

GM Primary Care 7-Day Access Evaluation

Final Report

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NIHR CLAHRC Greater Manchester

(The views expressed are those of the authors and not necessarily those of the NHS, the NIHR, or the Department of Health and Social Care)



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Executive Summary

- This report presents an evaluation of 7-day access to primary care services in Greater Manchester (GM), prepared in March 2017 by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) GM on behalf of NHS England GM.

1.1. Background

- Extended access to general practice in England (evening and weekend opening) has been a national health policy priority in recent years and is key to the GM Health and Social Care Partnership Primary Care Strategy.
- As part of devolution, seven CCG areas across GM not in receipt of GP Access Fund (GPAF) support received funding from NHS England (Greater Manchester) to implement extended access. These areas were: Bolton; Heywood, Middleton and Rochdale (HMR); Oldham; Salford; Stockport; Tameside & Glossop and Trafford.
- The seven new schemes were expected to start in December 2015 for 12 months, although some indicated a later start date. All operated on a 'hub' basis.
- The report focuses on six CCG areas: Bolton, Heywood, Middleton and Rochdale (HMR), Oldham, Stockport, Tameside & Glossop and Trafford as Salford did not establish a 7-day access service within the period of evaluation.

1.2. Methods

- The evaluation combined qualitative and quantitative analysis to assess: activity (what was done in terms of 7-day access availability and uptake); process (how was it implemented) and; outcomes (the impact on wider service utilisation i.e. A&E attendance; hospital admissions and OoH use).

1.3. Findings: Activity Evaluation

- Approximately 50,000 extra appointments were provided in total, 76% being booked and 67% attended. Provision and proportion booked/used increased over the 12 month period.
- The scale of provision varied substantially, from 144 appointments per 1000 patients in HMR, 23 per 1000 in Bolton and Tameside & Glossop, to 12-15 appointments per 1000 in Oldham and Trafford.

- The proportion of DNAs overall exceeded the typical rate of DNA for core hours, ranging from 10% (Oldham) to 17% (Trafford and Tameside & Glossop),
- The vast majority (82%) of appointments were with GPs.
- Weekday appointments enjoyed a higher rate of utilisation overall (76-86%) than Saturdays (66%) or Sundays (60%). Again, there was high variation between areas.
- Utilisation of Sunday appointments increased gradually throughout the year and varied substantially between areas.
- The proportion of DNAs was highest on Thursday and Friday and lowest on a Sunday.
- The overall patient profile of extended access users was disproportionately female, and relatively young (70% aged <50); fewer patients aged over 60 used the service.
- A 'hub dominance' effect was evident whereby patients registered at a hub practice were more likely to use extended hours than patients at other practices.
- HMR provided substantially more appointments than any other area and more than the other four combined. The highest overall utilisation of appointments was in Trafford (89%) and the lowest in Oldham (56%).
- As access in four areas (Bolton, Stockport, Tameside & Glossop and Trafford) was moderated by the need for patients to be referred through and by their own GP practice (the 'referral moderator' effect), activity data from these areas does not provide a clear measure of patient demand.

1.4. Findings: Process Evaluation

- There was significant variation in how areas framed and delivered 7-day access, reflecting local CCG area conditions and differing conceptions of the purpose and value of the service.
- Some areas designed 7-day access around routine rather than urgent care (limiting available hubs/appointment hours and promotion of the service and ensuring appointments were pre-booked, typically via GP practices). Others covered both routine and urgent care needs (offering more appointments from the outset, often from a larger number of hubs, and allowing patients to self-refer through central booking lines).
- Differences in estimated capacity to deliver the service and predictions of patient demand were also evident. Some postponed implementation due to wider primary care reconfiguration; some limited their service due to workforce challenges or began cautiously and increased the service gradually through the 12 month period; others provided a more extensive 7-day service from the outset.

- Key issues for implementation were identified:
 - Differences in communication strategy (with patients) moderated demand.
 - The relationship between CCG and (multiple) providers in an area, and the history of recent reorganisations of primary care was a key factor in successful engagement with providers.
- Workforce shortages affected service delivery, with competition for GPs and nurses from the same local labour market and associated increases in pay rates. Willingness to work short (2-3 hour) shifts was influenced by timing and location of sessions.
- Areas with well-established GP federations had certain advantages in the delivery of 7-day access on a hub basis.
- Common IT systems in GP practices across a CCG area facilitated patient record sharing with the potential for read/write access.
- Different estates strategies were evident depending on a range of local conditions and a view to longer-term neighbourhood-working. Use of LIFT centres could offer advantages, but also unanticipated challenges.
- The backdrop of wider primary care reorganisation in GM and across England affected implementation with some areas taking a cautious approach to ensure service sustainability under new models of care and others engaging proactively to accelerate integrated care and thereby maintain funding and sustainability.

1.5. Findings: Outcome Evaluation

- The outcome analysis suggests an association between 7 day access and A&E attendances.
- Rises in A&E activity were seen in all areas between 2015 and 2016 with the exception of Bolton and HMR, where A&E activity held constant.
- Self-referrals to A&E for minor ailments fell in Bolton and slightly declined in HMR, but rose in all other areas except Oldham, reflecting overall A&E attendance figures.
- There were reductions in minor intensity A&E activity in the age group 20-49 in Bolton and HMR, with no change in Oldham, and increases elsewhere.
- Hospital admissions fell between 2015 and 2016 in all areas, with the only statistically significant falls in HMR and Oldham. Admissions for Ambulatory Care Sensitive Conditions (ACSC) fell substantially in all areas except Bolton, led by a fall in ACSC admissions for those 50+.
- A&E activity in hub practices (which tended to have the highest rates of utilisation of 7-day access services) generally did not increase, while non-hub practices saw increases in A&E activity.

- Minor intensity, self-referred A&E activity by age showed reductions in attendance among those aged 20-49 (the cohort most likely to use the 7-day access service) in Bolton and HMR, and no increases in attendance from 20-49 year olds in Oldham.
- There is no strong evidence on an impact on hospital admissions.
- Reductions in OoH activity were observed but were likely to be compromised by a major change in NHS 111 policy across this period. No conclusions can be drawn on the impact on OoH.

1.6. Discussion

- Each area chose to implement 7-day access in a different way, depending on local conditions and varying conceptions of the nature and extent of the service. Areas also varied in terms of the level of caution or ambition displayed in their initial implementation, depending on perceptions of likely demand and capacity to meet this demand.
- The approach adopted generated different models of 7-day access in each area that varied in terms of the extent to which the service was publicised, route of referral/booking, number and location of hubs, choice of clinician to staff the service and availability.
- These decisions had implications for the level of demand for the service and utilisation, reflected in the wide variations in activity levels. In particular, extent of direct communication to patients and the route of referral/booking seemed to have the greatest influence on activity level. A 'referral moderator' effect appeared to moderate activity levels in areas where patients were not able to directly book extended access appointments.
- Activity varied substantially between areas and did not mirror provision; hence areas providing the highest number of total appointments saw higher levels of utilisation than other areas offering far fewer total appointments.
- Overall uptake, in terms of number of appointments used and percentage utilisation, appears to have improved overall over the 12 months, suggesting it takes a period of months for patients to become aware of the service and accustomed to using the new service.
- Each of the areas witnessed a 'hub dominance' effect, but the strength of this varied by area and by hub. Hub dominance is likely to be affected by communication strategy, provider engagement, local geography and transport and decisions about hub location.
- Each area also faced different challenges in implementing the service in terms of communications and engagement; workforce and staffing; GP federation

arrangements; information technology and governance; and estates. The level of challenge varied substantially presenting a clear need for cross-programme learning.

- The report's conclusions do not take long-term trends into account (an interrupted time-series analysis would be necessary to address this issue fully).
- The evaluation has not attempted a cost-benefit analysis of the 7-day access service. This would be recommended to inform detailed strategic decisions on the continuation or extension of this service.
- Impact on patient satisfaction was not evaluated due to a delay in the publication of national GP Patient Satisfaction survey data for the period. This will be provided as an addendum to the report when it is available.

2. Introduction

Since 2013, extended access to general practice in England (evening and weekend opening) has been a national health policy priority and is key to both the Greater Manchester (GM) Healthier Together Primary Care Standardⁱ and the GM devolution agreementⁱⁱ. This section presents the background to extended access in general practice, touching upon the multiple dimensions of access, summarising the national policy initiative and recent evidence from pilots, and introducing the regional policy context and initiatives in GM.

2.1. Access to General Practice

'Access' to healthcare can mean different things to different stakeholders, according to aspects that are particularly valued, resulting in some controversy over definitions of access. It is therefore helpful to identify the different dimensions of access to care from the outset^{iii,iv}. These dimensions include: *physical access to services* (distance to service and the logistics of the place and means of delivery); *timeliness* (speed and hours of access); and *choice* (ability to see a preferred doctor or nurse)^v. Access to a *range of quality services* (appropriate levels of expertise) which takes account of *system-wide dimensions* to meet individuals' social, educational, religious, cultural, language or other circumstances are also considerations in defining access^{vi}. In light of this, access is best understood as a multidimensional concept, and there may be inherent tensions in attempting to achieve different aspects of access to general practice, involving trade-offs^{vii,viii}. One way general practices can offer patients more *timely* access is to extend their opening times beyond core contracted hours^{ix} and this has been a key focus of national policy in recent years.

2.2. National Policy and the Extended Access Initiative

The GP Access Fund ('GPAF' – formerly the Prime Minister's Challenge Fund 'PMCF') awarded £50m to 20 pilot sites in 2014 (Wave 1), and a further £100m to an additional 37 sites in 2015 (Wave 2), to help improve access and prompt innovative ways of providing primary care services. The underlying aspiration was to relieve pressure on acute care by reducing costly accident and emergency (A&E) visits and unplanned hospital admissions through the provision of additional availability in general practice^x. In 2016, the *Five Year Forward View (FYFV)*^{xi} underlined the need for readily accessible GP services nationally, with the subsequent *General Practice Forward View (GPFV)* promising funding to enable every patient to have access to 'sufficient routine appointments at evenings and weekends to meet locally determined demand' by 2020, alongside out-of-hours (OoH) and urgent care services^{xii}. The

GPFV aimed in particular to enable easier access to general practice for people in employment^{xiii}, with the balance of 'pre-bookable' and 'same-day' appointments offered and the level of capacity provided left to commissioners to decide in the light of patient demand^{xiv}. The requirement for a national roll-out of a minimum level of extended access (tied to £138m recurrent funding 2017/2018 and £258m 2018/2019) was indicated by NHS England (NHSE) in late 2016^{xv}.

2.3. Recent Evidence from Extended Access Programmes

As part of the Primary Care Demonstrator Programme for GM, in 2014 NHSE GM provided £3.1 million to enable groups of practices to provide additional availability appointments. An evaluation of the initiative by the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care (NIHR CLAHRC) GM^{xvi} investigated the effects of these appointments on A&E attendances, OoH and walk-in centre activity, and patient satisfaction. The study found a 3% reduction in total A&E activity in 7-day access practices compared to the rest of GM, a 9% reduction in A&E attendances for minor conditions, and an 11% reduction for self-referrals to A&E. Reductions in OoH and walk-in centre activity of 38% and 14% respectively were found in one of the demonstrators. With regard to patient satisfaction, there was no effect found for several questions related to opening times, convenience and satisfaction. In terms of uptake, the study found that 65.5% of appointments offered were booked, with uptake of weekday and Saturday appointments greater than for Sunday across all sites. Later adjustments to the A&E activity analysis provided an alternative approach to adjust for selection bias and assessed self-referrals for minor conditions, finding an insignificant total A&E effect and a 26.4% reduction in self-referred attendances at A&E for minor conditions (10,933 fewer visits) in comparison to practices in GM without additional appointments. The costs of treatment for self-referring patients with minor conditions were found to have reduced by £767,976 in comparison to practices without additional appointments. The study highlighted the need for further evidence to ascertain the cost-effectiveness and sustainability of extended primary care access^{xvii}.

The interim evaluation of the national PMCF Wave 1 pilots reported most recently in December 2016^{xviii}, also finding a reduction in minor self-presenting attendance at A&E of 42,000 across the pilot schemes compared with the same period across previous years (a 14% reduction). This was estimated to generate a reduction in annual A&E expenditure of £1.9m, to be offset against the investment in primary care. No differences were seen in emergency admissions and use of OoH services. Patterns of uptake were similar to those found in the GM demonstrator programme, in that demand for routine appointments on Sundays was lower

than the more popular weekday and Saturday morning appointments. Findings from some pilots indicated that weekend appointments might best be reserved for urgent rather than pre-bookable routine care.

A separate evaluation of 7-day access arrangements as part of the Central London Clinical Commissioning Group (CCG) PMCF scheme compared changes in A&E activity for hub practices to changes in A&E for non-hub practices. Similar reductions in A&E were observed and found to be greater at weekends, and for conditions of moderate severity only; no effect was found for minor severity.^{xix}

A further evaluation of three Nottinghamshire weekend GPAF hub pilots recently found low uptake of available urgent care appointments at weekends (as low as 18% on Sundays) and bank holidays^{xx}. The highest use of appointments was for patients under 5 years of age, with low use by those of working age. This evaluation included a patient preference survey, to rank aspects of access that were most important to patients. These included; the ability to be seen on the same-day, continuity of health professional, and convenience of opening hours. The key finding from the survey was that speed of access (i.e. being able to have same-day appointments) was more important to patients than 7-day opening.

Both the GM demonstrator programme and the national evaluation of Wave 1 pilot sites included qualitative research that offered wider learning and insight into the process of implementing extended GP access. Qualitative analysis identified key enabling factors that offered advantages for service delivery and sustainability including: collaborative 'hub' working; Information Technology (IT) systems inter-operability; collectively agreed information governance (IG); appropriate workforce capacity; strong public engagement and communication with staff; and suitable estates and facilities.

Overall, evidence to date suggests that providing extended hours appointments is associated with reductions in minor A&E attendances. However there are associated cost implications, issues of poor uptake, and limited evidence of an impact on patient satisfaction.

2.4. The Regional Extended Access Context

In June 2014, the 12 GM CCGs committed to the Healthier Together Primary Care Standard that by the end of 2015, 'everyone in GM who needs medical help will have same-day access to primary care services, supported by diagnostic tests, seven days a week'^{xxi}. At the same time 7-day primary care access was made one of eight early implementation priorities under the GM devolution agreement^{xxii}. The GM vision was to ensure 'timely access to good quality 7-day a week primary care to screen, diagnose and treat and prevent disease as early as

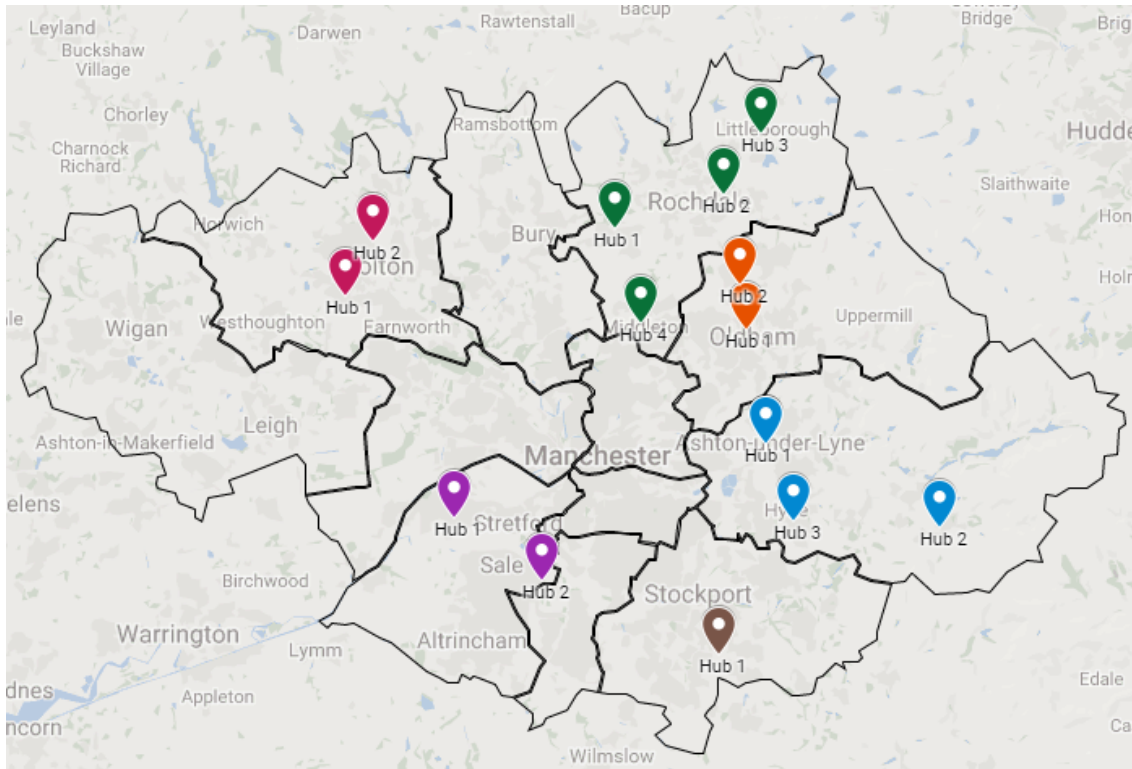
possible^{xxiii}. In line with the GM Health and Social Care Partnership Primary Care Strategy^{xxiv}, seven CCG areas across GM not previously in receipt of Wave 1 PMCF or Wave 2 GPAF funding received financial support from NHS England (Greater Manchester) to implement extended access.

2.5. Study Aim

Building on the GM demonstrator programme evaluation, during 2016/2017 NIHR CLAHRC GM evaluated the new 7-day access to primary care services on behalf of NHSE GM, combining a focus on **activity**, **process** and **outcomes** in order to provide a comprehensive assessment of the implementation and impact of the new services.

3. 7-Day Access Provision by Area

Figure 1: 7 Day Access Areas and Hub Locations



Map Data ©2017 Google

3.1. Bolton

In Bolton, extended access prior to the 7-day access initiative was offered by 46 out of a total of 50 general practices, under pre-existing Directed Enhanced Services (DES) arrangements. Its OoH service operated out of Waters Meeting Health Centre, and in-hours general practice services were being enhanced and supported by the 2015 Bolton Quality Contract (BQC). The 7-day access programme was introduced to Bolton in March 2016, with the establishment of two hubs: the Halliwell Surgery (near to the town centre) and Deane Medical Centre (to the west of Bolton). The hubs were identified by the local GP federation, in collaboration with the CCG and local GP practices, according to which practices were most easily accessible by public transport (both within 15 minutes by bus of the majority of the population of Bolton). The hubs opened Saturday and Sunday mornings and Bank Holidays only, with no evening availability. Each hub operated extended primary care access using existing Bolton GP practice staff, with three GPs and a practice nurse covering each shift. All appointments were routine and the service included managing investigations and making onward referrals as required. Different levels of support for the principle of 7-day access in the area, as well as

Bolton doing a 'soft' launch, affected uptake initially. The service was widely communicated to patients, through local media, social media and GP practices, but patients could not book directly and relied on their GP practice to refer them on and book appointments on the 7-day service. However, by August 2016, demand was reported to be outstripping availability for the service. Bolton's key challenge resulted from different IT systems being used by the different participating practices, generating practical complications.

