for a further three months would result in a positive return on investment
Morecambe (telephone based triage)	£30,000	14,800 telephone appointments available during extended working hours	Assuming a saving of 1,230 hours of GP face to face time with patients to date, this would have achieved an opportunity cost saving of £62,300; again more than offsetting its investment

56. 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.

57. 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. These questions will be addressed by additional work in the wave two evaluation.

Impact on the wider system

As was highlighted in the wider learnings and lines of enquiry, across all pilot schemes a reduction of 42,000 minor self-presenting A&E attendances had been observed up to the end of November 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 Emergency Departments both in terms of staffing and financial resources.

Focusing on those 13 pilot schemes with a reduction in minor 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 annual reduction is 32,000 attendances. In terms of financial savings, this would generate a reduction in expenditure for commissioners of £1.9 million.⁵⁸ This saving would, of course, need to be offset against the investment in primary care. Although the cost of treating deflected attendances from A&E into primary care is less and hence a saving to commissioners. With a sufficient scale of deflections, this could also provide a cost saving to hospital providers. Whilst further work is needed to 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 if this change was seen at a national level then the savings would be over £13 million. As above, savings would be offset against the investment in primary care.

For emergency admissions and out of hours, to date only some schemes achieved a reduction. For the former, this may not be entirely unexpected.



58. Note that the source of this data is SUS. This differs from the previous analysis in the first evaluation report which was based on HES and included an extrapolation of the data to represent a full year.

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.⁵⁹

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, in **Brighton and Hove**, the pilot has been 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 had a track record of working together on their Health Care Integration Board, which was in place for two years prior to PMCF. 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 leadership⁶⁰ 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.

Morecambe: funding was 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 trialled the service with nurse consultations, making the most of available resources and utilising a multi-disciplinary model, rather than abandoning the initiative.

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.

59. The findings presented in this chapter remain consistent with the findings presented in the first evaluation report.

60. For further information and examples see the 'Effective leadership' showcase: <https://www.england.nhs.uk/wp-content/uploads/2015/03/PMCF-Innovation-Showcase-Seven.pdf>

Phased implementation

Phased implementation and 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 and 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.

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

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 have been designed and tested ahead of rolling out throughout the clusters more widely. This approach also allowed for evaluation and learning to be embedded.

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 some initiatives 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 practices⁶¹

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 **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 was 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 have been 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** have both circulated a newsletter. **Brighton and Hove** 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 patients⁶²

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 implemented a number of initiatives surrounding patient engagement and communication. The pilot 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 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. The pilot has held open days as well as establishing 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.

61. For further information and examples see the 'Successful practice engagement' showcase: <https://www.england.nhs.uk/wp-content/uploads/2015/03/pmcf-innv-shcse-4-pract-engag.pdf>

62. For more information and examples see the 'Successful patient engagement' showcase: <https://www.england.nhs.uk/wp-content/uploads/2015/03/pmcf-innv-shcse-3-pat-engag.pdf>

Brighton and Hove created a 'Citizen's Board' to gather patient and community viewpoints on programme development and implementation and to hold the programme to account. It has provided useful input around communication and how to tackle low utilisation issues.

Care UK 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 only one 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 CCGs of all three areas (Bristol, North Somerset and South Gloucestershire) are directly involved. The team considers it a good sign that CCGs want to collaborate with Bristol Co-Operative 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 NWL's PMCF programme was aligned with the wider transformational change agenda being pursued by the eight CCGs. This helped secure PMCF initiatives buy-in and credibility early on and has also helped to ensure a legacy.

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 was GP surgery locations to facilitate extended hours and additional interventions. Nine pilots utilised 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.

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

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

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.⁶³

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 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 have not had 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** found resourcing GPs during weekday evening sessions to be a challenge. The pilot reports that this was 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 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.

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.

