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Prime Minister Challenge Fund Evaluation Interim Report

NHS England North Midlands

Centre for Health Innovation Leadership and Learning (CHILL), University of Nottingham

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1 Introduction

NHS England North Midlands has commissioned the Centre of Health Innovation, Leadership and Learning (CHILL) at the University of Nottingham to undertake a local formative evaluation of the Prime Minister Challenge Fund (PMCF) primary care transformation projects (PCTPs) in their area.

The objective of the evaluation is to examine PCTPs and the context in which they are implemented, and to establish lessons learnt to inform choices made in the adoption and implementation of these projects. The focus is on the 'proof of concept' of different types of PCTPs, and on approaches used in their implementation. Within this, it is important to identify and understand the influence of contextual factors on the types of initiative and the implementation approaches that are found to be most effective.

The NHS England North Midlands and nine local CCGs organised a combined and comprehensive PMCF bid. This Report has been prepared for NHS England and the CCGs. Its readership could be usefully extended to all those participating in the PCTPs and/or interested in selecting and implementing similar initiatives now, and in future.

1.1 Overview of report content

The following sections of this Report include information on:

- The evaluation process: describing the approaches taken to evaluate PCTPs (qualitatively and quantitatively).
- Access: describing the variety of ways access has been defined at the local level. Findings from an initial study of patient preferences are also presented.
- Types of initiative: examining and categorising different types of PCTP as described by participants.
- Emerging themes: describing some key themes that have already emerged during phase 1 of the evaluation, and which will be investigated further in phase 2.
- Next steps: an explanation of subsequent steps to be undertaken by the CHILL evaluation.

1.2 The evaluation process

The local formative evaluation conducted by CHILL comprises two streams. A qualitative stream focuses on understanding how and why initiatives are implemented by examining local contexts, assessing outcomes, and understanding what these are dependent upon. A quantitative stream seeks to quantify outcomes. This includes metrics provided by local PCTP initiatives on performance and impact, data collected on patient's perceptions of improvements in local services, their preferences regarding access in general, and the analysis of other available NHS data.

1.2.1 Overview of qualitative analysis

In phase 1 of the qualitative evaluation, work has focused on establishing profiles for the majority of the PCTPs across all CCGs in order to develop an understanding of the variety of initiatives being undertaken. Data collection has included interviews with CCG leads, service providers, and project leads on the ground where changes are being made. These have explored the rationale behind PCTPs, the implementation process, and the outcomes thus far. Approximately 25 interviews have been conducted with 33 individuals (some interviews involved multiple individuals), recorded and analysed. The profiles have been examined to identify significant issues and themes to inform phase 2 of the evaluation, where exemplar PCTPs will be analysed in relation to 'proof of concept' and implementation.

1.2.2 Overview of the quantitative analysis

In preparation for the quantitative evaluation work of the CHILL team, the NHS England North Midlands and CCG leads agreed a set of key metrics in April 2014. The intention was for data on these key metrics to be delivered to CHILL on a monthly basis by CCG leads, as part of the response and for accountability. There have been issues in obtaining this metrics data, and delivering it to the CHILL evaluation team.

To date, metrics data has been provided to CHILL by Erewash CCG and by Nottingham North & East CCG. Unfortunately, delays in delivery and/or requests for clarifications on data mean analysis could not be conducted in time for the deadline of this Report. Once clarifications have been made, the analysis will be provided in CCG overview reports (see Next Steps section).

CHILL has worked with Nottingham West CCG, Nottingham North & East CCG, Erewash CCG, and Rushcliffe CCG to develop service-specific patient questionnaires. At this point, Nottingham West CCG has deployed the questionnaire, and provided the data. We are still awaiting information on sample rates (i.e. the percentage of patients attending different surgeries that completed questionnaires during the 2 week sampling period) from Nottingham West CCG. Once this has been provided, the analysis will be provided in a Nottingham West CCG overview report (see Next Steps section).