3.2. Heywood, Middleton and Rochdale

Heywood, Middleton and Rochdale (HMR)'s 7-day access service began with the opening of their first hub in December 2015. Prior to this date, extended access in HMR had been offered through DES and Alternative Provider Medical Services (APMS) contracts, with a handful of practices (between 5 and 10 out of 37 in HMR) choosing not to implement the DES. These services were supported by normal OoH arrangements with the local OoH medical and dental care provider, Bury and Rochdale Doctors on Call (BARDOC). HMR's 7-day access service was set up on the back of an established winter pressure clinic service; this service delivered additional routine in-hours services from three sites to manage demand, and provided a model which was expanded to deliver 7-day access. HMR's primary care services provider, GP Care Services Ltd, took responsibility for implementing the 7-day access service. The service operated out of four hubs: Birtle View Medical Practice (Heywood), Kingsway Medical Practice (Rochdale), Littleborough Group Practice (Rochdale) and Peterloo Medical Centre (Middleton). Patients booked appointments directly through a central booking line (open 8am to 9pm) handled by BARDOC. HMR's key challenge lay in meeting its demand for 7-day access appointments.

3.3. Oldham

Prior to 7-day access in Oldham, 37 out of 44 practices offered extended hours under DES arrangements. In addition, in-hours general practice services were enhanced and supported through sign-up by all practices to the EQALS^{xxv} Plus and EQALS Boilerplate schemes. Oldham's primary care provider, *gtd Healthcare*, operated OoH services in Oldham, including a walk-in service at the Integrated Care Centre (ICC) site in central Oldham. Oldham's 7-day access service went live in December 2015, operating out of the ICC hub in Oldham town centre, and with *gtd Healthcare* operating a 24/7 central booking line. The Royton hub in Oldham north opened later in 2016^{xxvi}. Both hubs were located in Local Improvement Finance Trust (LIFT) centres and had certain contractual issues concerning building access, with estates being a central challenge. The service was not directly promoted to patients; instead,

information was provided to GP practices who gave out information to patients including details of a central booking line, open 24/7, which patients then contacted directly. Oldham's 7-day access service offered GP appointments only, and difficulties in securing drivers out-of-hours to pick up samples from the hubs meant it had yet to include diagnostics as part of its service.

3.4. Salford

At the time of data collection, Salford's 7-day access initiative was in development, with commissioning/procurement estimated to be finalised in the autumn of 2016. Consequently the future roll-out of 7-day access in Salford lay outside the timeline of this evaluation. However, extended access to primary care included a number of practices operating DES arrangements and three local extended access pilots, together offering a small number of extra appointments outside of core GP hours. The OoH service was being provided by Salford Royal Foundation Trust (SRFT). The plan for 7-day access in Salford was to replace the funding for the DES with five hubs across the CCG area.

3.5. Stockport

About 12 months prior to the call for 7-day access, all 47 of Stockport's GP practices signed up to a 'GP Development Scheme', introduced by the CCG, that streamlined a number of the old enhanced services, and requested that every practice sign up to the DES (if they had not already done so). This asked practices to double the capacity required by DES arrangements. In addition, Stockport's primary care services organisation, Mastercall Healthcare, provided Stockport's OoH service as well as providing home intravenous therapy and a number of other 'out of hospital' healthcare services. Stockport's GP Federation, Viaduct Health, subcontracted the 7-day access pilot to Mastercall Healthcare and used the Mastercall site as a single hub because it was already set up to see patients during evenings and at weekends. The service was not directly promoted to patients; instead, information was provided to GP practices. No direct booking line was provided for patients, who instead relied on their GP practice to refer them on and book appointments on the 7-day service. As the service was operating on the premises of the local OoH provider, the range of services available was comprehensive. For example, Stockport's 7-day access service offered routine GP and nurse appointments, ECGs, cervical smears and phlebotomy on Saturdays and Sundays, with sample collection and transfer to laboratory services at Stepping Hill Hospital. However, under-utilisation of the 7-day access programme in Stockport, by both patients and practices,

was reported as one of Stockport's key challenges, together with a lack of workforce buy-in, leading to redesign of the service.

3.6. Tameside & Glossop

Before the 7-day access pilot, approximately 26 practices out of 37 in Tameside & Glossop offered extended access through DES arrangements, with four more offering extended access on APMS contracts. Tameside & Glossop set up three hubs in response to the call for 7-day access based at Ashton Primary Care Centre, Glossop Primary Care Centre and Thornley House Medical Centre. These hubs delivered the 7-day service in collaboration with the local primary care provider, *gtd Healthcare*. The hubs went live in December 2015 and offered appointments weekday evenings and Saturday and Sunday mornings. Information on the service was cascaded through GP practices. No direct booking line was provided for patients, who relied on their GP practice to refer them on and book appointments on the 7-day service. The appointments were limited to GPs initially, although nurse appointments were planned to begin in November 2016, with a weekly cytology clinic held on a Tuesday at one hub. Further diagnostics had not been planned due to logistical difficulties in transporting samples out-of-hours. The 7-day service employed a general practice receptionist to act as Service Coordinator, with *gtd Healthcare* paying GP salaries using existing payroll infrastructure. Its main challenges included the recruitment of GPs for one of its more geographically remote hubs; a high number of did not attend (DNAs); and limited interoperability between practices on different IT systems for record sharing.

3.7. Trafford

For approximately five years before the start of the 7-day access initiative in Trafford, three quarters of the GP practices in the area had been offering extended access through DES or Locally Enhanced Services (LES) arrangements, with freedom to determine individual opening hours. In addition, an urgent care and walk-in centre affiliated with the OoH provider, Mastercall Healthcare, operated from the site of Trafford General Hospital. 7-day access appointments were introduced in Trafford in January 2016, operating out of two hubs: one at Flixton Road Medical Centre, covering west and north Trafford, and a second at Boundary House Medical Centre, covering central and south. The hubs were chosen by the CCG and local GP Federation, Trafford Primary Health (TPH), in collaboration with local GPs. The extended service operated on Saturday mornings only. Saturday opening was prioritised because most practices (approximately 21 of 32) continued to operate some extended opening under DES arrangements. Information about the 7-day service was circulated through

GP practices and on the GP federation website. There was no direct booking line and patients relied on their GP practice to refer them on and book appointments on the 7-day service. Obstacles encountered in the implementation of the initiative included IT limitations in relation to sharing patient records and securing workforce indemnity, particularly for nurses; limited diagnostics (only cytology and ECGs offered with no blood/urine testing).

A summary of the 7-day access as implemented in each area can be found in **Table 1** below.

Table 1: Summary of 7 Day Access Implementation by Area

	Approach and providers of 7DA service	Number of hubs and opening hours	Route of referral	Service	Diagnostics
Bolton	Led by Bolton GP federation in collaboration with local GP practices	2 hubs. Open weekends only. (9am-1pm Saturdays and 10am-1pm Sundays and Bank Holidays.)	No direct booking line: patients referred through own practice	Routine GP and nurse appointments.	Yes
HMR	Led by GP Care Services Ltd primary care provider in collaboration with BARDOC OoH provider and local GP practices	4 hubs. Open 7 days. (6:30-9pm Monday – Friday, 8am-6pm Saturdays and Bank Holidays, and 10am-1pm on Sundays.)	Patients referred through own practice and self-refer through 8am-9pm direct booking line	Routine GP and nurse appointments	Yes
Oldham	Led by <i>Innovative GP Care</i> GP federation in collaboration with <i>gtd Healthcare</i> OoH provider and local GP practices	2 hubs. Open 7 days (one hub reduced hours) (6.30-8pm Monday to Friday and 10am-2pm Saturday and Sunday.)	Patients self-refer through a 24/7 direct booking line.	GP appointments only	No
Salford	N/A	N/A	N/A	N/A	N/A
Stockport	Led by Viaduct Health GP federation in collaboration with Mastercall Healthcare OoH provider and local GP practices	1 hub Open weekends only. (10am-3pm Saturdays and Sundays.)	No direct booking line. Patients referred through own practice.	Routine GP and nurse appointments	Yes: ECGs, cervical smears, phlebotomy; sample collection.
Tameside & Glossop	Led by Tameside & Glossop GP federation in collaboration with local GP practices	3 hubs Open 7 days (6.30-8pm Monday - Friday and 9am-12noon Saturdays and Sundays.)	No direct booking line. Patients referred through own practice.	Primarily GP appointments only (nurse appointments available from November 2016)	Weekly cytology clinic on a Tuesday at one hub. No other diagnostics.
Trafford	Led by TPH GP federation in collaboration with local GP practices	2 hubs Open Saturdays only. (9am-1pm.)	No direct booking line. Patients referred through own practice.	Routine GP and nurse appointments	Cytology and ECGs offered; no bloods/urine testing.

4. Evaluation Methods

The evaluation focused on the seven new CCG areas receiving support from NHSE as part of the GM agreement (Bolton; Heywood, Middleton and Rochdale (HMR); Oldham; Salford; Stockport; Tameside & Glossop, and Trafford). Intelligence gathered from the five CCGs already in receipt of Wave 1 PMCF or Wave 2 GPAF funding (Bury; Wigan; North, Central and South Manchester) also informed the study, but these areas were not formally included in the evaluation. The seven new schemes were expected to start in December 2015 but some indicated a later start date. All areas adopted a hub approach.

The evaluation aimed to understand the implementation and impact of 7-day primary care services across GM, combining qualitative and quantitative analysis, supported by a measure of activity across the seven evaluation areas. The evaluation questions are presented in **Table 2**. Questions 1-3 relate to the **activity** analysis (i.e. what was done?). Question 4 relates to the **process** analysis (i.e. how was it done?). Question 5 relates to the **outcome** analysis (i.e. what was the impact of the new activity?).

Table 2: Evaluation Questions and Modes of Evaluation

ACTIVITY		
1. What new activity is associated with 7-day primary care services in each area, and at what cost?	Activity data supplied by each area	Received (5/7 CCGs)
	Cost data supplied by each area	No cost data received
2. How are these new services utilised by patients? What is the nature of demand for these new services?	Activity data supplied by each area	Received (5/7 CCGs)
3. How is the uptake of 7-day primary care affected by the socio-economic characteristics of the patient population?	Public data combined with activity data	Received (5/7 CCGs) Practice deprivation score only obtainable
PROCESS		
4. What organisational and operational issues arise in the implementation of 7-day access to primary care, and how have areas addressed these issues?	Evaluation generated data. Source: qualitative interviews	18 semi-structured interviews conducted (7 CCG; 8 provider; 3 Wave 1 or 2 sites)
OUTCOME		
5. What is the impact of 7-day access to primary care on: a) Attendances at A&E and hospital admissions? b) Use of OoH services?	a) Secondary Uses Service (SUS), via the GM Academic Health Science Network (AHSN)	Received
	b) OoH activity, supplied by NHSE /CCGs	Received (4/7 CCGs)

4.1. Activity Capture

Capturing reliable data on activity was one of the most difficult aspects of the Primary Care Demonstrator Evaluation (PCDE), and similar problems were found in the national PMCF Wave 1 evaluation. The activity capture in the present evaluation was designed to minimise the additional workload that data extraction placed on individual sites, whilst also seeking to ensure that data could be collected reliably and consistently across all areas.

To this end, a minimum data set (**Appendix Table A1**) was defined, to be agreed with all participating CCGs. It was intended that data should be reported according to a monthly schedule, to support formative evaluation and shared learning across sites.

The aim of the activity capture evaluation was to:

- A. Assess what new activity was associated with 7-day primary care services:
 - A.1. How many additional appointments were available by:
 - A.1.1. Day, week, month

- A.1.2. Discipline
- A.1.3. Whether available same-day or pre-booked
- B. Assess how this new activity was used:
 - B.1. How many additional appointments were booked
 - B.2. How many additional appointments resulted in a DNA
- C. Assess the types of patients utilising additional appointments:
 - C.1. By age and gender
 - C.2. Comparing practice profiles of patients attending/DNA to that of core hours appointment users (in terms of age and gender)

4.2. Process Evaluation

Purposive and ‘snowball’ sampling enabled semi-structured interviews to be conducted with CCG commissioner leads in each area (at the evaluation mid-point), followed by GP/primary care services provider leads (including OoH providers) towards the end. These interviews were supplemented by key informant interviews from Wave 1 or 2 sites.

The process evaluation aimed to understand the organisational and operational issues in the implementation of 7-day access to primary care faced in each area, and also how each area addressed these issues. A brief interview schedule can be found in **Appendix Table A2**. Interviews were transcribed and anonymised, before being analysed thematically using NVivo software and applying a combination of *a priori* and grounded codes.

4.3. Outcome Evaluation

The outcome evaluation concentrated on the impact of 7-day access on service utilisation.

Impact on Service Utilisation was measured using routinely-collected SUS data on hospital activity, plus activity data from relevant OoH providers supplied by NHSE/CCGs. SUS data was extracted for all areas of GM (seven 7-day access CCGs and five PMCF/GPAF areas) on a quarterly basis. The outcome evaluation aimed to measure before-after changes in the use of various services, as listed in **Table 3**. The specific SUS variables requested, and their groupings, can be found in **Appendix Table A3**.

Table 3: Service activity comprising outcomes analysis

Service location	Service type	Data period	Unit of analysis	Data source
Hospital	A&E attendance	Before: 01/01/2015 to 31/12/2015 After:	Practice quarter activity	SUS via GM AHSN
	A&E attendance (self-referral, minor intensity)			
	Admissions			

	Admissions (Ambulatory Care Sensitive Conditions - ACSCs)	01/01/2016 to 31/12/2016		
OoH	OoH attendance	Before: 01/04/2015 to 31/12/2015 After: 01/04/2016 to 31/12/2016	CCG daily activity	CCG self-reported activity

For all analysis, pooled cross-sectional datasets were used (pooled practice-quarter and CCG-day activity for hospital and OoH analysis respectively). Count models (negative binomial) were estimated that took into account the over-dispersed distribution of activity and practice or CCG list size.^{xxvii} Each type of activity was regressed on a 2016 year dummy. The estimated coefficient on the 2016 dummy provided a statistical test for significant changes in service use relative to 2015.

The before-after analysis had important limitations. Not having a comparison, non-treated group meant it was not possible to know what changes would have occurred in the outcome measure in the absence of treatment. This was particularly important where trends in the outcome measure might have been occurring over time. Time trends mean the observed changes in outcome may, in part, reflect a general increase (or decrease) in the outcome measure over time, exerting positive (negative) bias on the estimated effect. To reduce the potential bias caused by a trend over time, the evaluation compared 2016 activity to 2015 activity only, rather than more historic activity.

Additional analyses are detailed below involving models of practice-hub relationship, and separate age and gender service use models. If time trends are equivalent across schemes, then differences in effects, by relationship of practice to hub, or by demographic groups dominating extended appointment bookings, suggest 7 day access appointments are likely to impact on service use.

Hub vs Non-Hub: The activity data analysis also investigated whether practices hosting the hub for 7 day access had relatively more 7-day access appointments booked than non-hub practices. Where hub practices dominated appointments, it was expected that any effects of 7 day access appointments on service activity would be felt relatively greater for hub practices.^{xxviii} Additional analysis estimated two treatment group effects: hub and non-hub practice effects.

Age and Gender: Further additional analysis sought to better align the types of service use most likely to be impacted by 7 day access appointments. Appointment use by age and gender was observed in the activity data, enabling the evaluation to identify which age and gender

groups for hospital service use were most likely impacted by 7 day access appointments. Using these groups, additional analysis modelled hospital activity by age and gender.^{xxix}

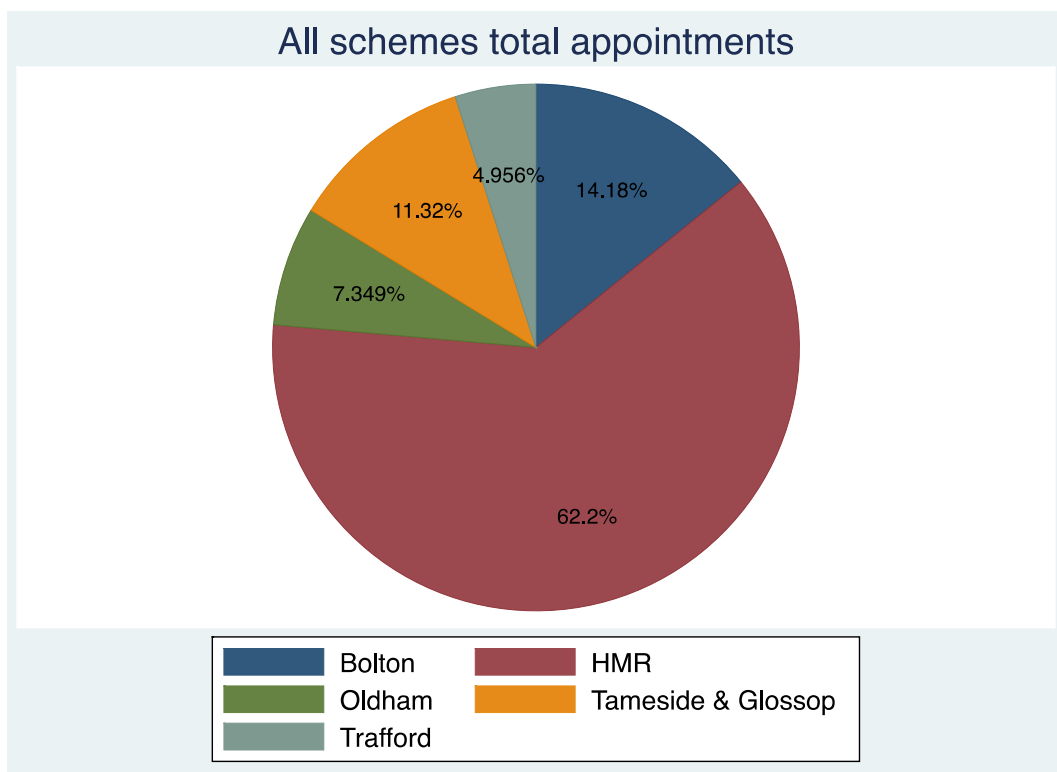
OoH: The methods for the OoH analysis replicated the before-after approach taken for hospital activity and, as such, are also limited by potential time trend bias. The methods taken were identical to those for the hospital outcomes analysis, with the exceptions that a) the data were provided by day, and b) the data reflected total CCG use, rather than practice-level use. Data were received by four of the seven schemes (HMR, Tameside & Glossop, Oldham, and Bolton). Whilst Bolton provided data from January 2015 to December 2016, all the other schemes provided data from April 2015 to December 2016. For comparability, all estimation was made using April 2015-December 2015 as the before period and April 2016-December 2016 as the after period.