Recruitment

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

Warrington found recruiting GPs to be a key challenge, as did **DCIoS** where the challenges in filling GP posts was already identified as problematic prior to PMCF. Therefore, the scheme 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 reported 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.

63. The findings presented in this chapter remain consistent with the findings presented in the first evaluation report.

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. 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**) trialed an IT approach whereby a bridge was created between two systems, but this could only provide access to a limited amount of patient data so it is not necessarily a sustainable solution to address issues round interoperability.

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 Adastra, 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

The five practices in **Workington** use INPS Vision. This system prevents nurses working in Workington from using a single tablet iPad that works across all five practices; instead, they have needed a tablet per practice, the costs of which were deemed prohibitive. Nurses were 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.

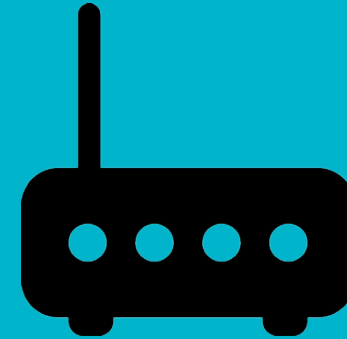
Bury

Bury highlighted limited IT provider capacity to prioritise their development, highlighting that GPs in extended working hours could not print prescriptions electronically which limited the pilot's 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

The provider that **Watford** originally commissioned to deliver its telemedicine solution was unable to meet the requirements and the pilot had to procure an alternative provider. This caused considerable delays to the project.



Contractual and legal issues

Following the challenges encountered by wave one pilots, NHS England provided considerable technology support for the wave two schemes. Technical assistance has been provided by a dedicated digital team; this team also established a procurement hub to help schemes access the technology solutions for their initiatives.

Indemnity insurance

There has been a lack of understanding about the difference between out-of-hours services and extended access. This has caused a shortage 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 also meant that certain nurse-provided services could not 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.

In response to requests from schemes, and with the support of NHS England, the medical defence organisations have updated their products. In most instances where clinicians in extended hours services have access to the patient's record, cover is now provided at the same rate as for general practice.

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.

Care Quality Commission registration

The need for Care Quality Commission (CQC) registration for hubs and federations was an unexpected additional cost for some schemes 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 its 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: www.cqc.org.uk/sites/default/files/20151112_GP_federations_registration_advise_revised.pdf

Information governance (IG)

It is recognised 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 Two compliant before they could legally sign the Data Sharing Agreement.

NHS England has recognised many of these issues and put into process a range of measures and support for the benefit of the wave two schemes.

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.



Collection of data

As mentioned previously 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. Traditionally general practice has not been required to provide data on activity rates. Information is collected about appointments by clinical systems but reporting and analysis functions are limited. **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 has commissioned the procurement of a software tool to extract practice based aggregated data. This will ease the burden of data collection by individual schemes and ensure consistency in the data capture process.

Conclusions

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 low.

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

Based on the evidence on current provision and additional extended hours it is suggested that, for example, for a pilot operating an extended hours hub which serves a 40,000 registered population then around 20 hours per week of extended hours provision would be about the norm in order to meet the levels of demand experienced in these pilots and to optimise utilisation. 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.

On average, the annual cost per registered patient to support additional extended hours is £5.60. This represents a full cost covering all clinical staff time and overheads associated with setting up a new service; typically 50% of this cost can be attributed to GP time. The annual cost per hub serving 40,000 registered patients is therefore around £224,000.

Contact modes⁶⁴

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. 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. Beyond this, and as part of the GPAF wave two evaluation there will be ongoing work to understand more work still 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 had fewer tangible benefits and have generally had low patient take-up to date. These modes of consultation will continue to be looked at during the wave two evaluation.

Collaboration and skills mix⁶⁵

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.

Mobilisation and implementation

Effective mobilisation⁶⁶ 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.