Finally, the CHILL evaluation team has conducted a conjoint analysis survey of patient preferences on access to GP services with Stenhouse Medical Centre in Arnold (Nottingham North & East CCG). A draft report has been delivered to Nottingham North & East CCG. A summary of the findings is included in this Report.

To summarise, the quantitative stream of the CHILL evaluation is constrained by the lack of data provided to date.

2 Initial Findings

2.1 Access

Improving access has been interpreted differently across CCGs, and these differences have influenced the types of PCTPs which have been developed. In different cases 'access' has been viewed as access to:

- GPs for consultations (face-to-face, telephone, or virtual);
- overall services provided by general practices, including services delivered by other staff as well as GPs within a practice;
- a range of clinical services, with an emphasis on the most appropriate service being delivered to patients, at the right place and time (e.g. through an integrated acute care service);
- clinical information, and support, towards patient self-management (e.g. using general practice websites).

From face-to-face interviews, the practice perspective is that there are a number of different types of streamlining that can be introduced to ensure patients are allocated the most appropriate service or level of care. The findings indicate that the following factors are important in relation to patients' access:

- ensuring that patients with the most acute or urgent conditions are likely to receive swift attention;

- allocating patients to clinicians according to the level of specialism required (i.e. providing an intervention at the lowest possible skill-level to ensure efficient allocation of resources);
- allocation of appointments taking into account a trade-off between pre-bookable appointments (available for routine and/or non-urgent appointments) and urgent appointments;
- diverting patients to other sources of help, where appropriate (either as an adjunct to practice care, or as an alternative);
- encouraging and enabling patient self-management where appropriate.

2.1.1 Patient preferences in relation to access

Patient demand is an important factor determining the provision of access to primary care services. Conjoint analysis is an approach to measuring preferences (utilities) that estimates both the relative importance of different aspects of care, as well as the total satisfaction or utility that respondents derive from healthcare services (Ryan and Farrar 2000; Rubin et al 2006). Within the conjoint framework, it is assumed that if A is preferred to B then the utility or benefit derived from choosing A (with a given set of attributes and levels) will be greater than that of B (with a given set of attributes and levels).

A conjoint patient survey was conducted at Stenhouse Medical Centre in Arnold. This survey seeks to measure the relative importance of three attributes affecting patients' access to primary care that are highlighted in the PM Challenge - the availability of same day appointments at GP practices, continuity of care (i.e. being able to see the same GP or nurse), and extended opening hours at GP surgeries.

The main benefit of conjoint analysis is that one asks patients to explicitly state their preferences across a complete set of options. In this survey, this number of attributes and levels gives rise to a complete set of 8 (2x2x2) possible service combinations (or options) - Table 1 below. Patients were asked to score each combination between 100 and 1 (where 100 is the highest possible score, and 1 is the lowest possible score).

Using this information, one can identify and estimate the trade-offs which patients are happy to make between the three different aspects of GP access. The estimated contribution – known as a "partworth" – for a particular aspect (e.g. the availability of same day appointments) indicates the utility to patients of that particular aspect of access.

For GPs and Commissioners, the partworth is of direct interest because it is the benefit, as perceived by patients, in moving from one set of services to an alternative service option, given a set of trade-offs.

In addition to analysing the three main access attributes, the study takes into account individual characteristics, such as age, gender, ethnicity, socioeconomic variables, and long-term conditions that could also influence preferences for a GP access.

Patients were contacted upon entering Stenhouse Medical Centre, for a two week period, from 23/02/2015 to 06/03/2015. Questionnaires were distributed at both morning and afternoon clinics. Patients were asked to complete a questionnaire while waiting for their appointment. The effective sampling rate over the two week sampling period was 52%. The sample dataset comprises completed 388 questionnaires. For the set of 8 choices, this provides 3104 observations.