5. Activity Data Analysis

5.1. All Schemes Reporting Activity Data

A total of 51,806 additional appointments were provided across all the schemes (**Appendix Table A4**). 62.2% of these were provided by HMR (**Figure 2**) [Nb. In light of HMR dominating provision, the combined summaries of the activity data across all the schemes largely reflect HMR activity]. HMR and Trafford 'blocked' some of their appointments, which resulted in a total number of available appointments of 49,491.

Figure 2: All schemes total appointments



On average, 76% (37,560) of available appointments were booked, although this varied across CCGs and hubs. Trafford CCG had the largest proportion of booked appointments (89%), closely followed by Tameside & Glossop (80%) and Bolton (79%). Oldham CCG had the lowest uptake, with only 56% of appointments booked.

40,353 (82%) of available appointments were with a GP and 8,793 (18%) with a nurse (**Appendix Table A5**).^{xxx} The discipline split varied across CCGs but was fairly consistent across hubs within CCGs. Appointments were exclusively GP-based in Tameside & Glossop^{xxxi} and Oldham, whilst, on average, 79% of appointments in HMR were GP-based, 59% in Trafford, and 82% in Bolton.

Of the 37,560 booked appointments, 45% were booked on the same-day as the appointment, while 55% were pre-booked (i.e. booked at least one day before the appointment). There were wide CCG variations in how pre-booked and same-day appointments were split. All appointments in Trafford and Bolton were pre-booked whilst appointments in Oldham were mainly booked on the same-day.

The number of appointments booked and attended across the five schemes which reported activity data amounted to 33,266; this amounts to 67% of available appointments (66% in HMR; 66% Tameside & Glossop; 74% Trafford; 51% Oldham).^{xxxii} The proportion of DNAs ranged from 17% of booked appointments in Tameside & Glossop and Trafford, to 10% in Oldham. Complete data was not submitted for patient attendance in Bolton meaning it was not possible to identify those appointments resulting in a DNA.

Figure 3 plots appointments used, DNA and not booked (volume and percentage of appointments) over the 2016 calendar year. Uptake appears to have improved over time for all the schemes reporting activity data combined ('All Schemes Combined'). Initial utilisation in January appeared low but increased overall through the year.

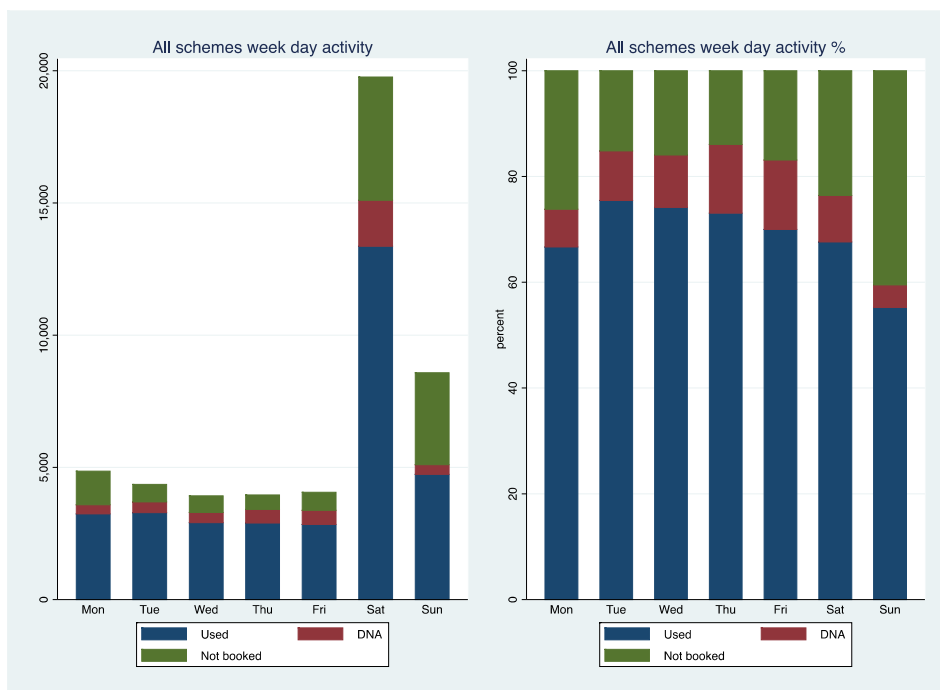
19,765 appointments (40% of all additional appointments) occurred on a Saturday. Sunday was the second most active day (8,574, 17%) (**Figure 4**). 60% of appointments on a Sunday were booked (55% removing DNAs), and 76% (68% excluding DNAs) on a Saturday. Weekday attendance was generally higher at 76-86% (67-75% excluding DNAs).

The increase in uptake over the calendar year seen in **Figure 3** suggests that there was a gradual embedding of the service in the population. To assess whether uptake on Sundays changed over the period, we compared uptake on a Sunday by week (**Figure 5**). Uptake appears to have improved on a Sunday over the period (excluding the final Sunday in week 52 which fell on Christmas Day in 2016).

Figure 3: Appointments used, DNA and not booked by month, all schemes



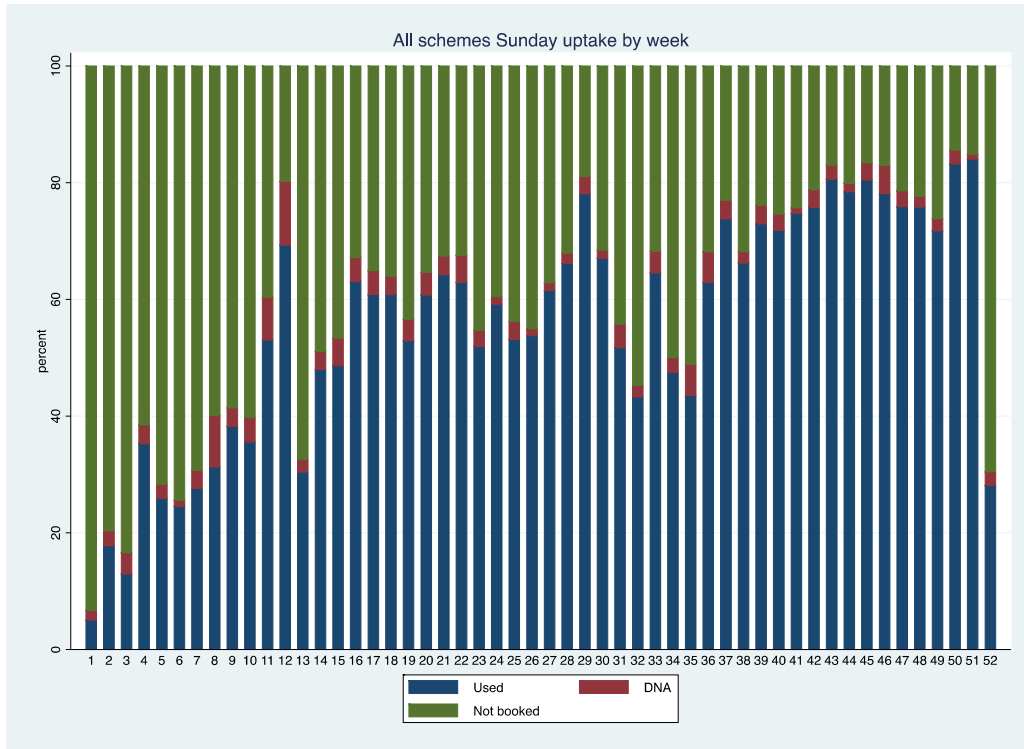
Figure 4: Appointments used, DNA and not booked by day of week, all schemes



Patients attending appointments (excluding those that DNA) were compared to patients reporting attendance at their practice within the past year, as recorded by the GP Patient Survey (GPPS) in January-March 2013.^{xxxiii} Patients booking additional appointments provided under the 7-day access arrangements tended to be younger in comparison to core hour patients (**Figure 6**). The demographic profile of additional appointment users was more

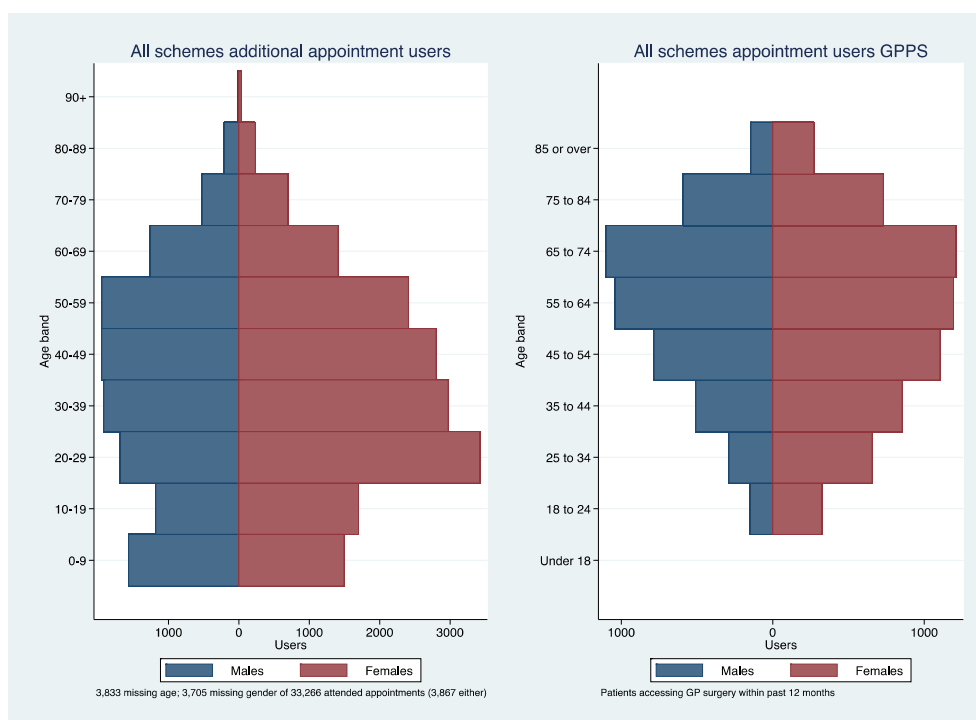
in line with the profile of the all patients registered at the practice than core appointment users identified in the GPPS (**Appendix Figure A1**).

Figure 5: Appointments used, DNA and not booked, Sundays through year, all schemes



Approximately 60% of booked appointments were made by female patients (**Appendix Figure A2**). With over 50% of users aged under 39 (70% under 49), this data would suggest that additional appointments are likely to be attracting a select group of patients, distinct from core hour users. The age and gender distribution of appointment users did not appear to vary by day of week. There was, however, a slightly higher proportion of appointment users aged 0-9 years on a Saturday and Sunday than throughout the week.

Figure 6: Profile of 7DA users and core hours users, by age and gender, all schemes



The provision of appointments at a hub may produce variations in access across practices within a CCG. Practices hosting the hub may have relatively higher use due to geographical proximity for hub practice patients, for example, and practice (and patient) awareness of availability may also influence access. To gauge the scale of these potential issues the evaluation compared the proportion of appointments that were used by patients registered with the practice that hosted the hub with the proportion used by non-hub practice patients. On average, 26% of appointments were booked by hub patients, who represented only 8% of the total patient population.^{xxxiv}

The 'hub effect' for each hub in each area is summarised in the sections below, showing the activity from each GP practice in an area, with the hub host practice dominating utilisation in each case. The extent of hub domination varied between hubs, however; this is reflected in the steepness of the drop-off in activity reading from left to right.

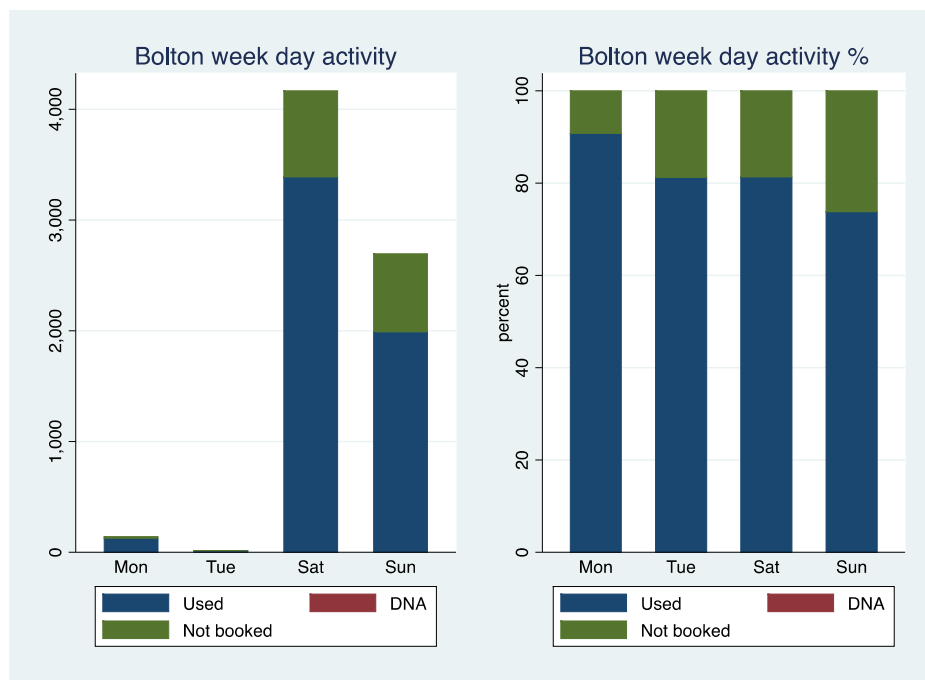
5.2. Bolton (Appendix Tables A4-A5; Figures A3-A5)

The Bolton scheme was serviced by two hubs; both hubs started 2nd April 2016. 7,019 appointments were provided over the live period (23.23 per 1000 patients) (**Appendix Table A4**). Of all appointments, 5,519 were booked (79%). No data was provided to enable the identification of those booking and attending the appointments, meaning it was not possible to identify the proportion of appointments that were booked and subsequently used.

Of the available appointments, 82% were for a GP, with similar proportions across hubs, and the remaining 18% for a Nurse (**Appendix Table A5**). All appointments were pre-booked.

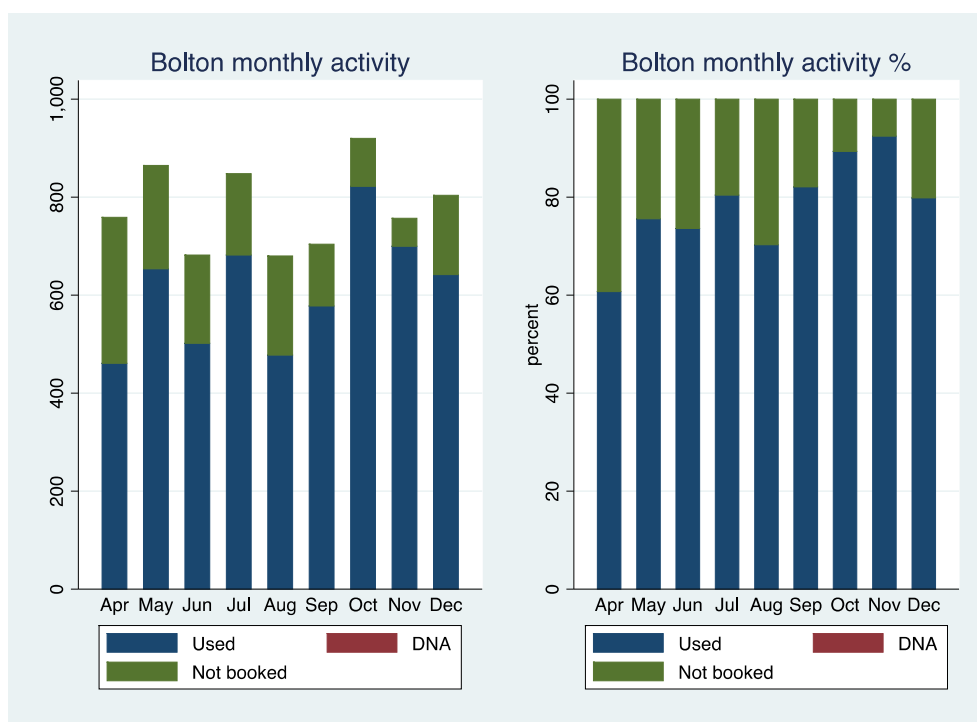
The majority of additional appointments were for a Saturday and Sunday, with very small appointment provision on a Monday and Tuesday (**Figure 7**). Uptake was lowest on Sundays but Sunday utilisation in Bolton was still greater than that observed in the other schemes. Sunday uptake increased over the calendar year, with a dip during the summer (**Appendix Figure A3**).

Figure 7: Activity by day of week (absolute and %) (Bolton)



Uptake improved over time from approximately 60% in April 2016 to 80% by December 2016 (**Figure 8**). DNAs were not identifiable from data provided hence uptake was likely lower than reported here.

Figure 8: Activity by month (absolute and %) (Bolton)



Demographics were similar to the All Schemes Combined data, with patients more representative of practice list demography than those observed in the GPPS for core hour appointments (**Appendix Figures A4 and A5**). The demographics by day were not identifiable in the data provided. Hub dominance was not identifiable as patient practice was not provided consistently in the data.

5.3. HMR (Appendix Tables A4-A5; Figures A6-A9)

HMR dominated appointment provision which in turn dominated the findings of the five schemes ('All Schemes Combined') level (**Appendix Table A4**). The HMR scheme was serviced by four hubs; all hubs started in January 2016 (1st January, 2nd January (two hubs), and 11th January). 32,693 additional appointments were provided in total over the live period (143.77 per 1000 patients). 30,782 appointments were available, of which 23,345 were booked and 2,959 of these DNA resulting in total use of 20,380 appointments (66% of available appointments). Uptake across the hubs ranged from 62% to 73%.

Of the available appointments, 79% were for a GP with slight variation across hubs (74% to 84%), and the remaining 21% for a nurse (**Appendix Table A5**). The majority of hub appointments were same-day with 42% pre-booked (booked at least one day in advance). Uptake improved over time, from approximately 40% (excluding DNAs) in January 2016 to 75% by December 2016 (**Figure 9**).