64. For more information and examples see the 'Using technology to enhance access' showcase: <https://www.england.nhs.uk/wp-content/uploads/2015/03/pmcf-innv-shcse-2-tech.pdf>

65. For more information and examples see the 'Collaboration in delivery' showcase: <https://www.england.nhs.uk/wp-content/uploads/2015/05/pmcf-innov-showcase-five-collaboration-delivery.pdf>

66. For more information and examples on mobilisation see the 'Pace of implementation' showcase: <https://www.england.nhs.uk/wp-content/uploads/2015/03/pmcf-innv-shcse-one-pace.pdf>

Scale and scope

The wave one pilots were 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.⁶⁷ Experience from the 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. Consideration also needs to be given to co-terminosity with the CCG, with one or more federations / networks operating within this as locally appropriate.

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 hub 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 in most pilot areas provide 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.

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 procurement and CQC registration have been 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 have been better placed to secure future funding.

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, 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

There were some issues raised around inequality of 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 inequalities 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 in agreement 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 eighteen months in moving away from independent working to delivering services at scale through collaboration is added value in itself.

Based on the evidence gathered through the evaluation of the wave one pilots, overleaf is a recommended roadmap for the implementation of new and innovative primary care services to improve patient access.

Roadmap for implementation: lessons from the wave one

Context

Alignment

Does your local economy currently have other transformational change programmes underway?

YES Ensure that your primary care plans are integrated with wider change processes to help with buy-in and momentum. Engagement with practices will need focus on how inter-practice collaboration fits in with wider change plans.

NO A more intensive programme of continued engagement with practices will be required to secure buy-in and also ownership. The NHS Sustainable Improvement Team can provide support in this.

Have your CCG(s) been closely involved in developing your plans?

YES This will set you up well for sustainability.

NO Plan to engage with the CCG regularly throughout implementation to share emerging findings and help ensure that successful initiatives are recognised in commissioning decisions.

Practice relationships

Is there a history of practices collaborating to offer joint services to patients?

YES Build on these relationships and don't seek to reinvent the wheel. Encourage the establishment of federations if they are not already in place to formalise joint working (although plan in time for this).

NO More intensive engagement with practices will be required to help with mind-set and behaviour changes. Informal networks may be more appropriate initially; this may also enable quicker mobilisation Aim to co-produce plans with practices for deeper commitment.

Size, scale and collaboration

How many practices are involved in your plans?

Large
Over 30 Larger scale collaboration can take longer to mobilise; this needs to be reflected in your project plan. Phasing delivery is recommended. Direct engagement with the project team may be difficult to maintain so consider other channels of communication to ensure practices feel connected.

Small
Under 30 Mobilisation is likely to be quicker (as long as there is GP buy-in) and initiatives should be easier to tailor to GP and patient needs. Without critical mass, however, it will be more difficult to demonstrate system-wide changes (i.e. impacts on A&E) and you may need to pay more attention to creating alignment with other parts of the wider system.

Geography

Are participating practices spread across a rural or urban area?

Urban Hub and spoke models of delivery can work well as most patients are likely to be in close proximity to the hub. Good transport links are still an important consideration.

Rural Geographical proximity to the hub can pose problems for face-to-face access; telephone, web and initiatives with home visit options may work better.

Service Offer

Extended hours

Will you be delivering non-core GP appointment hours?

YES There will be variability of demand through the week; week nights and Saturdays have been more popular with patients to date, whilst Sunday slots have been problematic to fill. Important to measure demand and adjust capacity to utilisation. Evidence suggests on average schemes are providing an additional 30 minutes per 1,000 registered patients. For example, 20 additional hours per week per 40,000 patient population will meet demand for non-core hours provision.

NO Ensure that there is no patient demand for this service. Consider a non-core hours GP telephone triage model or telephone consultations if GP capacity or hub premises are difficult to secure. Monitor patient demand and feedback.

Modes of contact

Are you introducing different ways in which to contact your GP?