Table 1. Combinations Presented to Patients to Score

				Score
1.	Same day appointments are available	Appointment with your usual Doctor or Nurse	Surgery open 8am-8pm Mon-Fri, and opening at weekends	
2.	Same day appointments are available	Appointment with your usual Doctor or Nurse	Surgery opening hours are 9am-5pm, 5 days a week	
3.	Same day appointments are available	Appointment with any available Doctor or Nurse	Surgery open 8am-8pm Mon-Fri, and opening at weekends	
4.	Same day appointments are available	Appointment with any available Doctor or Nurse	Surgery opening hours are 9am-5pm, 5 days a week	
5.	No same day appointments are available	Appointment with your usual Doctor or Nurse	Surgery open 8am-8pm Mon-Fri, and opening at weekends	
6.	No same day appointments are available	Appointment with your usual Doctor or Nurse	Surgery opening hours are 9am-5pm, 5 days a week	
7.	No same day appointments are available	Appointment with any available Doctor or Nurse	Surgery open 8am-8pm Mon-Fri, and opening at weekends	
8.	No same day appointments are available	Appointment with any available Doctor or Nurse	Surgery opening hours are 9am-5pm, 5 days a week	

For this particular sample population, we find that, on average, patients' preferences for the availability of same day appointments are *four times* higher than indicated preferences for either continuity of care or extended GP opening hours. Respondents' preferences scores are:

- 41.8 (95% CI = 37.6 - 46.1) for options that contain same day appointments compared to those options that do not offer same day appointments.

- 9.5 (95% CI = 5.3 - 13.7) for options including the ability to see their usual GP or Nurse compared to options where the patient would be seen by any available practitioner.
- 9.2 (95% CI = 5.6 - 12.8) for those options that included extended opening hours (i.e. 8am - 8pm plus weekend availability) compared to 9am to 5pm on weekdays.

While a key focus of the Prime Minister's Challenge is on extending the hours of access to GP surgeries, these findings indicate that same day availability and continuity of care are of greater importance to patients.

Previous studies have suggested that patients may be willing to substitute continuity of care for speedier appointments. However, the patients in this survey view these as complementary and not as substitutes. Respondents' preferences score for the interaction between same day appointments and see their usual GP or practice nurse is 7.4 (95% CI = 2.7 - 12.1).