Figure 9: Activity by month (absolute and %) (HMR)



Additional appointments were provided across each weekday (**Figure 10**). The majority of additional appointments were for a Saturday, with over twice as many appointments available compared to other days of the week. Uptake was lowest on Sundays, although Sunday uptake increased over the calendar year (**Appendix Figure A6**).

Demographics were similar to the All Schemes Combined data with patients more representative of practice list demography than those observed in the GPPS for core hour appointments (**Appendix Figures A7, A8 and A9**).

Hub dominance was evident with 32% of appointments being made by patients registered at the hubs (which represent 19% of registered patients in the CCG). Two hubs differed from this pattern in that the concentration of attendees from hub practices was more diluted (**Figure 11**).

Figure 10: Activity by day of week (absolute and %) (HMR)

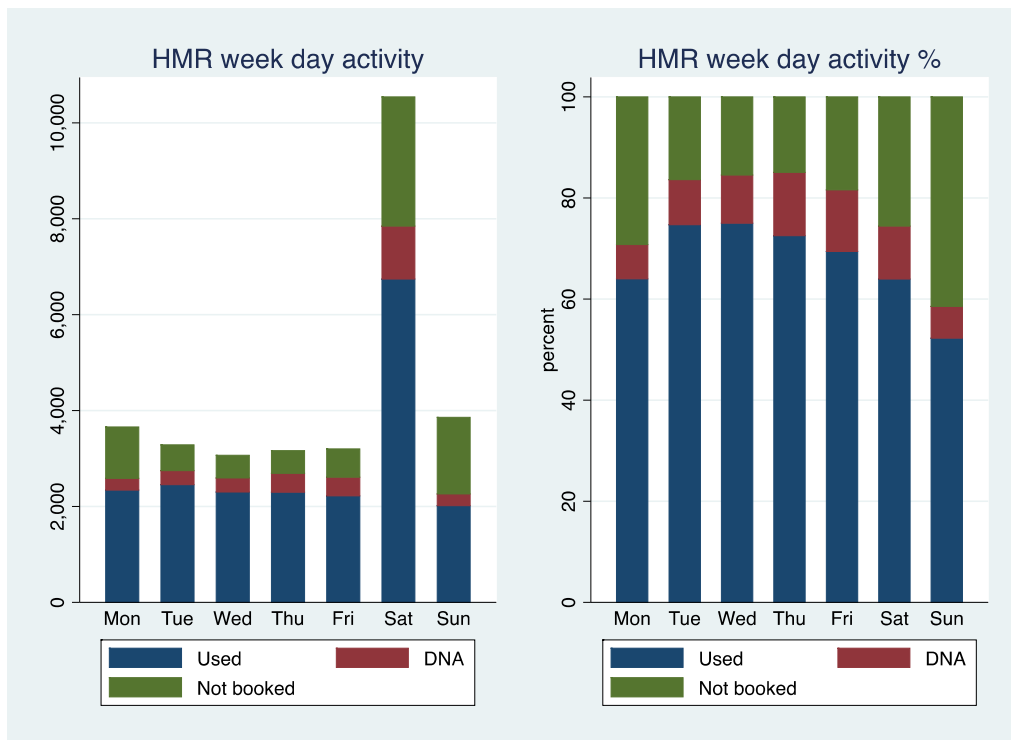
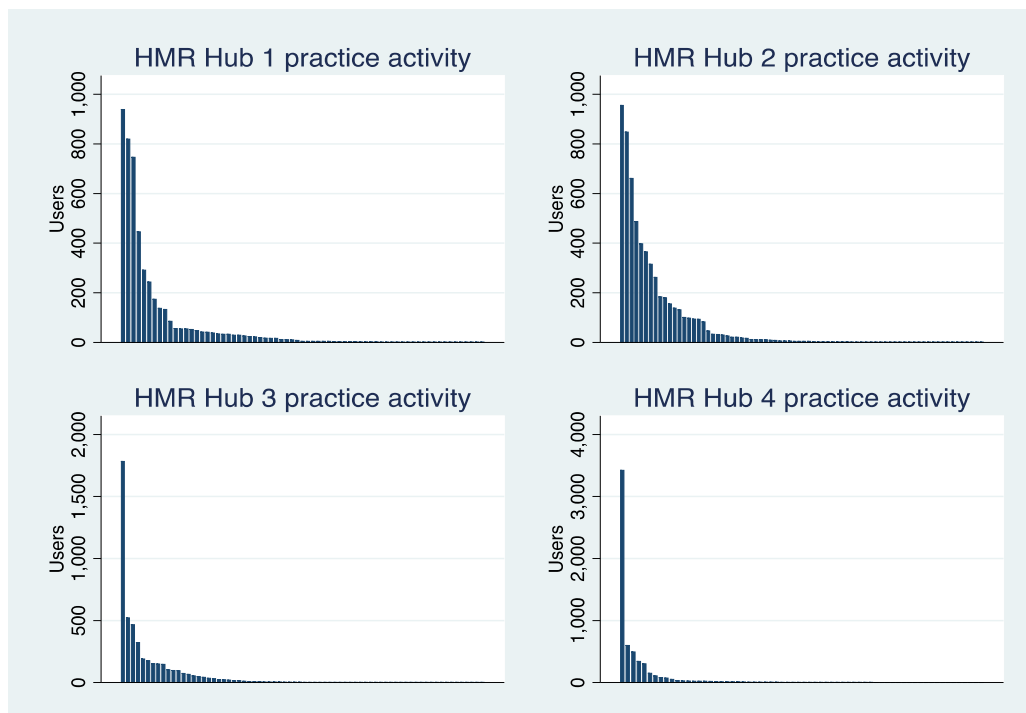


Figure 11: Hub activity by practice (HMR)



5.4. Oldham (Appendix Tables A4-A5; Figures A10-A13)

The Oldham scheme was serviced by two hubs; one hub started 5th January 2016 and one 10th August 2016. 3,637 appointments were provided over the live period (14.63 per 1000

patients). 2,050 of these were booked and 202 of these DNA resulting in total use of 1,848 appointments (51% of available appointments). There was variation across the hubs ranging from 39% uptake to 53% uptake (**Appendix Table A4**).

Of the available appointments, 100% were for a GP (**Appendix Table A5**). All appointments were booked directly by telephone, with 74% booked on the day of appointment, the highest of any scheme.

Provision increased over time, most noticeably with the introduction of the second hub in August (**Figure 12**). Uptake reduced in spring but appears to increase in autumn/winter, possibly reflecting the embedding of the second hub service. Uptake on a Sunday showed no trend over the calendar year (**Appendix Figure A10**).

Figure 12: Activity by month (absolute and %) (Oldham)

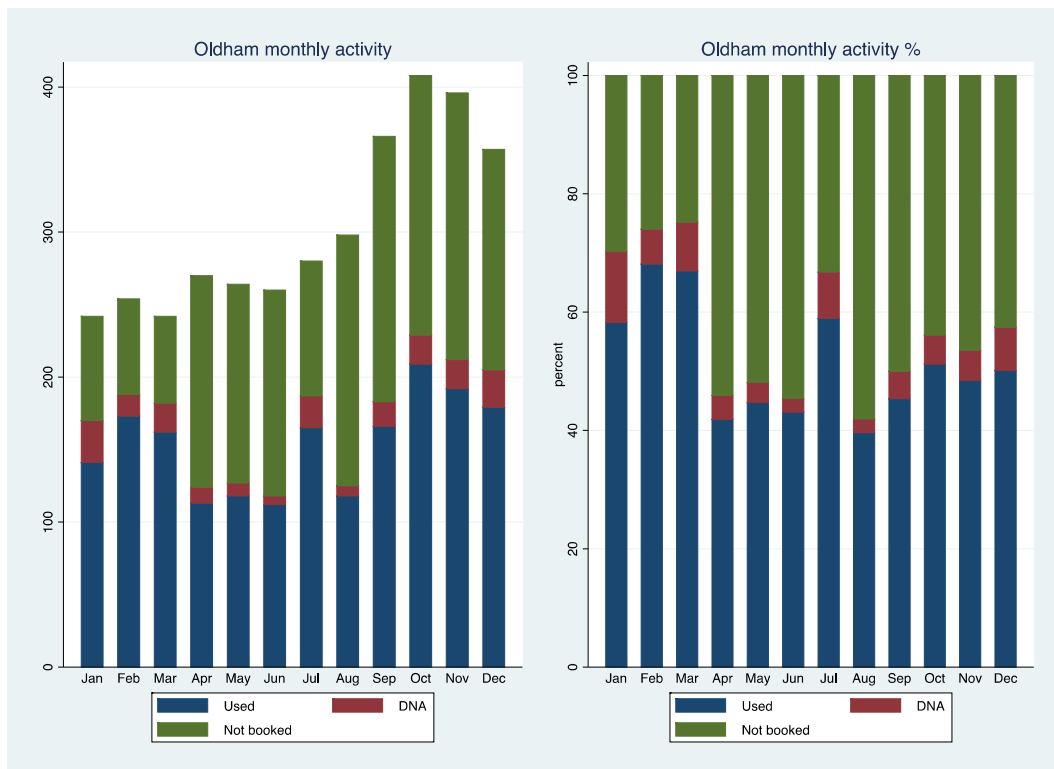
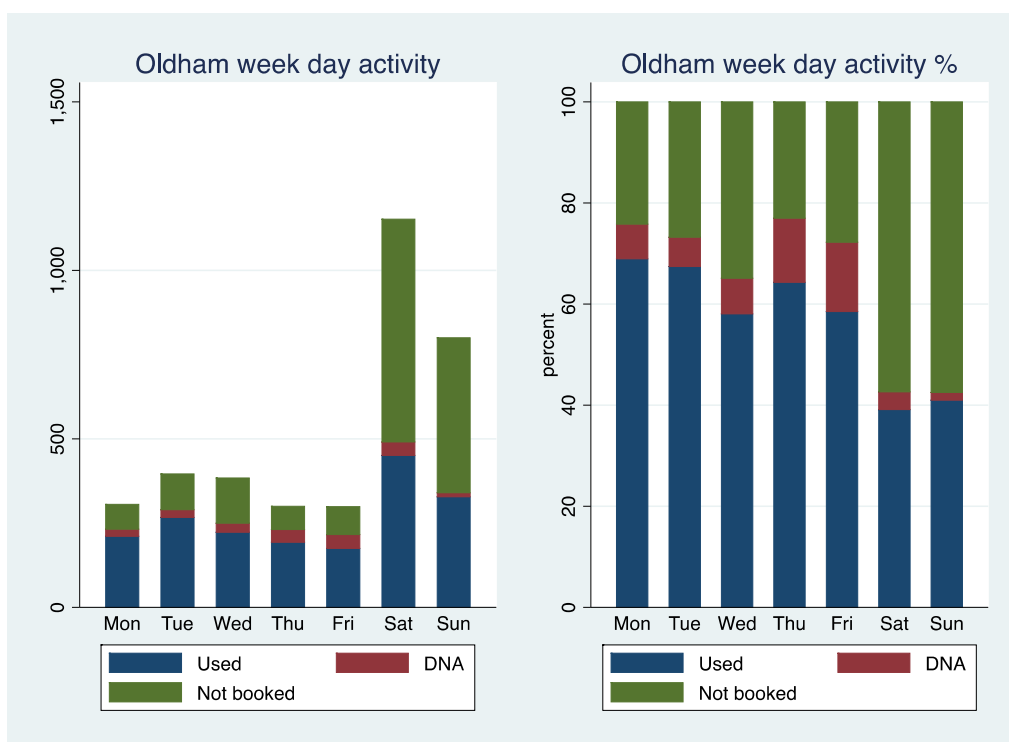


Figure 13: Activity by day of week (absolute and %) (Oldham)

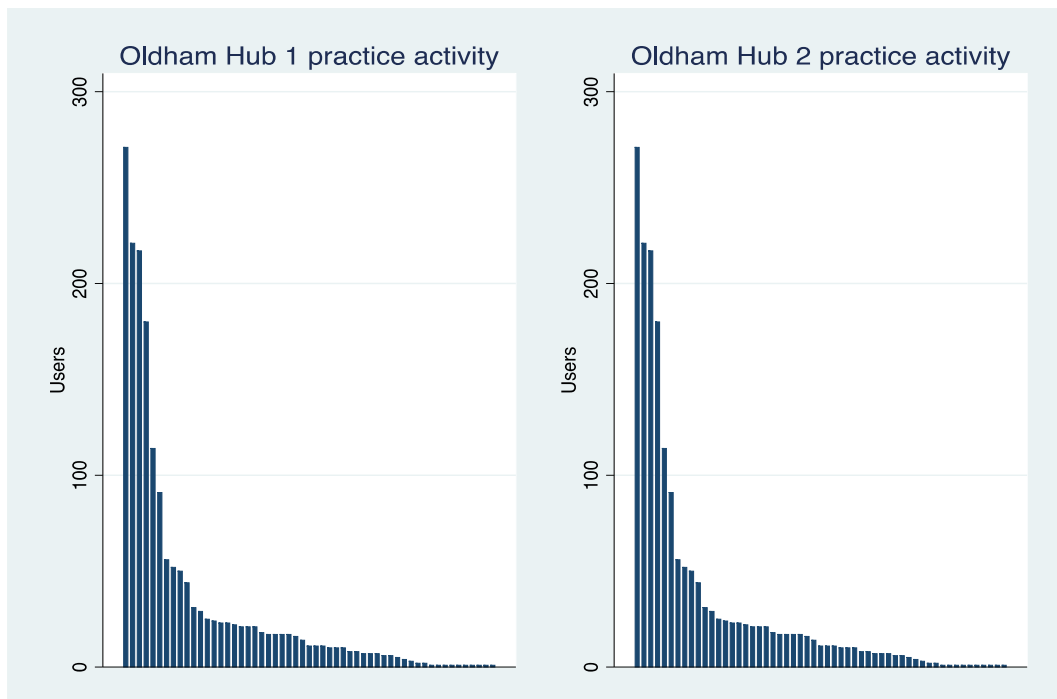


Appointments were available each weekday, although the majority of additional appointments were for a Saturday and (less so) Sunday, with over twice as many appointments available at the weekend compared to other days of the week (**Figure 13**). Uptake was lower than the average for the All Schemes Combined data on most weekdays and noticeably so on Saturdays and Sundays (approximately 40% compared to 65/60% on Saturdays/Sundays).

The demographics were different from those observed across all the schemes also (**Appendix Figures A11 and A12**). There was a large proportion of male patients aged 0-9 years which is at odds to list size [NB: the GPPS does not permit a comparison of the under 18 age group]. The proportion of patients aged 0-9 was approximately double those seen in the All Schemes Combined data for each day of the week (**Appendix Figure A13**).

Hub dominance was similar to the All Schemes Combined data with 28% of appointments being made by patients registered at the hubs (compared with 30% in the All Schemes Combined data). In addition, hub patient populations represented 14% of patients in the CCG. Hub dominance was similar across both hubs (**Figure 14**).

Figure 14: Hub activity by practice (Oldham)



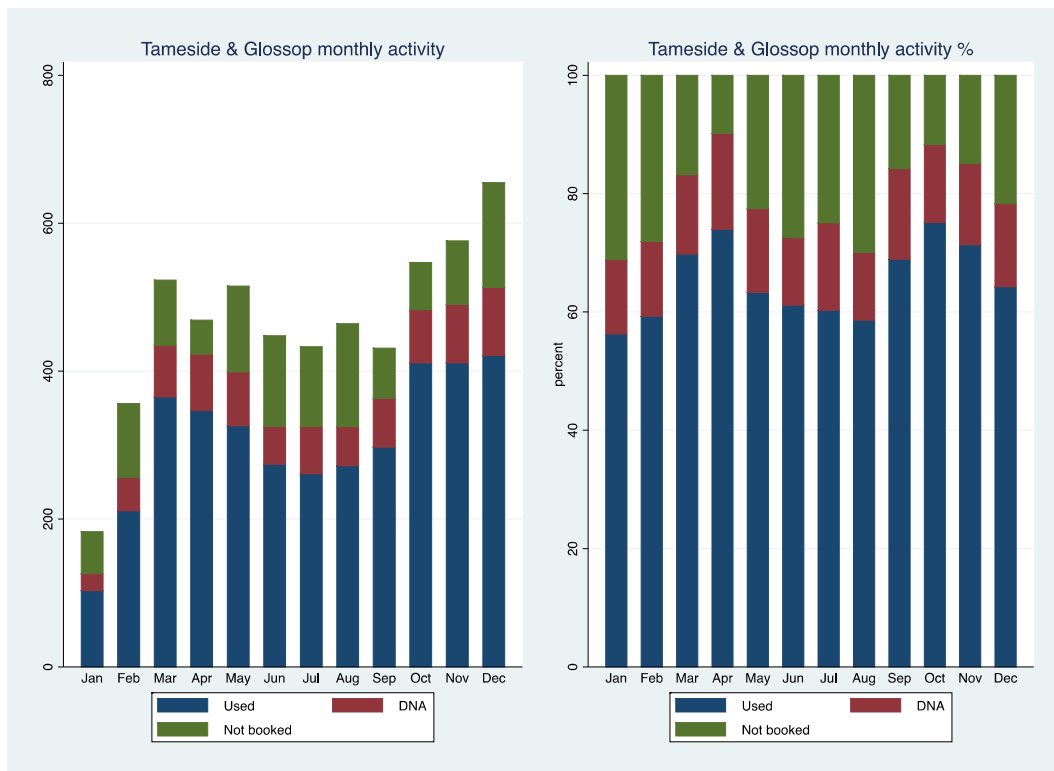
5.5. Tameside & Glossop (Appendix Tables A4-A5; Figures A14-A17)

The Tameside & Glossop scheme was serviced by three hubs; two hubs started in January 2016 (3rd January and 30th January) and one in February (25th). 5,600 appointments were provided over the live period (22.92 per 1000 patients) (**Appendix Table A4**). Out of this total, 4,463 were booked and 758 of these DNA resulting in total use of 3,699 appointments (66% of available appointments). There was slight variation across the hubs ranging from 63% uptake to 68% uptake.

Of the available appointments, 94% were recorded as GP appointments. However, as no appointments for nurses were provided, it is likely that the remaining 6% reflects incomplete data (**Appendix Table A5**). 55% of all appointments were pre-booked but this was varied across the hubs, with two seeing 62% and 65% pre-booked appointments and one 40% pre-booked.

Appointment provision increased over the live period, although uptake varied over time, with increases in spring and autumn met with decreases in summer and winter (**Figure 15**).