YES
telephone Investment in telephone consultation technology can prove cost-effective due to GP time-savings and are a convenient mode of consultation for some patients. A triage or navigation system which identifies whether an appointment needs to be with a GP or another practitioner can maximise the utility of this mode.

YES
Online tools Limited evidence about the success of online diagnostic tools to date. Trialling with a cohort of practices will help test whether it is an appropriate solution for your local area. Engagement with GPs will be necessary to secure buy-in.

Email & Video Not yet an evident large patient demand for these tools. Trialling with a cohort of practices will help test whether these are an appropriate solution for your local area. Engagement with GPs will be necessary to secure buy-in.

Other practitioners

Are you planning to integrate different practitioners into your service model?

Nurses / ANPs Additional use of nurses has proved popular with patients and has released GP time. Recruitment can be a challenge, so allow time in project plans. Short-term contracts are not attractive to all so, where possible, long-term contracts should be created.

Pharmacists Another effective way to release GP time and generally good buy-in from the pharmacy profession. Practice based pharmacists may be more effective at reducing demand than bookable appointments in community pharmacy.

Physiotherapists This appears safe and welcomed by GPs and patients for appropriate problems. Training and confidence in reception staff is crucial to making best use of 'physio first' services.

Paramedics / A&E Working with A&E can help tackle demand but impacts are more pronounced when the scale of collaboration is bigger. This doesn't necessarily ease pressure on GP time as some patients will be re-routed to a primary care setting for treatment. However, evidence suggests home-visits by paramedics can relieve pressures on GP time. Engagement with A&E providers is crucial.

Other initiatives

Are you considering implementing other initiatives?

YES Ensure that other initiatives are based on evidence of both patient demand or GP need / buy-in. Clinical leadership is important. Phase introduction around other services to reduce burden on practices.

NO Consider whether any non-patient facing activities might be beneficial in terms of saving GP time. These interventions are often reliant on training existing practice staff rather than recruiting new practitioners.

Set Up

Leadership

Do you have an identified leadership team with time set aside?

YES Ensure leaders are receiving ongoing support and coaching and that you are continually sharing out leadership to build the wider team.

NO Begin by identifying natural leaders who can be trained and supported to set vision, engage partners and steer change.

Premises

Are you setting up a new hub location?

YES The hub will need CQC registration; this takes time so delivery plans should plan for this in advance.

NO Using existing practice premises can avoid mobilisation delays. However, care needs to be taken to ensure equity of access for all patients that the hub is serving.

Interoperability

Are practices sharing access to patient records where previously they didn't need to?

YES Securing read-write access to patient records and data sharing agreements in place is time consuming and needs to be factored into project plans. Close working with IT providers, practices and NHS England's digital team is essential.

NO Of practices currently sharing records, a significant barrier will be removed. If there are no plans to share records, this could limit the type of service offered to patients. Again, the NHS England digital team can provide advice and support.

Project management

Do you have a dedicated project management team in place?

YES This will help project delivery. Ensure there is clinical representation/leadership.

NO Making the change to inter-practice collaboration is resource intensive. Without a dedicated delivery team, timelines are likely to slip and practice buy-in will be difficult to maintain.

Engagement

How are you planning to engage with practices and patients?

Practices Continued engagement is critical to secure buy-in, listen to feedback and learn lessons. This should involve all practice staff and be a two way process.

Patients Engagement at project-set up will help provide evidence of demand for services. Ongoing feedback will help to tailor and flex resources.

Investment

What financial investment is likely to be required?

Extended hours Evidence suggests that the average cost for each additional non-core hour is £215, which includes clinical times and overheads. Based on 40,000 patient hub, costs are around £5.60 per head of population per annum

Infrastructure Programme management federated working is estimated to be around £1.20 per head of population per annum.

Ongoing monitoring

Have you set up mechanisms to access service impacts?

YES Ensure results are shared with commissioners.

NO Introduce systems to gather real time data about activity and outcomes. This will allow services to be optimised rapidly and benefits to be demonstrated to commissioners.