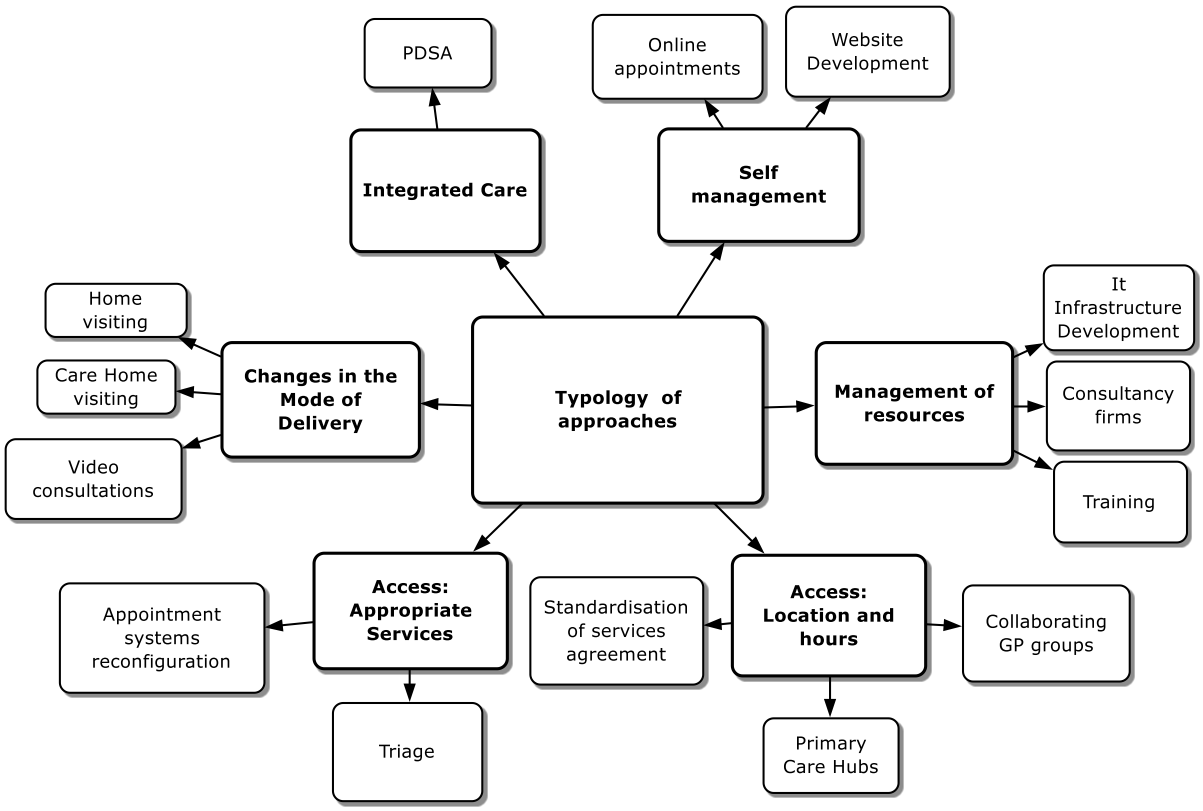
Finally, we report that the above results are consistent for men and women, and for people with and without long-term conditions. We do find a small, negative interaction between age and the offer of same day appointments, indicating that older patients have, on average, marginally lower preferences for same day appointments than younger patients.

As noted, these findings are based on a dataset collected from one Medical Centre. The CHILL evaluation is seeking to run the same survey in 3 more GP practices, and will report the collective results in the Final Evaluation Report.

2.2 Types of initiative

A revised version of a typology of PMCF projects, initially formulated at the start of the evaluation process, has been developed. This development is based on the information gained from interviews conducted in the profiling exercise. See Figure 1 below.

Figure 1 Typology of Projects: April 2015



In the typology, projects are grouped together according to the types of activities and processes that have been employed to improve access. We find that elements that were part of one project are often used, in some form, in another project. For example, most projects use some form of triage to manage access to GPs.

2.2.1 Access to appropriate services

Improving the way in which patients are routed to an appropriate health care professional or service, was judged to be an important aspect of improving access to care in the evaluated PCTPs. Key activities are the triaging and prioritising of patients according to their needs, and the reasons why patients make requests to see a GP. These often necessitate complementary changes, notably the development and use of alternative types of consultation, and changes in the appointment procedures, in order to accommodate triaging and prioritisation.

Three forms of triage have been found to be in operation across different PCTPs. The first is a form of filtering. Here a non-clinical member of staff, such as a receptionist or health care

assistant, ascertains the patient's requirements (either on the telephone or face-to-face) before offering/booking a service for them.

A second form of triage involves the patient's needs being assessed by a non-clinical operator, using a template or algorithm. This, for example, is typically used in out-of-hours 111 services. In this form of triage, the patient is directed to the appropriate level of care or service, based on the outcome of the assessment. The outcome of the assessment could be one of the following: attend the Emergency Department, set up an appointment to see a local GP at one of the local GP out-of-hours services, advise the patient to go to a walk-in centre, or pass the patient on to NEMS.

Clinical triage is a third form. It is carried out by clinically trained staff, such as advanced nurse practitioners / prescribing nurses, or GPs. Depending on the PCTP, clinical triage may be the first triage which a patient encounters, or it may follow on from one of the other two forms of triage discussed above.

We found that primary care staff and practitioners presented different views on how different forms of triage should be categorised, and on where it fits into processes that handle patient access.