Figure 15: Activity by month (absolute and %) (Tameside & Glossop)



Unlike the average for the All Schemes Combined data, Tameside & Glossop provided similar appointment volumes on Sundays as well as Saturdays (**Figure 16**). Uptake was relatively higher in Tameside & Glossop on weekdays than the All Schemes Combined data but was similar on a Saturday. Uptake on a Sunday was lower than the All Schemes Combined data at below 40% and followed a similar trajectory in uptake over the calendar year as total uptake (**Appendix Figure A14**).

Demographics were similar to the All Schemes Combined data with patients more representative of list size demography than those observed in the GPPS for core hour appointments (**Appendix Figures A15, A16, and A17**).

Hub dominance was less evident compared with all schemes combined with 13% of appointments being made by patients registered at the hubs compared to 30% in all schemes combined; and hub patient populations represented 6% of patients in the CCG. Hub dominance was more evident in two of the three hubs (**Figure 17**).

Figure 16: Activity by day of week (absolute and %) (Tameside & Glossop)

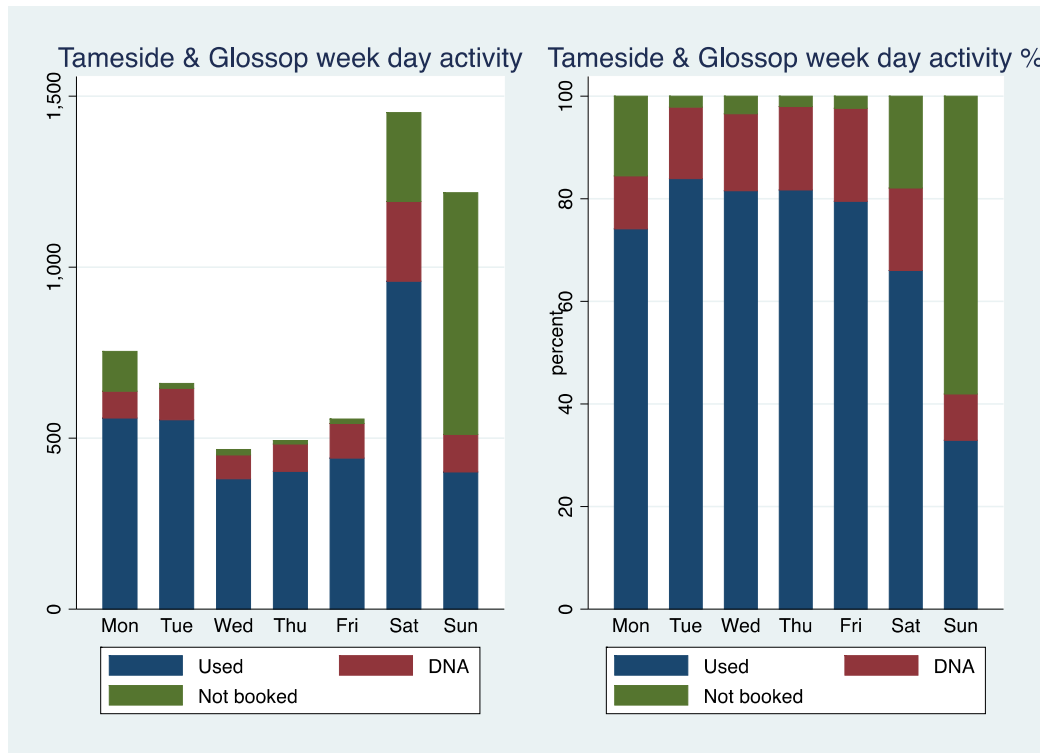
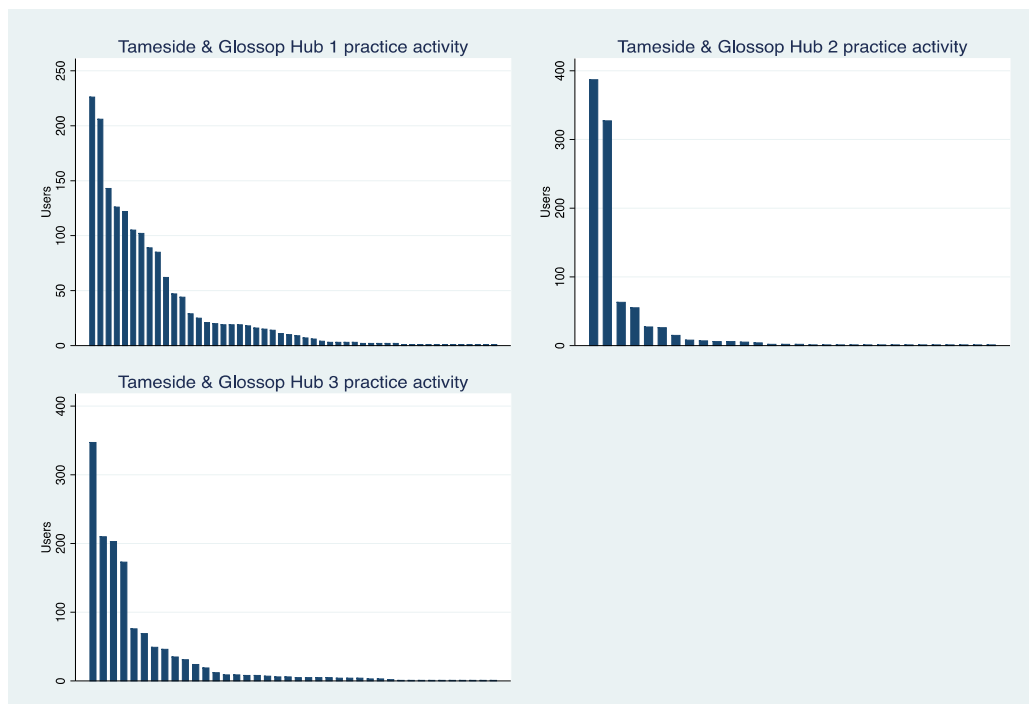


Figure 17: Hub activity by practice (Tameside & Glossop)



5.6. Trafford (Appendix Tables A4-A5; Figures A18-A21)

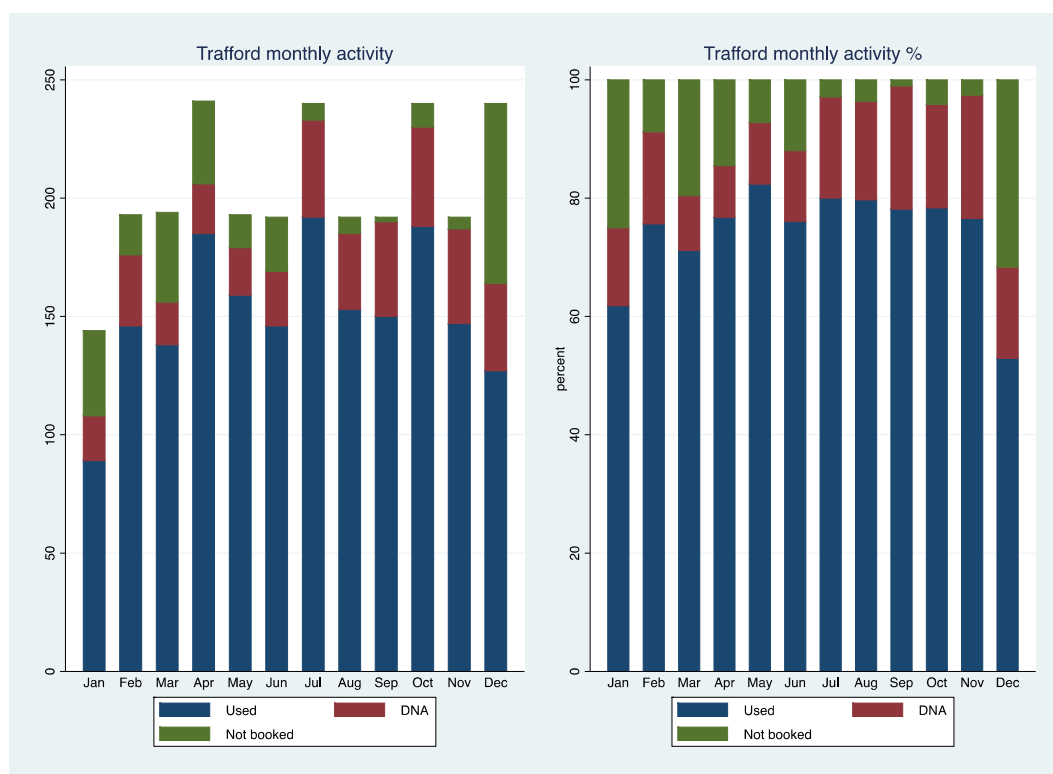
The Trafford scheme was serviced by two hubs; both hubs started on 16th January 2016. 2,857 appointments were provided over the live period (11.96 per 1000 patients) (**Appendix Table**

A4). 2,453 appointments were available of which 2,183 were booked and 362 of these DNA resulting in total use of 1,820 appointments (74% of available appointments, 1 appointment had no DNA information). There was consistency across both hubs.

Of the available appointments, 59% were for a GP, with slight variation across hubs (58% and 59%), and the remaining 41% for nurses (**Appendix Table A5**). All appointments were pre-bookable. Additional appointments were exclusively on a Saturday (**Appendix Figure A18**).

Uptake improved over time from approximately 62% (excluding DNAs) in January 2016 to 75% by November 2016, although uptake saw a large drop in December (to approximately 50%) (**Figure 18**).

Figure 18: Activity by month (absolute and %) (Trafford)

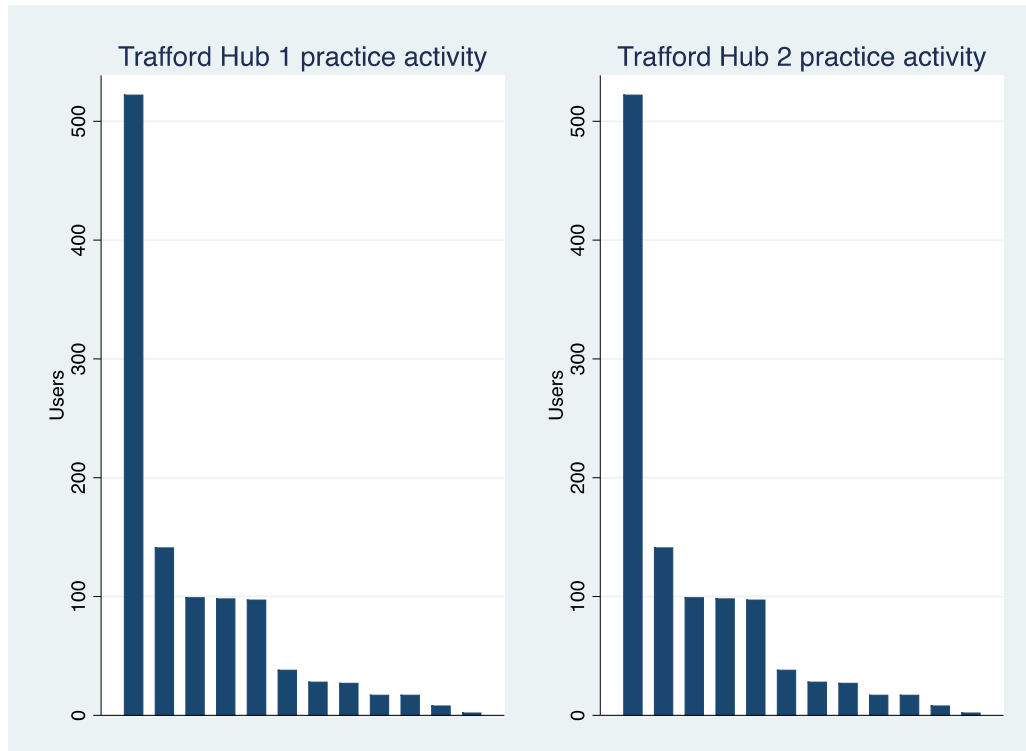


Demographics were similar to those observed across all schemes with patients more representative of list size demography than those observed in the GPPS for core hour appointments (**Appendix Figures A19, A20, and A21**). The users in Trafford had a higher concentration of females compared to the All Schemes Combined data (approximately 65% compared to 60%).

Hub dominance was more pronounced in Trafford with 46% of appointments being made by patients registered at the hubs (compared to 30% in all schemes combined) and hub patient

populations representing 6% of patients in the CCG. Hub dominance was almost identical in both hubs (Figure 19).

Figure 19: Hub activity by practice (Trafford)



5.7. Summary

The activity analysis provides important insight into the provision and uptake of additional appointments provided under 7-day across five out of seven areas (those that were active and supplied data). It provides a detailed picture of the age and gender of patients using the additional appointments and when they were used, and provides the basis for a careful outcome analysis. It should be noted that this data does not provide a clear measure of demand in four areas (Bolton, Stockport, Tameside & Glossop and Trafford) due to the ‘referral moderator’ effect i.e. access in these areas was moderated by the need for patients to be referred through and by patients’ own GP practices as patients could not book appointments directly.

In total, almost 50,000 additional appointments were provided across the five areas which supplied activity data. Of these appointments, 76% were booked by patients and 67% attended in total. The scale of provision varied substantially, from 144 appointments per 1000 patients in HMR, 23 per 1000 in Bolton and Tameside & Glossop, to 12-15 appointments per 1000 in Oldham and Trafford. The proportion booked and proportion used increased through

the 12 month period. The proportion of DNAs ranged from 10% to 17% by area, which exceeds the typical rate of DNA for core hours appointments (estimated to be around 5%).^{xxxv}

The vast majority (89%) of appointments overall were GP appointments and a slight majority overall were pre-booked at least one day before the appointment itself. Weekday appointments enjoyed a higher rate of utilisation (76-86%) than Saturdays (76%) or Sundays (60%). The proportion of DNAs was highest on Thursday and Friday and lowest on a Sunday. Given wider discussions about Sunday opening, it is worth noting that utilisation of Sunday appointments increased gradually throughout the year; by the last working week of 2016, the average utilisation of Sunday appointments had reached over 80% across all programmes (although this figure contains high variation, as discussed below). These figures provide a useful indicator of the incidence of demand overall, notwithstanding the 'referral moderator' effect, and should inform detailed planning of additional appointments through the week, as well as informing predictions of increased utilisation over time.

The overall patient profile of additional 7-day access appointment users is consistent across all areas: users are disproportionately female and relatively young (70% aged <50). Comparing this with users of core hour appointments (according to GPPS data), it is clear that far fewer patients aged over 60 make use of the 7-day access service; while such users may benefit from reduced pressure on core hours appointments, this data does not provide any information on this secondary impact. Planners can use this to estimate demand for their local populations and to decide the kind of services which should be offered in additional 7-day access appointments.

In each of the areas, there is a 'hub dominance' effect, whereby patients registered at a 7-day access hub practice are substantially more likely to make use of the additional appointments than patients at other practices. In some localities, this 'hub dominance' is more pronounced than in others; in Oldham, Tameside & Glossop and Trafford there are several practices whose patients do not make any use of the service. There are various potential factors underlying service utilisation, including patient awareness, practice staff awareness/tendency to recommend and refer, distance from hub, transport arrangements, and perceived importance of appointment. The process evaluation sheds some light on this issue, but clearly this raises the issue of equity of provision (and consequently access) and undermines the likely impact of the initiative in some areas.

Comparing the areas, it is clear that over the period of assessment, HMR provided substantially more additional appointments than any other area, indeed providing more than the other four areas combined. The highest overall utilisation of appointments was found in Trafford (89%), albeit with the lowest total provision of appointments of the five areas

examined, and the lowest utilisation was found in Oldham (56%). Sunday utilisation varied substantially between areas which offered Sunday appointments; HMR having near 100% booked appointments on Sundays by December, while Sunday utilisation in Tameside & Glossop remained at around 40% (despite having nearly 100% booking rate for weekday appointments).

On the surface, these marked variations in utilisation are difficult to account for. Some of this variation, however, can be explained with reference to the way in which 7-day access was designed and implemented in each area. This is addressed in the next section.

6. Process Analysis

6.1. Conceptualisation of 7DA

The design of 7-day access to primary care varied between areas, reflecting the expectation that each area would design the service to fit with existing provision and to meet local needs. To some degree, such design decisions reflected the type of patient who it was anticipated might use the service. Most areas were committed to a clear focus on 7-day access as an extension of routine primary care, and avoiding the use of the service for urgent care:

We've invested in a service that's trying to enhance routine primary care, it's not urgent care (...) There were some real concerns from a clinical point of view, that you're duplicating what the OoH service is doing [Area 2 Commissioner]

While the main concern here seemed to be the danger of duplicating an existing service, this case was supported in some areas by reference to the difference in personal and organisational indemnity insurance necessary for clinicians staffing urgent care appointments, which was seen to be significantly higher than the cost for pre-booked appointments.

All sought to mould the service around patient demands, informed by experienced demand and changes in capacity, although some were more explicitly flexible:

We've not dictated that it has to be booked in a certain way, it just has to be booked because it's not a walk-in service, and then the patient flows have determined that we've not sold it or badged it in any particular way, we've just said there is this capacity and the way in which it's been used is that people want that access [Area 7 Commissioner]

The precise range of services offered in each area varied owing to a number of restraints, including workforce and infrastructure. For instance, difficulty in recruiting nurses in some areas resulted in fewer nurse appointments being offered, while in other areas, low demand for nurse appointments led to a reduction in provision. Similarly, some areas struggled to find an affordable and convenient solution to the issue of collecting blood and other samples, while other areas found this unproblematic, depending on the response from the local hospital and/or local OoH provider.