A common view was that, should the member of staff talking to patients be in a position to make a clinical decision, the interaction between the staff and patient might then be redefined as a consultation, as the outcome may be a plan of care or some form of treatment, as opposed to an assessment of the level of care needed.

2.2.2 Extended access - location and hours

The projects in this category aim to directly extend the availability of appointments. The objective here is to increase GP and nurse appointments. The PCTPs that have been evaluated seek to achieve this in one of two ways. One way is to extend surgery opening hours. The other way is through the provision of a local GP-led extended hours service at a shared location, or 'hub'. GPs have formed collaborating or federated groups to implement and operate an extended 'hub' service.

Some projects in this category established an agreement that practices within a CCG would adopt a standardised way of working. For example, in one CCG, all practices were encouraged by their CCG or Clinical Cabinet to open five days a week and to no longer close at lunchtime. As part of the standardisation of services agreement, a number of CCGs developed or commissioned a set of training packages for receptionist and administrative staff.

2.2.3 Mode of delivery

This category includes those initiatives in which an alternative mode of delivering care has been introduced, such as nurse-led care home visiting services and changes in the provision of home visiting. It was thought that these activities took up a lot of GP time, and that most could be carried out effectively by Advanced Nurse Practitioners (ANPs). The rationale presented by the PCTP teams is that these changes in delivery free up GPs' time and, over time, should lead to an increase in GPs' availability for additional appointments. Other initiatives within this category include the use of technology, such as video consultations, which has been introduced as an alternative to patients going to their GP surgery for face-to-face consultation.

2.2.4 Integrated Care

This category of PCTP initiatives involves putting in place systems and procedures, at various organisational levels, that improve the patient's journey between primary and secondary care services. The objective is to improve the relationships and connections between the multiple agencies involved in providing urgent and emergency care within a locality. It is expected that this will prevent inappropriate emergency department attendance.

2.2.5 Management of resource

PCTPs in this category are focused on finding ways to manage resources more effectively in order to meet the growing volume of demand for primary care services. Core within these PCTPs is the assessment of existing practice systems, capabilities, and capacity in order to improve access. The rationale here is that a better understanding of demand and capacity will enable practices to deploy their resources more effectively, and ensure that they have in place the right skills mix to address the needs of their patients.

To achieve these changes, some PCTPs have commissioned consultancy firms to provide practice staff with the support needed to examine their systems, and audit their workload and operations. Consultants have also worked with local practices to identify what needs to be changed or improved in order to increase capacity and the availability of appointments. CCGs undertook a procurement process to identify a shortlist of providers. Practices are at liberty to choose from one of the shortlisted consultancy firms.

2.2.6 Patient self-management

This category of PCTPs covers a mixture of approaches that aim to encourage patients to be more proactive in making decisions about their own health needs. This approach makes use of different health education and technological resources, and services, as a first line of self-care. This includes investing in website development to increase the use of online appointment booking systems, website developments that signpost other primary care services (such as those offered by pharmacists), and the use of electronic communication systems to contact GPs.

3 Emerging findings

This section of the Report highlights a number of findings which have emerged during phase 1 of the evaluation, and which require further investigation in phase 2 in order to test their validity. In some instances, impacts may only be evident in the longer term.

3.1 Inherent assumptions and outstanding questions

There seem to be many inherent assumptions regarding the effect of improving access to primary care. Many of these have yet to be challenged and evidenced. The rationales can be generic, although in many instances they relate to a specific type of PCTP initiative. A number of these are described below.

In relation to extended hours;

i. Extended hours should lead to reduced ED attendance. In a number of cases, there are indications that those patients who use extended hours services are not necessarily those that would proceed to ED.

ii. Patients want to access their GPs in extended hours. There is evidence that local patient preferences appear to be for same day appointments, followed by continuity of care. Extended hours is ranked third amongst patient preferences (see the conjoint analysis described above). The lack of preference for extended hours also seems to be reflected in the number of unused appointments at weekends observed in a number of cases.

In relation to changes to appointment systems and forms of triage;

iii. Patients need same-day care. It is typically accepted that same-day appointments for urgent care are important and result in fewer DNAs. However, the use of same-day appointments may also be the result of patients having longer waits for booked appointments, as a result of changes made to the appointment system to accommodate same day appointments. That is, booking of same day appointments may be due to the patients and GP staff responding to a situation where the waiting time for alternative bookable appointments are impractically long.

Generally;

iv. GP time released through initiatives will free up appointment times for other patients. This does not seem to have been realised in many of the PCTPs. Released time is being utilised in other ways (reducing time pressures on GPs, and/or improving the quality of service to patients).

3.2 Unanticipated outcomes

A number of unintended consequences have been identified, and in many cases these raise concerns about sustainability.

Primary care services are complex systems where changes made in one area can impact on other areas, often with unanticipated outcomes. A broad range of examples of this include:

- Budgeting conflicts that may be responded to in detrimental ways. For example, ED attendance can benefit hospitals in terms of payment; NEMS is paid irrespective of number of patients attending (limiting concerns, possibly encouraging redirection of patients to extended hour services).
- Increased use of service providers with associated costs.
- Poor resource allocation occurs where extended hours contracts offered to GPs as part of the PMCF (that are relatively well paid) result in GPs reducing their input to NEMS urgent care services. This has the potential to significantly reduce the cover for urgent care over weekends and bank holidays.
- Triage and use of same day appointments may result in a deterioration of services for patients with chronic conditions who require more routine appointments.

- Skills shortages at a national level (widely reported) are also manifest as in many recent initiatives, patient demand is being re-directed to different staff such as advanced nurse practitioners (ANPs). This is leading to supply issues as demand for people with particular skills increases. Also, in some locations it is difficult to attract and recruit GPs, and this is very apparent in areas with high levels of deprivation. This may have considerable implications on PCTP feasibility and sustainability.

3.3 Heterogeneity of patient needs and behaviours

Broad assumptions regarding patient preferences, needs and behaviours to primary care access need to be avoided. It is apparent from our findings that, when making any assessment of different forms of access, the likely implications for different patient cohorts need to be carefully considered. For example:

- where IT is used as a gateway to enable patients to self-direct their care, the impact on those who are less capable of using these systems or managing their situation needs to be considered;
- the allocation of appointments to same-day or urgent cases can disadvantage patients with chronic conditions that require routine care.

Patient behaviours have been highlighted as problematic by many interviewees. When assessing the value of change, it is important to question whether:

- there may be supply-induced demand arising from changing patient expectations. Based on these concerns, some PCTPs have responded by not advertising extended services, relying on patients coming through the 111 service. This can result in the under-utilisation of services;
- patient satisfaction with access may not be well balanced with the best use of the limited resources for medical need;
- patients' expectations may be raised by changes to services (e.g. complaints are being received about delays in GP call back times, whereas previously patients access would have been less immediate);
- it is important to question whether patients have been, or can be, re-educated to change their behaviours. We note that this is difficult to gauge in the short term, and with a small number of patients experiencing the service changes.

3.4 Importance of less tangible objectives and outcomes

In selecting to undertake a specific PCTP, it is apparent that some practitioners have taken a forward view on what is required for all or some of the stakeholders within their project. For example aiming to:

- improve collaboration between individuals within general practices and the CCG, leading to an improved ability to support transformation in primary care;
- focus on service integration and the building of relationships between individuals in them, supporting future vanguards. (E.g. the integrated urgent care initiative at Newark fosters relationships between primary care and secondary care service providers);
- reduce time pressures on GPs. Though contrary to directly increasing patient access, this may have significant value in promoting GP retention and performance.