The design of the service in each area was also informed, inevitably, by the budget available for the service. Some areas initially designed expansive services, in terms of number of hubs, hours of operation, and staffing, but then had to reduce the scale and scope when costs and funding became clearer. Most areas recognised this uncertainty as a necessary part of the iterative process of commissioning and provision; however, some areas felt that it had been

beneficial to move more slowly to implementation as they could tailor the service in light of the actual resource available:

In a way the slower nature of our implementation has worked okay for us because we've not had to take things away so we've been able to flex our model. [Area 6 Commissioner]

In some areas, there remained concerns that the service was too expensive, particularly where utilisation was low. Other areas saw this as inevitable for a pilot initiative:

I think some of the practices do feel that it is expensive. But because it was a pilot, we were expecting that to happen. [Area 2 Provider]

6.2. Communications and Engagement

Clearly, the affordability of the service reflects not only the absolute cost of provision but also the rate of utilisation. Utilisation rates were influenced not only by total patient demand, but also by patient awareness. In those areas where bookings could only be made on the part of patients by their GP practice, and particularly where the service was not widely publicised, this demand was also moderated by practice staff awareness, their understanding of and attitude towards the 7-day access service and hence the likelihood that they would refer patients on. In several areas, the decision was taken not to promote the service directly to patients due to capacity concerns:

The communication was to practices, not a general public-wide communication because of that route but also because initially the anxiety was, it is a pilot, we don't know what will happen at the end of 12 months. So there's a risk that you create patient expectation and then pull it away (...) open the gate too much you'll have a risk of a stampede of people that you then just create dissatisfaction with a service that's barely gone live. [Area 4 Commissioner]

Hence communication of the service to patients varied significantly between areas (see **Appendix Table A7** for full details). This ranged from extensive campaigns in some areas (including advertisements on buses, social media campaigns and public events) to areas which did not promote the service directly to patients at all. In these areas, promotion of the service relied entirely upon the engagement of GP practices and practice staff:

Because it's small, you can't go out to full consultation with patients, because this service is not accessed directly by patients, it's accessed by providers. And it's at the

discretion of the provider practice to refer somebody into the service, or to make an appointment on a Saturday. [Area 2 Provider]

The effectiveness of communication with patients via GP practices is likely to have varied in line with the effectiveness (or otherwise) of attempts to engage providers, particularly GPs, in each area. As noted above, several providers were more sceptical of the value of 7-day access to general practice; either in principle, or relative to other priorities or commitments in primary care:

Their other fear is that it's going to create a new work stream that is going to create more demand, it's not going to take away from the work that's going on [Area 5 Provider]

In light of this, there was evidence of different levels of engagement in reality (**Appendix Table A7**), which is likely to have affected the likelihood of practices actively referring patients onto the 7-day service:

I don't think they're saying they're not doing it, but they're not actively promoting it, they won't be actively saying to a patient you can get seen on a Saturday, we've got nothing for two weeks. It's very low key. [Area 2 Provider]

In some areas, this led to a circular argument; information about the service was not made widely available (to avoid generating excess demand); a limited service was offered in terms of capacity, opening times and number of locations; and with this in mind, staff may have been less likely to refer the patients on. Low utilisation was then cited to justify maintaining a low-profile, low-scale offering:

What we said was, if the demand requires additional hubs, then we will open them as the demand increases. It hasn't. [Area 5 Commissioner]

In most areas, however, increasing engagement with practitioners and patient awareness over the evaluation period appears to have led to increased utilisation.

As all initiatives of this kind rely on strong relationships between commissioners and providers, several accounts emphasise the importance of effective engagement, particularly where there are a range of views on the importance and nature of 7-day access. To some degree, this involves careful communication and clarification of the service proposed:

(...there was a misconception) amongst GPs and other practice staff as well about exactly what 7-day services referred to, so a lot of GPs were like 'well, we're not going

to stay open 7-days' and they didn't realise that it was going to be hubs. [Area 6 Commissioner]

Elsewhere, the challenge was to find a common ground between commissioners and providers, founded on an understanding between both parties built up over time, and with the overall aim of reaching agreement without threatening good relations in the longer term:

So it's a long relationship we've had with them, and we've invested so much in terms of the support that we've given them, and the work that they've done for us. So we always go back to that, and say, you can't just do something like this straight off. And so, we engage, we really emphasise that engagement is important, with practices. [Area 3 Commissioner]

The importance of reaching a sustainable agreement explains the more cautious and gradual implementation in certain areas:

You've got to demonstrate the case for change, and why it would be a good idea, and it has to work for the provider and commissioner. If it's no good, you can't force it. And you've got to push ahead with the willing, and the others tend to follow then, because they can see the benefit. [Area 2 Commissioner]

Here commissioners chose to build a case incrementally to generate confidence across an area.

6.3. Workforce and Staffing

Several workforce-related challenges involved in the successful delivery of 7-day access emerged. A key challenge was that areas were often forced to compete for the same limited workforce, with the GP pool especially diluted because staff might work in both 7-day and OoH services. One consequence was that providers could find themselves in contention to attract workforce:

The workforce that we all use will be from the same pool, so the workforce that are providing in-hours' activity within [Area 2], are a range of GP partners, GP salaried, and locums. If you think about the GP clinical team, and certainly some of those locums will work for the OoH service, some of the partners might even do additional work. So it's a risk for us that we fish in the same ponds. [Area 2 Commissioner]

Competing against other providers for staff often resulted in 7-day access offering more attractive rates of pay, enticing staff away from OoH services (which some felt were more challenging to work in) and thereby forcing pay rates up across GM.

Another issue was difficulty in providing a consistent, standardised practice nurse workforce in 7-day access. There was variation in the level of nurses' skill sets and this could limit the services offered. Some areas had begun to recognise the need for appropriate workforce development and training to ensure a minimum skill-set for all practice nurses so that a consistent range of services could be made available.

The location of 7-day access hubs and the length of shifts also impacted on workforce arrangements. It was easier to staff services in locations where individuals were working anyway and could avoid travelling for a short two-hour shift. For nurses this could be compounded due to lower rates of pay than GPs such that working short sessions was often not financially viable for them. This suggests that careful planning and shift design are needed to deliver 7-day access in meaningful blocks of time that maximise the workforce capability across the region.

Indeed, encountering such challenges brought recognition in some areas that a collaborative GM-wide human resources (HR) planning approach was required to more effectively match extended hours capacity with demand:

The other question is about how GM collectively works out these issues about recruitment, and so on, because there's a sense at the moment that there could be a lot of poaching. You know, you fix a problem in [Area 1] by pinching people from [Area 2]. That doesn't actually solve anything at all, it just moves the problem around really. [Area 4 Commissioner]

Several felt that delivering 7-day access increased the pressure on general practice, particularly given wider general practice transformation across GM. Against this back-drop, it was seen as important to emphasise the *collective* provision of 7-day access across CCG areas, rather than delivery by individual practices. This collective working was also seen to potentially support the development of potential future solutions to limited GP capacity through a wider skill-mix and the embedding of new professional roles (such as care navigators) in primary care:

I suppose the other work we're doing around workforce development is to support that in the long term really, like you say, to kind of have more variety in the workforce across

primary care, so that the right type of person is doing the right type of appointment really. And that might give capacity elsewhere. [Area 1 Commissioner]

6.4. GP Federations and Partnership Working

During the evaluation period, five out of the seven CCG areas had established GP federations. The remaining two had emergent federations in various stages of development.

There was a circular mutual relationship between federating and providing 7-day access. Predictably, an established federation could facilitate service delivery by supporting coordinated working across practices. Similarly, the collaborative working involved in providing a locality-wide 7-day access often paved the way for the development of a federation itself:

We were thinking, well financially, the only way that we can provide this service, is to have a hub model run by somebody else, we can't have all 50 practices doing their own, we need to centralise it – and it's shouting out for a federation. [Area 3 Commissioner]

Being part of an established federation was perceived to offer benefits that extended wider than 7-day access. One advantage was the potential for economies of scale that could be offered (e.g. sharing back office functions or pooled workforce indemnity). However in the landscape of integrated health and social care and neighbourhood working, federating was seen by many as a key factor in sustaining general practice in the future, in part by providing a mechanism by which general practice could have a collective voice in the development of local care organisations (LCOs):

So it's developing the new provider organisation that's going to take over. We need GP leadership in that. And [Area 5 GP federation] is about the only way in which we're going to get GPs together enough to provide a single GP voice rather than 44 or 144. [Area 5 Commissioner]

It was also recognised that federating required a profound change in identity, going beyond individual practice level thinking. Convincing GPs who may value independence and autonomy (many of whom came in to general practice for those very reasons) was challenging and required investment and time:

Again, it's about that whole concept of practices working together and collaborative working. So we're trying to tie two things together, which was a programme of locality leadership that we've invested in [Area 2], which is about bringing providers outside of this very insular organisation, and thinking about themselves within the context of a

neighbourhood, a locality and within GM. So, we've done a fair bit of work on them in that respect, and that reinforced the development of the Federation. [Area 2 Commissioner]

Alliances that formed due to partnership working on the extended access initiative and that preceded the formal establishment of federations fostered wider relational benefits. Crucially these groupings facilitated positive CCG-provider links and effective co-working with potential longer-term benefits:

It's had a massively positive impact, we felt it going through the process but I do think it will have massive positive impacts on the way in which we commission, the way in which we work with providers, the way in which we set services up, the way we've decided to redesign things rather than go out to procurement for individual contracts. It's changing the landscape and it's contributed to that. I'm not saying that on its own has done that, but it's certainly helped us on a journey to working differently. [Area 7 Commissioner]

6.5. Information Technology (IT) and Information Governance (IG)

The roll-out of 7-day access in GM was facilitated in many areas by the existence of a common general practice IT system. The key advantage to a common system was that clinicians were able to access patients' medical records more easily for 7-day access appointments. Areas which had widespread buy-in to a single IT system recognised the value of this, but also recognised the challenge in encouraging practices to move to a common system:

We have the advantage in [Area 2] that the majority of our practices are on a single system, that's been running for the past 18 months. And that in itself is a challenge, because practices are very loathed to change their system. They're used to it, it works for them, and they know what they're doing, and the idea that suddenly everything they do is now something else, it's a big thing. [Area 2 Commissioner]

In some areas then, GPs were deeply reluctant to change to a different IT system given their investment in and familiarity with their own:

*That's a dialogue that's going on between us and general practice at the moment, very much around a single system. But the thing is... it might not be that a single system is the right answer... (...) This has been going on for a while, and you get all this where practices will say 'of course we should be on a single system, the same system, as long as it's **mine**'. [Area 3 Provider]*

So whilst it might be generally desirable to move to a single IT system, there are practices (and clinicians) who feel tied to particular and different IT systems. In areas where multiple systems were in operation, workarounds were possible, although these brought their own complexities:

We've got three (systems) in [Area 3]... So within each session we have a GP who comes in and does SystmOne, and they see all the patients from practices who are on SystmOne. And, we have another GP or two, who sees patients who are on Vision and Emis. So we've got a solution... [Area 3 Provider]

While some systems allowed for direct read-and-write access to patient records, in some settings there was discomfort among GPs about other GPs being able to write into their patients' notes. In these situations, it was arranged so that 7-day access clinicians would instead create a secondary record of written notes from the appointment that the patient's individual practice would then incorporate into their own system at a later date:

They don't write into the patient's records, and it depends who you speak to, but most [Area 6] practices are quite happy with that, that they haven't got a GP that they don't know writing into the records, whether it's for QOF reasons or whatever. [Area 6 Commissioner]

Different areas had opposing views on this; some GPs might be willing to allow read-write access to avoid duplicating the work involved in transferring notes from a 7-day access appointment, while others would prioritise control over what is written in their patients' records and therefore accept additional work:

Well, I do want you to write directly into the records so we don't have a duplicate, but then I don't want you to write into my record because I want control over what you're writing, so it is a mixed economy. [Area 7 Commissioner]

6.6. Estates

The 7-day access hubs across the different CCG areas in GM varied in number, size and type of premises used to provide appointments, reflecting a complexity behind the processes involved in determining their locations. Whilst ease of access and geographical spread provided the starting points for most areas, there were other significant factors affecting the choice of the hubs, including the type/quality of building, the level of workforce engagement from the 'home' practice, and different visions of what 7-day access should entail. Some areas also engaged in a public consultation to inform decisions about hub locations, while others

gave all practices in a specific area the opportunity to bid to host the 7-day access hub. Decisions in some areas were further complicated by the long-term expectation that such hubs may play a bigger role in neighbourhood based primary care in the future:

I think we tried to change the model more recently, to be more of a natural forerunner into the new neighbourhood working. [Area 3 Commissioner]

Several areas chose to locate their 7-day access hubs in Local Improvement Finance Trust (LIFT) centres, which typically were newer and larger than other practice premises. In terms of organisational and logistical benefits, LIFT centres were described as good opportunities to tap into a wide pool of staff, hosting large GP practices (or more than one practice) with lots of GPs already working there. This was significant, where the alternative would have been to ask GPs to travel to a different practice to the one in which they normally work for 7-day access appointments. Several centres were not fully utilised, meaning there was pressure to make better use of such centres as resources and an expectation that there would be future capacity to extend services:

We had these ideas that we might put an ANP in there for diabetes, there might be a special almost like chronic disease management centre at one of the hubs (...), we've had to strip that back for the time-being and then wait and see. [Area 6 Commissioner]

In practice, various areas encountered contractual and operational problems in arranging evening and weekend access to LIFT centres, with delays, expense and complexity also involved in arranging networking, security, insurance and building work:

I think, to be honest, if you start to concentrate on the LIFT centres, it's really expensive. Because you're opening up a whole centre, you're having to get security there to lock up. And it just adds, you know, it's more economic to go with a private practice. [Area 7 Provider]

Similarly, perceptions surrounding 'urgent' care versus 'routine' care affected the choice of estate in most of the areas. Some areas felt that OoH centres, or GP practices in urgent care centres such as hospitals, were inappropriate choices for 7-day access hubs. In contrast, other areas used their OoH premises since, needing to set up a hub quickly, patients could be seen there outside core hours in a location with the requisite heating, lighting and workforce.

6.7. Sustainability and New Care Models

Many areas perceived the long-term sustainability of 7-day access to primary care as intimately linked to wider changes in GM. In common with perspectives on GP federations, a

circular relationship was evident between 7-day access 'hub' working and wider service change. While 7-day access was often viewed as a platform for 'at scale' general practice, for some, the creation of an LCO first would be the catalyst for 7-day access provision to follow:

We've all read the five year forward view. We've read the GP forward view. LCO, ACOs, this is the future... [Area 3 Provider]

In many areas, this provided a strong argument for committing to the 7-day access service, as a natural first step towards new models of care in GM.

What we're looking at in the next iteration is amalgamating it with our vanguard-type work, and the GP element of what we've got will support the weekend district nurse, social work teams, as much as having any appointments. So it will start to become slightly something different...[Area 5 Commissioner]

In other areas, this provided a rationale for delaying the implementation of 7-day access so that it could be incorporated into other local changes:

There's been a lot of things that have been needed to kind of be progressed before we were probably ready to fully progress with a city-wide extended access anyway. [Area 1 Commissioner]

One disadvantage of the uncertainty surrounding new models of care was that it affected the onward planning of future 7-day access services. Thus, current extended hours arrangements would in some cases have to be re-configured under primary care at scale arrangements, to take account of wider changes in relation to access:

There were very good reasons why we didn't put those 7-day access hubs in certain places. We're going to have to now, because of the speed at which we had to implement them, we couldn't fight those battles at the time, whereas now it's a much larger wide-scale piece of work and we're going to have to do that to get them in the right places which I think we will. (...) it's not just around access to primary care, it's around obviously access for much broader range of services. [Area 7 Commissioner]

In the absence of a clear roadmap to guide changes, most areas remained apprehensive about how different stakeholders (general practice, district nursing and the voluntary sector for example) would link together under new arrangements. As well as testing the capacity for collaborative working across an area, the initiative offered the chance to build confidence and trust between commissioners and provider organisations, with an eye to more challenging initiatives in future:

Really important that we checked with (Area 2 Provider), and working with them around their sustainability, can they scale up? Do they think they can continue? What's the risk to their sustainability, or their ability going forward? Actually they coped really well, they coped well with it because we managed it, and we did something that we thought we could be successful at. [Area 2 Commissioner]

The question of financial sustainability was clearly critical in forward planning in most areas, with several expressing concern about the viability of the service in the longer term without a different scale of funding:

The level of funding available to us as a pilot and the level of funding allocated to us we currently don't match even particularly closely. So no, it's not financially sustainable. [Area 4 Commissioner]

In other areas, it was felt that despite the uncertainty, the question of the funding of any long-term provision of 7-day access would be clearly wrapped up in the longer-term moves towards LCOs and health and social care integration:

When it did go back to the CCG it was, the funding isn't there, but obviously new models of care is coming out in April, we have to see what that is, so we will pilot it, we'll extend the pilot until the end of March. (...) So, you need to start to look at that, but it's difficult at the moment, because we don't know whether it's going to be extended beyond March, or will it come under new models of care and be a completely different format? We just don't know. [Area 2 Provider]

6.8. Summary

The process analysis revealed substantial variation in how the seven areas covered by the evaluation framed and consequently delivered 7-day access. In part, this variation reflects differences in local conditions; local plans were designed to take into account current provision of out-of-hospital care, plus the geographical and demographic conditions faced in each CCG. In addition, service design also reflected differing conceptions of the purpose and value of 7-day access to primary care, and attachment to the current system of delivery through general practice DES/LES arrangements, OoH providers, walk-in centres and similar.

A fundamental difference could be identified between areas which made a specific decision to design the 7-day access service around routine rather than urgent care, and areas which were content for the service to cover both routine and urgent care needs. A second key distinction between areas centred on estimated capacity to deliver the service in each area, and

predictions of patient demand. Some areas were more cautious in terms of the level of service offered and were careful to limit patient access in view of anticipated challenges in relation to staffing the service and the need to engage providers. In contrast, other areas appeared more confident in their ability to safely staff a more extensive 7-day service from the outset. These decisions were made more complex by the ongoing, wider transformation of primary care in several areas, such that some areas postponed the implementation of 7-day access until other restructuring was complete, and therefore could not be included in the evaluation. Some, but not all, of the more cautious areas gradually increased the scope of their 7-day service through the 12 month period.

Both of these strategic decisions about nature and extent of the service offered impacted directly on key design decisions. Areas adopting a more cautious approach tended to offer more limited provision, in terms of total available appointment hours and number of hubs in operation, at least initially, and tended to promote the service in a more limited way. The more ambitious areas offered more appointments from the outset, often from a larger number of hubs, and advertised the service more widely. There were benefits to each approach; those adopting the cautious approach emphasised the value of incremental learning and the need to carry their providers with them by not moving too quickly and building confidence over time. By contrast, those adopting a more ambitious approach from the outset emphasised the clarity and consistency of their message to patients, but also had to tackle challenges earlier (for instance, arranging collection of diagnostics).

Key issues for implementation were communications/engagement; workforce; federations; IT/IG and estates. These are summarised in turn below.

Differences in communication strategy (with patients) made a significant difference here – it could be seen across areas that demand for the 7-day service was moderated in some areas by the extent of communication with patients about the service. In areas where the service was not advertised directly to patients, patients relied on the awareness and commitment of each GP practice to refer patients on (i.e. alert them to the service, recommend it and either make a booking or provide the patient with the booking line number). As a consequence, in areas which required patients to be referred by their practice, it is hard to gauge the actual demand for service, as demand was effectively moderated by (a) how knowledgeable practice staff were of the service (b) how appropriate they judged the service to be, and (c) how willing they were to refer patients to 7-day access appointments. Areas with direct booking telephone lines, supported by extensive public communication to patients as well as GP practices, arguably offer a better measure of actual demand for the 7-day service.