3.5 Barriers to information sharing and collaboration

Technical, commercial, and confidentiality concerns, as well as governance issues, have limited the availability of, and ability to share, data. This hampers both the internal monitoring of projects, national reporting, and the analysis that can be undertaken by CHILL as part of the evaluation.

There have been extensive discussions and duplication of effort of staff from CCGs, service providers and general practices trying to establish how to share data across practices and service providers with different systems (SystmOne, EMISweb and OHH systems).

Further barriers relate to concerns regarding data use that might impact on patient confidentiality. Although some of these issues may be addressed through the appropriate management of information, in many instances at practice, CCG and regional team levels there has been limited knowledge and consensus regarding the information that is available, the implications on its use, and what can feasibly be shared.

It is important to recognise that there is a range of technical capabilities amongst practice managers. In some instances it appears that practice managers are struggling with extracting relevant data from practice systems (e.g. appointment systems) without support. These systems were not originally intended to provide data for evaluation purposes, and (hence) steps should be taken to provide assistance.

In a number of PCTPs, service providers have been utilised to implement, manage and/or deliver the service. It is apparent that there are similar issues here, with provider organisations supplying limited, or generic and uncleansed data on services.

The feedback from practices, indicates that project leads have in many cases struggled to identify and implement meaningful metrics for their PCTP, despite in some cases recognising that outcomes need to be tested. Their perception is that there has been no clear remit to collect and analyse data, or sufficient advice on what is required, or the procedures for collection. They believe that the need was not communicated to them as part of the bid. This indicates a lack of understanding of contractual arrangements.

There also seems to be limited awareness, amongst practice managers, of the value of the analysis to them.

3.6 Preparedness and pragmatism

In an environment where funding is hard to come by and must be obtained by quick responses to calls, it is not surprising to find instances where stakeholders have identified the PMCF as a useful resource for speeding up the development of planned projects , or partially defined projects that they wished to pursue (e.g. continuing a care home and home visiting services, developing existing websites to improve use). Levels of preparedness have been observed, in both CCGs and general practices.

Experienced practitioners will also define projects in a way that enables them to retain advantage from the expenditure in the longer term. For example, by investing in tangible changes (e.g. equipment or facilities), as opposed to funding temporary additional running costs (such as additional GP payments over the time the project). Additionally, funding may be utilised to support other aspects of the business, such as improved efficiencies or increases in service provision.

3.7 Governance of PMCF projects and their implementation

The governance of projects varies considerably across CCG's and PCTPs, and in many instances is a reflection of the relationships between CCGs and service organisations, and general practices within their area. The form it takes may have significant implications for the success of a project, and this needs to be taken into account. In particular, the origin and ownership of the initiative ideas, the leadership of projects (both in relation to who leads

and how leadership is structured), the approach taken to knowledge sharing and collaboration, as well as levels of PPG participation.

Forms of governance are influenced by the situations stakeholders face in their specific primary care context, and include assumptions made about other groups' agendas and responses. It is likely that the number of general practices associated with the CCG will also have an influence on how projects can be managed, as where the number of GPs is low it is more feasible to implement a more collaborative approach. In some cases, CCG and other service provider organisation staff may take the lead role; in others incentive schemes are run that give general practices autonomy; in others practices and their CCG are working in close collaboration. Examples include Southern Derbyshire CCG, which employs a top down approach for website development; Mansfield and Ashfield where practices have the autonomy to define and manage their own projects within an incentive scheme; Rushcliffe where the CCG works closely with the clinical leads to influence GPs.

Each approach has advantages and disadvantages. These are contextual, and require further investigation in phase 2 of the evaluation. The influence of professional groups and networks, including clinical cabinets, also needs to be considered. Their influence may be significant. Interview responses from stakeholders also suggest that, in some cases, the accountability of different organisations and professional groups may be blurred, leading to inertia and miscommunication, with structures and organisational relationships not fully understood or acted through. In some cases, a specific CCG may pursue a combination of approaches. The danger here is that staff involved in PCTPs may be confused if accountabilities seem ill-defined.

Different approaches have also been taken in relation to the use of service providers (such as Greater East Midlands Commissioning Support Unit (GEM) with Southern Derbyshire CCG). This could potentially lead to issues of accountability, particularly where accountability has been given for aspects of the project not fully in the service provider's control.

Clinical accountability and legal issues around this can lead to restrictions on the form of governance which needs to be taken. For example, Rushcliffe has addressed the need for a single practice to take accountability for the extended weekend service.

Lack of recognition of the purpose of the pilots in relation to testing for proof of concept implies that accountability for monitoring of performance and impact has not been well conveyed within the original bids, and arrangements made with project leads.

Tight timescales on bids and delayed funding has had a considerable impact on PCTP implementations, though the detrimental impact of this has varied and may have been more problematic for particular forms of governance. Due to delays in the administration of the bidding and funding process at a National level, and then at the regional Team and CCG

levels, GP and CCG leads had to put together proposals at short notice, and funding intended for projects to commence in April 2014 was not made available until June 2014; in the worst case scenario, some general practices could only start up their projects in January 2015 with their deadline for completion fixed for March 2015. On a positive note, under these huge time pressures, exceedingly high levels of commitment amongst people in stakeholder organisations has been apparent.

3.8 Diffusion and adaptation

A number of observations can be made on the diffusion of ideas on PCTPs, and their adaptation over the course of the PMCF first wave.

- Diffusion: there has been significant communication on projects and their outcomes through a number of forums. Of particular note is the local PMCF Delivery Group, comprising NHS England North Midlands and local CCG leads. This has raised an awareness of the approaches being taken across the area.

- Adaptation: invariably when PCTPS are implemented, adaptations evolve in other aspects of the service. For example, triage requires adaptations to appointment systems, and decisions need to be made regarding the relative balance between urgent same-day and pre-bookable/routine appointments.

- Pragmatic adaptation: this can occur and may be problematic if it redefines the PCTP, based solely on prevailing circumstances. Examples include:
    - instead of accepting patients purely as urgent same day appointments, some appointment slots at a weekend hub are being embargoed for patients who have previously requested appointments with their own GPs. An advantage here is that a GP concerned about a specific patient can ensure that patient's condition is monitored over the weekend, potentially avoiding an admission to ED;
    - utilising Emergency Care Practitioners (ECPs) from ambulance services to support GP home visits. This was feasible because ECPs were contracted as additional support for the local hospital (in Newark), and their skills were not being fully utilised;
    - encouraging other health care providers to use an extended hours service that is currently under-utilised. An example of this is found in Rushcliffe where other providers are encouraged to make use of a hub.

The extent to which these are improvements vs. short-term work-arounds needs to be better understood.

4 Next steps

1. An 'Overview of the Evaluated PCTPs' is to be prepared for each CCG. These will be tabled for discussion and, where necessary, for validation. In cases where further information and/or data is required to establish 'proof of concept' or fully describe implementation, this will be requested (at both the CCG and practice levels).

2. Some of the evolving themes will be investigated further via a more detailed analysis of exemplar PCTPs – these evaluations are described as 'deep dives'. PCTPs will be selected for this, based on an assessment of which PCTPs can generate quantitative and qualitative findings, and are of most benefit to primary care in the area. The PCTP at Stenhouse Medical Centre (Nottingham North and East CCG) on triage has already been selected, and further exemplars are to be selected.

3. The Final Evaluation Report will include more detailed profile information on PCTPs, detailed evaluations of the deep dives, and quantitative analysis of metric data on PCTPs delivered to CHILL.

4. A dissemination event tied to the Final Evaluation report will be run in partnership with the East Midlands Academic Health Science Network (EM-AHS) to support the diffusion of knowledge gained through the CHILL evaluation across PCTPs.