In terms of engagement (of providers), different approaches can be identified, as noted above. The main factor underpinning these differences appears to be the relationship between CCG and (multiple) providers in an area, and the history of recent reorganisations of primary care. Thus, in certain areas which had undergone major recent changes (for instance, agreement of enhanced standards for primary care) it proved more difficult to engage providers to make further changes to provision. Here, it was often seen as a necessity to progress slowly to avoid damaging the partnership between commissioners and providers, and several expressed pride in their ability to make gradual progress in this way. In other areas, however, it seemed relatively unproblematic to engage providers at scale and move relatively quickly, without apparent negative impact on the relationship.

A major constraint on the service which could be offered in each area was the availability of staff, such that some areas struggled to cover the service in the early months. Shortages of both practice nurses and GPs affected provision, and it was notable that, as staff were typically drawn from the same regional labour market, actions taken in one CCG area had knock-on effects in neighbouring areas. One consequence noted with concern was the possibility that this competition for a scarce resource would drive up rates of pay or generate gaps elsewhere, either in neighbouring areas or in related services (such as OoH providers). While short shifts at the end of the normal working day may be attractive if located in the same workplace, short shifts at weekends or where people needed to travel were less attractive, particularly for nurses. Work was done in many areas over the 12 month period to identify the precise combination of GP and nurse appointments necessary to match local demand, as well as standardising the necessary broad skill set demanded of practice nurses to cover the range of appointment types. However, given the interconnected nature of some of the challenges, several areas highlighted the necessity of a GM-wide approach to primary care workforce issues to coordinate the supply and training of staff in the medium and long term.

Supporting findings from previous work in GM^{xxxvi}, it was noted that areas with fully-functioning GP federations had certain advantages in the delivery of a CCG-wide service such as 7-day access. In part this reflected the organisational advantages of coordinating providers and establishing a single representative voice. In practice, it was seen that not only did the existence of a GP federation facilitate 7-day access but, equally, the focus on 7-day access often facilitated the development of emergent federations in certain areas. In several areas, it was felt that the benefit, in terms of stronger CCG-provider relations and more cohesive relations between general practices in localities, would be felt in the long-term, as this would facilitate the expected future reorganisation of primary care in GM.

Findings around IT and IG also reflected prior research^{xxxvii} in underlining the advantages enjoyed by areas where practices had moved to a common IT system, facilitating patient record sharing with potential read/write access. Various areas explained the substantial difficulty faced in persuading practices to move to the same IT system, and were reconciled to more complicated work-arounds in the short to medium term. There were mixed responses to the facility to write directly to patient records, however, with some GPs preferring a more cumbersome system of transferring notes from 7-day access appointments manually to allowing other to directly write to their patients' records.

Finally, the evaluation highlighted different estates strategies implemented in each area, depending on a range of local conditions, and a range of processes undertaken to decide on the location of hubs, often with a view to longer-term moves to neighbourhood-based primary care in GM. Specific benefits, but also unanticipated challenges, were noted when making use of LIFT centres to accommodate 7-day access. In some areas, hub locations were chosen on the basis of short-term availability and suitability, recognising that in the long-term and with the benefit of longer planning time, different arrangements might be made.

The impact of the issues highlighted above varied significantly by area. Some areas found provider engagement challenging, but reported little difficulty arranging estates and IT; other areas despite strong engagement found estates and securing workforce particularly problematic. While to some degree this simply reflects local conditions, there was also significant opportunity for cross-area learning. Several local solutions were found by specific areas, for example in arranging diagnostic test collections or negotiating with LIFT facility owners, which could usefully be adopted by other areas.

Returning to the initial argument about different conceptualisations of what 7-day access should entail and how it might be sustained, it bears emphasising that this initiative was undertaken against a backdrop of some uncertainty about a wider reorganisation of care in both GM and across England. For some areas, this justified a cautious approach, to ensure the service would fit with new models of care in a sustainable fashion, with ongoing concerns about affordability in the long term. For other areas, this context provided motivation to engage proactively with this initiative to inform and accelerate local engagement with new models of care, which were seen to provide the answer to long-term questions of funding and sustainability.

7. Outcome Analysis

The outcome analysis aimed to measure before-after changes in the use of four types of hospital activity and OoH services that could potentially be affected by the introduction of 7-day access to primary care (see **Table 3** for a list of data analysed).

7.1. Hospital Services Analysis

Average activity for the four hospital activities analysed are contained in **Appendix Table A8**. Estimates of the change in activity in 2016 compared to 2015 are provided in **Table 4**.^{xxxviii}

Table 4: Summary of changes in A&E attendances, hospital admissions, and OoH

Scheme	A&E attendance	A&E self-referral (minor)	Admissions	Admissions ACSC	OoH
All	+3	+3	-2	-11	-16
Bolton	-1	-15	-2	-10	+2
HMR	+1	-2	-5	-14	-26
Oldham	+4	+1	-7	-8	-35
Stockport	+7	+16	-3	-11	-
Tameside & Glossop	+5	+10	-1	-11	-26
Trafford	+6	+16	+3	-14	-

Nb. Grey shaded cells indicate no statistically significant effect detected.

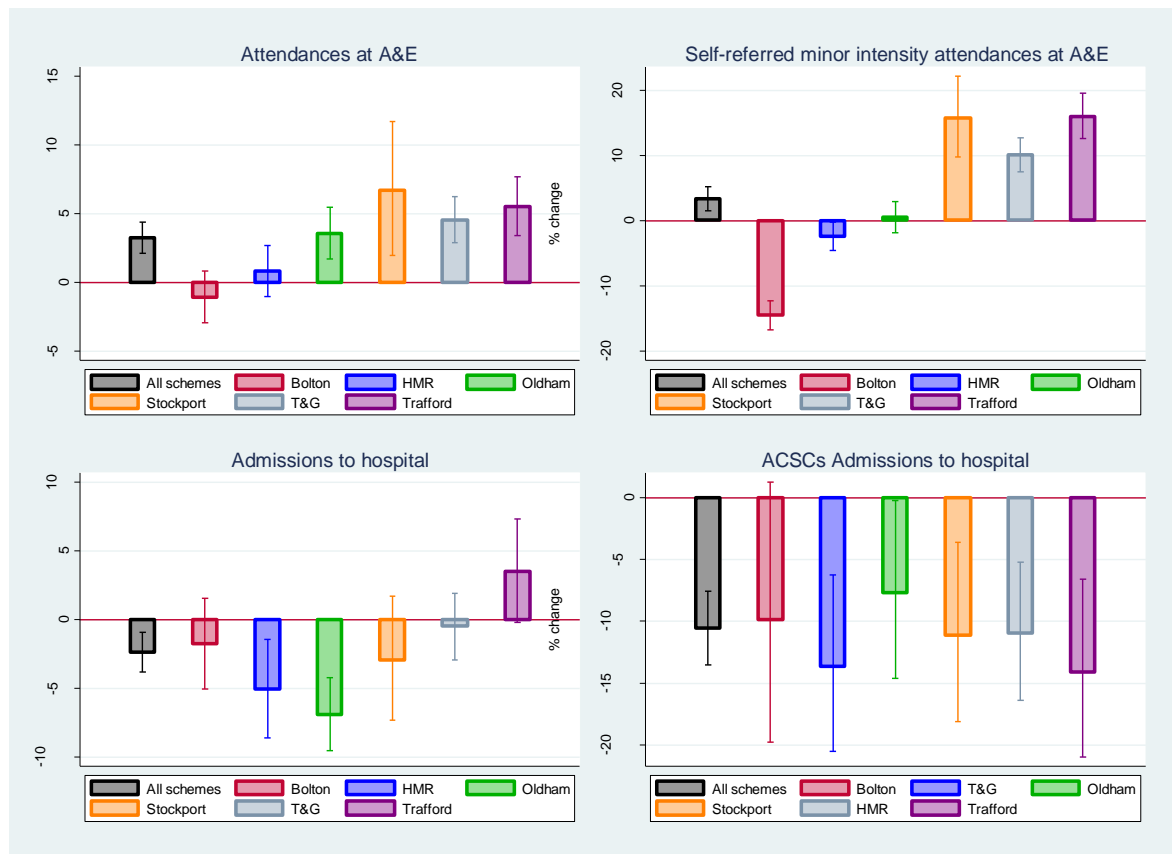
The analysis reveals the following:

- Total A&E attendances;
 - Increased in all schemes combined (+3%), Oldham (+4%), Stockport (+7%), Tameside & Glossop (+5%), and Trafford (+6%).
 - No statistically-significant change was observed for Bolton and HMR.
- Self-referrals to A&E with minor intensity;
 - Reduced for Bolton (-15%) and HMR (-2%).
 - No change observed in Oldham.
 - Increased in all schemes combined (+3%), Stockport (+16%), Tameside & Glossop (+10%) and Trafford (+16%).
- Total hospital admissions;
 - Reduced for all schemes combined (-2%), HMR (-5%), and Oldham (-7%).

- No change observed for Bolton, Stockport, Tameside & Glossop and Trafford.
- Admissions for ACSC conditions;
 - Reduced for all schemes (all schemes combined (-11%), HMR (-14%), Oldham (-8%), Stockport (-11%), Tameside & Glossop (-11%), and Trafford (-14%).
 - The exception was Bolton where no significant change was observed.
- OoH usage;
 - Reduced overall (-16%) and for HMR (-26%), Oldham (-35%) and Tameside & Glossop (-26%).
 - Saw no significant change in Bolton. No data received for Stockport or Trafford.

Figure 20 represents this graphically with 95% confidence intervals attached.

Figure 20: Changes in A&E Attendance and Hospital Admissions by Area



The confidence intervals are the thin lines with caps at the top and bottom, they refer to the range in the estimate where there is a 95% likelihood that the observed change can be attributed to 2016, rather than to chance. It is not a statement of the clinical or policy significance of effects. If the 95% confidence interval includes zero (cuts the x-axis) then there is no statistically significant evidence of an effect of 7 day access appointments on that measure of service use.

7.2. Additional Analysis: Hub v non-Hub Practice Effects

Additional analysis was conducted to compare A&E activity and hospital admissions between practices located within hubs versus non-hub practices. As hub practices dominate 7-day access appointments, we may expect any effects of 7 day access appointments on service activity to be felt relatively greater here than for non-hub practices.^{xxxix}

Estimated effects for hub and non-hub practices can be found in **Table 5**.^{xl} For all schemes combined, hub practices saw no significant change in both types of A&E attendances modelled. In contrast, non-hub practices experienced increases in both types of A&E attendances. No significant effect was observed for hub practices for total admissions, while non-hub practices saw a 2% reduction, and a larger reduction was observed for hub practices for admissions for ACSCs (-15% compared to -10%).

Considering the schemes separately, there is no significant change in total A&E attendance observed for hub practices aside from Tameside & Glossop (+9%), while significant increases are seen in non-hub practices in all areas except Bolton (-1%) and HMR (no significant change). There is no significant change in hub practice self-referrals to A&E for minor intensity aside from Bolton (-13%) and Tameside & Glossop (+7%).

No significant effect on admissions was observed for hub practices in all schemes combined and Bolton, similar reductions were seen in hubs practices compared to non-hub practices in HMR, reductions were greater in hub practices in Oldham (-12% compared to -6%) and Trafford (-1% compared to zero change in non-hub practices) and increases were found in Tameside & Glossop hub practices (+14%) in contrast to non-hub practices (zero change).

Table 5: Changes in A&E attendances and hospital admissions (hub vs non-hub practices)

Scheme	A&E attendance	A&E self-referral (minor)	Admissions	Admissions ACSC
All				
Non-hub practice	+3	+4	-2	-10
Hub practice	+2	-1	-4	-15
Bolton				
Non-hub practice	-1	-15	-2	-9
Hub practice	0	-13	+1	-18
HMR				
Non-hub practice	+1	-3	-5	-15
Hub practice	+1	-1	-5	-2
Oldham				
Non-hub practice	+4	+1	-6	-6
Hub practice	0	-4	-12	-20
Tameside & Glossop				
Non-hub practice	+4	+10	-1	-12
Hub practice	+9	+7	+14	+13
Trafford				
Non-hub practice	+6	+16	+4	-12
Hub practice	0	+15	-1	-33

For admissions for ACSCs a larger reduction is observed for hub practices in all schemes combined (-15% compared to -10% in non-hub practices) and Trafford (-33% compared to -12%). An increase was observed in Tameside & Glossop hub practices (+13% in contrast to -12% for non-hub practices). No significant change in admissions were observed in both hub and non-hub practices in Bolton and Oldham, and in HMR no significant change was observed for hub practices in contrast to a reduction observed for non-hub practices.

7.3. Additional Analysis: Gender and Age

Analysing the hospital data by gender (**Table 6**) did not prove to be productive.^{xii} No common effect was evident in A&E attendance or admissions, confounding the expectation that the effect of 7-day access might be greater for women than men given the activity data. While this

was evident in some cases, the effect was very variable and inconsistent across as well as within activities.

Table 6: Changes in A&E attendances and hospital admissions by gender group and area

Activity by gender	All	Bolton	HMR	Oldham	Tameside & Glossop	Trafford
A&E attendance						
Male	+2	0	-1	+1	+3	+4
Female	+3	-3	+1	+5	+5	+6
A&E self-referral (minor)						
Male	+2	-13	-3	-1	+8	+15
Female	+3	-17	-3	+1	+12	+16
Admissions						
Male	-3	-2	-5	-6	-3	+3
Female	-3	-2	-6	-9	+2	+4
Admissions (ACSC)						
Male	-14	-13	-17	-14	-17	-15
Female	-9	-8	-11	-3	-6	-13

Turning to the issue of age, hospital activity was grouped into three age groups: 0-19 years old, 20-49, and 50 years old and over. As noted in the activity data analysis, 7-day access appointment use was dominated by patients under 50. If additional appointments impact on hospital use then the effects may be most likely to be visible among those under 50.

For A&E attendances the separate age splits reveal that total A&E attendances were increasing across the schemes for those aged 50 and over. Since this group used relatively fewer 7-day access appointments this activity change may not be reflective of these appointments and more reflective of the trend in A&E activity over time. For the age group 20-49 no change was found in A&E attendance for all schemes combined, HMR, Oldham, and Tameside & Glossop; a reduction in Bolton (-4%), and an increase in Trafford (+7%). For age group 0-19 an increase of 3% was found for all schemes combined and this appears to be driven by increases in Tameside & Glossop (+6%) and Trafford (+5%) as Bolton, HMR, and Oldham exhibit no change.

Table 7: Changes in A&E attendances and hospital admissions by age group and area

Activity by age group	All	Bolton	HMR	Oldham	Tameside & Glossop	Trafford
A&E attendance						
0-19	+3	-2	0	+3	+6	+5
20-49	+1	-4	-1	+1	+2	+7
50+	+3	+3	+1	+6	+5	+5
A&E self-referral (minor)						
0-19	+5	-8	-2	+4	+10	+17
20-49	+1	-19	-4	-3	+9	+16
50+	+3	-15	-4	-1	+12	+15
Admissions						
0-19	+1	0	-1	-1	+3	+5
20-49	-6	-2	-9	-17	-4	+8
50+	-4	-3	-5	-5	-1	+1
Admissions (ACSC)						
0-19	-2	+4	-5	-4	+1	-10
20-49	0	-2	+5	-4	+2	-8
50+	-14	-13	-18	-8	-15	-16

For self-referrals with minor intensity A&E attendance, the increase in attendance for all schemes combined (+3%, **Table 4**) is driven by increases in attendance for those aged 0-19 (+5%, **Table 7**)^{xliii} as no change was observed for age groups 20-49 and 50 years plus. The increase for those aged 0-19 comes from increases in attendances in Oldham (+4%), Tameside & Glossop (+10%), and Trafford (+17%). For age group 20-49 no change in attendance was found, this was the combination of statistically significant reductions in Bolton (-19%) and HMR (-4%), statistically significant increases in Tameside & Glossop (+9%) and Trafford (+16%) and no change in Oldham. No change was found for age group 50 years plus and this was similarly made up of reductions in Bolton (-15%), increases in Tameside & Glossop (+12%) and Trafford (+15%) and no change in HMR and Oldham.

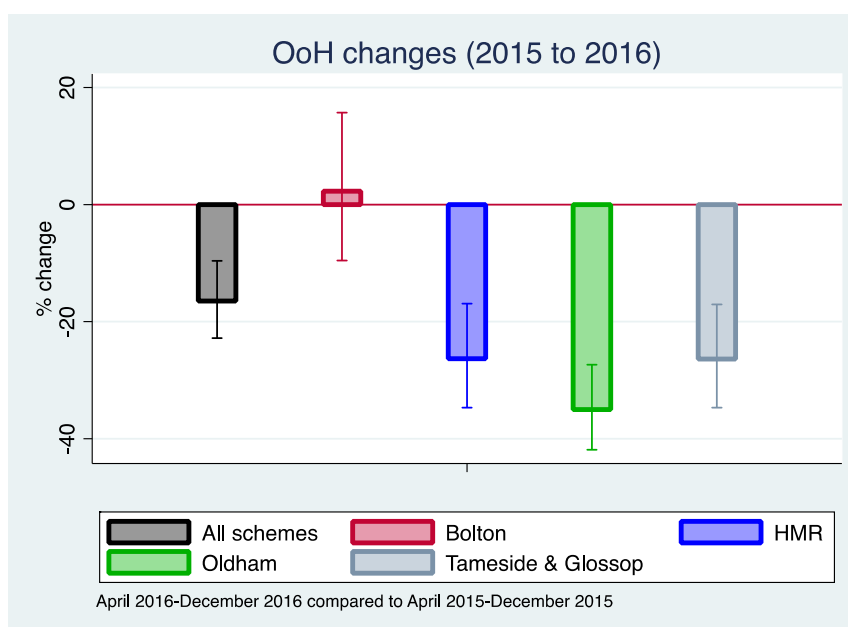
No change in total admissions was found for any scheme for those aged 0-19, the significant changes observed in **Table 4**, where all ages are combined, were due to reductions in admissions for ages 20-49 and 50 years plus in HMR and Oldham (whilst Trafford saw an increase in admissions for age group 20-49).

For ACSC admissions the reductions in **Table 4** were driven by reductions in age group 50 years plus across all schemes since no statistically significant change in admissions were observed for ages 0-19 or 20-49 across the schemes.

7.4. OoH Analysis

The OoH analysis aimed to test whether OoH activity changed with the introduction of 7 day access appointments. For each CCG submitting OoH activity there appears to be evidence of a downward trend in OoH activity throughout 2015, and the decline continues through 2016 in all areas except Bolton, where a rise is seen (**Appendix Figures A29, A30, A31, A32**). **Figure 21** shows the change in 2016 for each scheme and for all schemes combined.

Figure 21: OoH changes 2015 to 2016 by area



In 2016 OoH activity was, on average, lower by 16% and a significant reduction can be seen in all areas except Bolton. Changes in NHS 111 provision over this period, discussed below, suggests that it may not be possible to draw clear conclusions about the effect of 7-day access initiatives from this decrease in OoH use.

7.5. Discussion

The analysis provides some evidence of an association between 7-day access and A&E attendances in certain areas. Rises in A&E activity can be seen in all areas between 2015 and 2016 with the exception of Bolton and HMR, where A&E activity held steady. This may represent a positive outcome in these areas, insofar as that Bolton and HMR appeared to be

'bucking the trend' of increasing A&E activity elsewhere. This should also be placed in the context of an average 5.3% increase in total A&E attendance in England from 2015 to 2016.^{xliii} This is hard to firmly establish without full interrupted time-series analysis incorporating A&E activity over a number of years – an analysis that has not been conducted here.

The suggestion that extended access in some areas has reduced A&E activity may be supported by the comparison of A&E activity between hub and non-hub practices. With the exception of Tameside & Glossop, hub practices saw no change in A&E attendances, while non-hub practices saw increases in both kinds of A&E attendance. These differences may indicate that 7-day access appointments may help relieve some pressures in hospitals. They also emphasise that variations in access to such appointments on the basis of hub status need to be addressed for these effects to be maximised.

The link is also supported by analysis of self-referrals to A&E for minor intensity ailments, where the most direct impact of primary care might be expected to be seen. These fell in Bolton and slightly declined in HMR, but rose in all other areas except Oldham, often substantially. This reflects the overall A&E attendance figures for all schemes combined. The suggestion that 7-day access is associated with reduced minor intensity A&E activity is somewhat strengthened by the sub-group analysis by age. Focusing on minor intensity A&E attendance, there were statistically significant reductions in the age group 20-49 in Bolton and HMR, no change in Oldham, and increases elsewhere.

The evidence regarding the impact of 7-day access on hospital admissions is less convincing. Hospital admissions fell between 2015 and 2016 in all areas, but the only statistically significant reductions identified here are in HMR and Oldham. Admissions for ACSCs fell substantially (and significantly) in all areas except Bolton. While at first glance, this seems to suggest an effect, closer attention challenges this interpretation. The fact that this reduction occurred in all areas regardless of amount of 7-day access activity undermines the suggestion that these are linked. Subgroup analysis suggests that this is led by a decrease in ACSC admissions for those 50+, which further diminishes the likelihood that this is linked to the 7-day service (the use of which is dominated by those under 50).

Finally, the striking falls in OoH activity in all areas except Bolton are hard to match with the 7-day access appointments in each area. The OoH analysis is problematic due to concurrent changes in NHS 111 arrangements. From November 2015 onwards, practices were required to amend their answering machine message to direct patients to NHS 111 rather than the local OoH provider when practices were closed. This was perceived to drastically reduce OoH activity in all areas. The reductions in OoH activity observed in this analysis therefore are likely

to be largely driven by this change in NHS 111 policy. It is not possible to separately identify an effect resulting from the 7-day access service.

Broadly, the results suggest an impact resulting from the way appointments could be booked across CCG schemes (same-day/pre-booked). HMR and Oldham were the two areas where appointments were predominantly booked on the day. However, no association can be seen between same-day/pre-booked and A&E attendance in these areas, which is surprising as one might expect a more directly causal connection here.

8. Conclusions

NIHR CLAHRC GM evaluated the implementation of 7-day access to primary care across seven CCG areas in GM on behalf of NHSE GM. This report presents the evaluation of activity, process and outcomes in these areas to provide a comprehensive assessment of the implementation and impact of this service between January and December 2016. One area (Salford) did not establish the service within the period of evaluation; another (Stockport) were unable to provide activity data. The evaluation therefore focuses on five CCG areas; Bolton, Heywood, Middleton and Rochdale (HMR), Oldham, Tameside & Glossop, and Trafford.

Each area chose to implement 7-day access in a different way, depending on local conditions such as geography, premises and workforce availability and existing provision of out of hospital care. Service design was also informed by the specific combination of providers contributing to 7-day access in each area (including GP practices, GP federations and OoH services). Furthermore, commissioners and providers in each area had differing conceptions of how the service should work and what it should seek to deliver, in terms of patient need and wider primary care strategy in the area. Areas also varied in terms of the level of caution or ambition displayed in their initial implementation, depending on perceptions of likely demand and capacity to meet this demand. This led to very wide variation in the number of appointments provided in each area, from 144 appointments per 1000 patients in HMR, to 23 per 1000 patients in Bolton/Tameside & Glossop and 12-15 appointments per 1000 patients in Oldham and Trafford.

These differences generated different models of 7-day access in each area, varying in terms of the extent to which the service was publicised (and whether it was publicised directly to patients or via GP practices); route of referral/booking (directly by patients or via GP practices); number and location of hubs (ranging from 1 to 4); choice of clinician to staff the service (GP/nurse) and availability (7-days, weekends only or Saturdays only). Each of these decisions had implications for the level of demand for the service and utilisation.

The activity analysis focused on five CCGs. Nearly 52,000 additional appointments were made available across these areas over the 12 month period, of which 76% were booked. The average user of the service was relatively young (70% aged <50) and more likely to be female than male. Overall, weekdays had higher utilisation than Saturdays and Sundays, but activity levels varied significantly between areas suggesting that local conditions and implementation played a major role. Overall uptake, in terms of number of appointments used and percentage utilisation, appears to have improved steadily over the 12 months. Each of the areas witnessed a 'hub dominance' effect, whereby patients registered at the hub practice were more likely to use the service than other patients, but the strength of the hub dominance effect varied by

area and by hub. This had implications for equity of access and for the impact of the service overall. The activity analysis offers detailed information which could support planners in projecting demand and tailoring services to suit local needs.

HMR provided substantially more appointments than the other four areas combined, and had good rates of utilisation reflecting wide publicity for the service, good coverage with four hubs, a direct booking line for patients and strong buy-in from GP practices. In Oldham, a direct booking line but an indirect communication campaign via GP practices saw much lower activity, although fewer DNAs than other areas. In general, in other areas where patients could not book appointments directly but did so through their GP practice, there was evidence of a 'referral moderator' effect; patient demand for the service was effectively 'moderated' by the conduct of staff at their GP practice. As a result, caution should be taken when interpreting activity levels as measures of patient demand, as practice staff awareness/understanding and orientation towards the 7-day service and ease of communication with the GP practice (particularly outside core hours) serve to moderate demand in several areas.

Demand varied substantially between areas and did not mirror provision; Trafford enjoyed the highest overall utilisation (89%) although provided the fewest appointments; Oldham provided a similar number but had the lowest utilisation (56%) while HMR saw good utilisation despite providing more appointments than all the other areas combined. Such differences are particularly marked on Sundays; HMR achieved almost 100% utilisation of Sunday appointments by December, while Tameside & Glossop, with near 100% utilisation on weekdays, achieved around 40% on Sundays.

Each area also faced different challenges in implementing the service, examined here in terms of communications and engagement; workforce and staffing; GP federation arrangements; IT and IG; and estates. The level of challenge varied substantially, such that IT/IG or estate-related challenges which proved intractable in one area were found to be easily resolved in another. This presents a clear need for cross-programme learning to share knowledge. Several issues, particularly workforce challenges, were seen to be inter-related and could only be effectively resolved at a regional (not CCG) level through coordinated action across GM. Uncertainties over the wider reorganisation of health and social care in GM limited the ability of areas to commit to certain decisions for this service which might conflict with large-scale, emergent changes across the region.

The outcome analysis generates a mixed picture, with clearer evidence of impact on A&E attendances than of impact on admissions, with HMR and Bolton showing the clearest suggestion of impact. In a national context of increasing A&E attendances in England, two areas (Bolton and HMR) saw no increases in A&E activity. Notably, these were the two areas

with the highest number of 7-day access appointments used. This interpretation is supported by the analysis of hub and non-hub practices. Comparing A&E activity in each, the analysis shows that hub practices (which tended to have the highest rates of utilisation of 7-day access services, as noted) generally saw no increase in A&E attendances, while non-hub practices saw increases in A&E activity. Analysis of minor intensity, self-referred A&E activity by age showed reductions in attendance among those aged 20-49 (the cohort most likely to use the 7-day access service) in Bolton and HMR, and no increases in attendance from 20-49 year olds in Oldham. There is no strong evidence on an impact on hospital admissions, and analysis of OoH service use was compromised by a major change in NHS 111 policy across this period, meaning that no clear conclusions could be drawn here.

Two major caveats must be attached to the analysis. The first is that the reliance on before-after outcome analysis means that conclusions do not systematically take long-term trends into account. An interrupted time-series analysis would be necessary to address this issue fully. Secondly, the evaluation has not attempted a cost-benefit analysis of the 7-day access service, which would be recommended to inform strategic decisions on the continuation or extension of this service. Impact on patient satisfaction was not evaluated in this report due to a delay in the publication of national GP Patient Satisfaction survey data for the period in question. This will be provided as an addendum to the report.

9. Recommendations

- *Develop a common model of 7-day access:* A clear common understanding of the purpose of 7-day access is important if a shared framework is to be developed and implemented in GM. Attention needs to be paid to an appropriate level of local discretion to allow the service to achieve its objectives without undermining effectiveness and coherence. The design of services should also be informed by the available evidence base.
- *Enable focused collaborative work at local level to implement framework:* There is a great deal of evidence that good commissioner/provider relationships underpin successful delivery of 7-day access, in terms of developing both a common vision and an operational model that is sustainable in the longer-term. This type of engagement would entail give-and-take on both sides and may require extensive discussions to help each party build an understanding of what is feasible and confidence in the model at a local level.
- *Establish focused workshops to share learning across Greater Manchester:* While each area involved in this evaluation faced some challenges which could be deemed unique, the majority of challenges encountered were common to all areas and most were overcome in at least one area, generating significant learning and knowledge about how such challenges can be successfully addressed. Further implementation of 7-day access across GM should be supported by regular opportunities for shared learning across the region, ensuring that the learning accrued in one area can effectively support and inform the activities of another.
- *Target coherent communications strategy directly to patients:* Areas relying on indirect communication campaigns through practices alone tended to generate low levels of total activity and poorer service utilisation overall. Direct promotion of the service to the public offers clarity of message and ensures that equity of coverage is not undermined by inconsistent messaging from different practices.
- *Promote availability of the 7-day service to all practices:* Hub-based extended access models were found to disproportionately benefit patients registered with the practice(s) located at the hub site, a 'hub domination' effect. While distance and access to transport mean that this cannot be entirely eliminated, active efforts need to be employed to minimise hub domination by promoting wider awareness and confidence in the service among local health and community professionals.
- *Careful planning of hub locations essential to maximise utilisation:* The evaluation provided clear evidence of the complexity of decision-making involved in selecting hub locations in each area, and this is best effected by involving providers and crucially patients.

- *Explore premises service agreements in estates planning:* Several areas encountered unanticipated contractual obstacles related to certain kinds of estates, especially LIFT premises, in implementing 7-day access services. Detailed and early consideration of contracts and facilities management arrangements is important to avoid delays and minimise expenditure where 7-day access services require changes in security, networking, insurance, or building work.
- *Support use of a common practice IT system within CCG areas:* Areas where practices operated from a common IT system were able to share patient records much more readily than areas with multiple different systems, where more complicated work-arounds were needed. While strong attachments to familiar systems among GP practices are widely reported, there is a clear need to encourage and, where possible, incentivise a collective move to a common system, at least within individual areas, to support 7-day access and other forms of collaborative working.
- *Embed 7-day access strategy within wider out of hospital care:* There is a pressing need for forward planning in service design to reduce duplication in out of hospital care and early work is underway in this regard in Greater Manchester^{xliv}. The 7-day access schemes interact
- Other services and overlaps between different services (A&E, walk-in centres, and others) must be addressed to avoid confusion, for staff and patients, and resulting inefficiencies.
- *Prioritise GM-wide manpower planning for primary care:* There is a pressing need for adequate and appropriate workforce planning at the regional level, as recognised by the emergent Workforce Strategy in Greater Manchester^{xlv}. This is essential both to ensure sufficient supply of staff and to standardise training, particularly in the case of nursing staff, but also to manage pressures so as to avoid wage inflation caused by shortages in specific areas as far as possible.

Footnotes

- ⁱ <https://healthiertogethergm.nhs.uk/what-healthier-together/primary-care/>
- ⁱⁱ <http://www.gmhealthandsocialcaredevo.org.uk/assets/GM-Strategic-Plan-Final.pdf>
- ⁱⁱⁱ Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R., & Hudson, M. (2002). What does 'access to healthcare' mean? *Journal of Health Services Research and Policy*, 7(3), 186-188
- ^{iv} Boyle, S., Appleby, J. and Harrison, A. (2010) A Rapid View of Access to Care www.kingsfund.org.uk/sites/files/kf/field/field_document/rapid-view-access-care-gpinquiry-research-paper-mar11.pdf Accessed 21 January 2015
- ^v Ibid., p 8-9
- ^{vi} Ibid., p 8
- ^{vii} Chapman JL, Zechel A, Carter YH, Abbott S (2004) Systematic review of recent innovations in service provision to improve access to primary care. *British Journal of General Practice*, 2004, 54, 374-381
- ^{viii} Aboulghate A, Abel G, Elliot MN, Parker RA, Campbell J, Lyratzopoulos, Roland M (2012). Do English patients want continuity of care and do they receive it? *British Journal of General Practice* doi: 10.3399/bjgp12X653624
- ^{ix} Goodwin N, Dixon A, Poole T, Raleigh V (2011). Improving the quality of care in general practice. Report of an independent inquiry commissioned by The King's Fund. London: The King's Fund
- ^x <https://www.gov.uk/government/news/prime-minister-pledges-to-deliver-7-day-gp-services-by-2020>
- ^{xi} <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>
- ^{xii} <https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf> p47
- ^{xiii} Ibid., p 33
- ^{xiv} Ibid., p 48
- ^{xv} <https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/>
- ^{xvi} Collaboration and Leadership in Applied Health and Care (CLAHRC) Greater Manchester (2015). NHS Greater Manchester Primary Care Demonstrator Evaluation: Final report. <http://clahrc-gm.nihr.ac.uk/wp-content/uploads/PCDE-final-report-full-final.pdf>
- ^{xvii} Whittaker W, Anselmi L, Kristensen SR et al. (2016). Associations between extending access to primary care and emergency department visits: a difference-in differences analysis. *PLOS Medicine* doi: 10.1371/journal.pmed.1002113
- ^{xviii} <https://www.england.nhs.uk/wp-content/uploads/2016/10/gp-access-fund-nat-eval-wave1-sml.pdf>
- ^{xix} Dolton, P., Pathania, V. (2016) Can increased primary care access reduce demand for emergency care? Evidence from England's 7-day opening, *Journal of Health Economics*, 49, 193-208
- ^{xx} <https://www.nottingham.ac.uk/business/businesscentres/chill/documents/chill-7-day-gp-access-report.pdf>
- ^{xxi} <https://healthiertogethergm.nhs.uk/what-healthier-together/primary-care/>
- ^{xxii} <http://www.gmhsc.org.uk/assets/GM-Strategic-Plan-Final.pdf> p14
- ^{xxiii} Ibid., p 9
- ^{xxiv} www.gmhsc.org.uk/assets/GMHSC-Partnership-Primary-Care-Strategy.pdf
- ^{xxv} EQALS: Enhancing Quality and Access to Local Supply
- ^{xxvi} A third hub, the Failsworth hub, opened in Oldham south in January 2017 and was a 3PD scheme.
- ^{xxvii} Over-dispersed activity occurs where activity is skewed, this occurs when the variance in activity is greater than the average level of activity.
- ^{xxviii} In addition, Dolton and Pathania (2016) found hub/non-hub differences in the effects of 7 day access appointments on a range of hospital service use for a Central London PMCF scheme.
- ^{xxix} For example, if the activity data found 7 day access appointments were used mainly by females then if hospital activity is affected by 7 day access appointments, we might expect the effect to be seen in female rather than male activity.

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- xxx There were missing discipline type for 345 appointments in Tameside & Glossop CCG
- xxxi Nurse appointments in Tameside & Glossop came into effect from November 2016
- xxxii The inability to identify DNA attendances in Bolton means we assume all Bolton attendances were attended, this has the implications of exerting positive bias on the uptake proportion.
- xxxiii Patients aged under 18 are not surveyed in the GPPS and the bandings of age are not aligned between the two datasets.
- xxxiv The reporting of the practice a patient is registered with was not recorded in Bolton (5,519 appointments), and missing data varied across hubs and CCGs (see **Appendix Table A8**) amounting to 8,012 (21.33% of all appointments booked).
- xxxv <http://www.gponline.com/10m-gp-appointments-lost-dnas-year-warns-gpc/article/1424483>
- xxxvi CLAHRC Greater Manchester (2015). NHS Greater Manchester Primary Care Demonstrator Evaluation: Final report. <http://clahrc-gm.nihr.ac.uk/wp-content/uploads/PCDE-final-report-full-final.pdf>
- xxxvii CLAHRC Greater Manchester (2015). NHS Greater Manchester Primary Care Demonstrator Evaluation: Final report. <http://clahrc-gm.nihr.ac.uk/wp-content/uploads/PCDE-final-report-full-final.pdf>
- xxxviii Estimates are rounded to the nearest whole number, greyed cells indicate no statistically significant change was observed, white cells indicate no data available. Full estimation details, with estimates to two decimal places are provided in **Appendix Table A9**. Average rates of hospital activity are provided in **Appendix Figures A22, A23, A24, A25, A26, A27, A28**
- xxxix In addition, Dolton and Pathania (2016) found hub/non-hub differences in the effects of 7 day access appointments on a range of hospital service use for a Central London PMCF scheme
- xl No Stockport analysis is conducted for hub models due to the lack of activity data provided. Full estimation details, with estimates to two decimal places are provided in **Appendix Table A10**
- xli Full estimation details, with estimates to two decimal places are provided in **Appendix Table A11**
- xlii Full estimation details, with estimates to two decimal places are provided in **Appendix Table A12**
- xliii NHS Digital. A&E attendance statistics: <https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2016-17/> Admission statistics: <http://content.digital.nhs.uk/catalogue/PUB23360/prov-mont-hes-admi-outp-ae-April%202016%20to%20December%202016-rep.pdf>
- xliv https://www.greatermanchester-ca.gov.uk/download/meetings/id/1892/07_urgent_and_emergency_care_reform
- xlv <http://www.gmhsc.org.uk/assets/GMHSC-Partnership-Primary-Care-Strategy.pdf>