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Delivering Care 7 Days a Week: Reviewing methods of introducing and financing evening and weekend appointments

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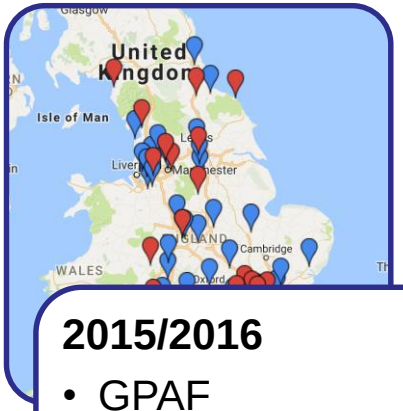
Background

- Extending access to primary care into the evenings and weekends is a key component of NHS England's vision for primary care by 2020/21 (NHS England, 2016)
  - The policy seeks to enable local commissioners of health care to redesign primary care services and commission extra capacity so that by 2020 '*everyone has access to GP services, including sufficient routine appointments at evenings and weekends to meet locally determined demand, alongside effective access to out-of-hours (OoH) and urgent care services*'
- NHS England and NHS Improvement (2016) state appointments should
  - Comprise of minimum 30mins per 1,000 patients
  - Include pre-bookable and same-day appointments
  - Cover 1.5 hours after 18:30 on weekdays
  - Be on both Saturday and Sunday in line with patient needs

Background: England

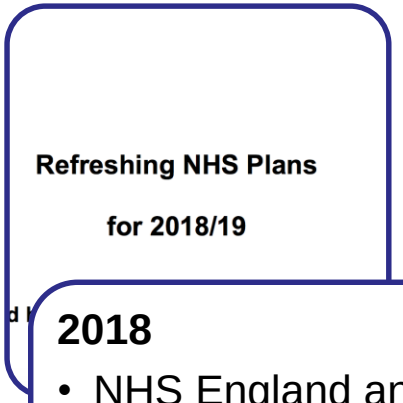
2014/2015

- PMCF
- 1,100 practices with evening and weekend primary care access
- Mott MacDonald and SQW evaluation



2015/2016

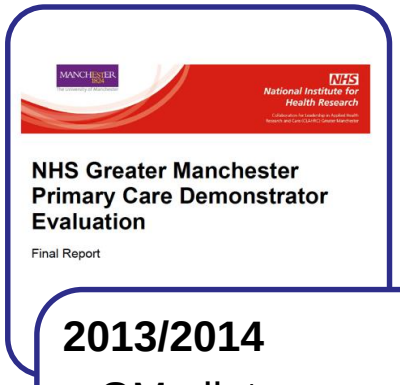
- GPAF
- 1,400 practices with evening and weekend primary care access
- Mott MacDonald and SQW evaluation



2018

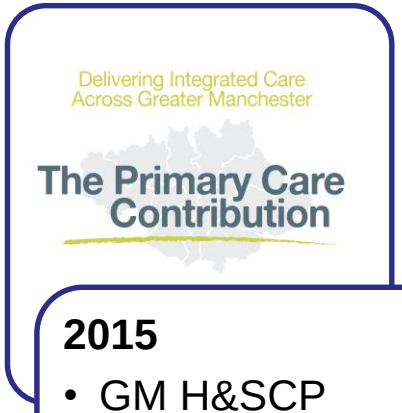
- NHS England and NHS Improvement announce 1st October 2018 all CCGs to provide evening and weekend access to primary care

Background: Greater Manchester



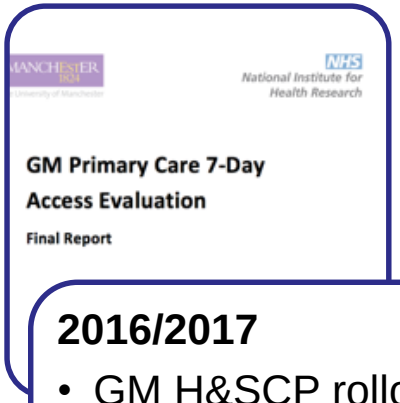
2013/2014

- GM pilot 'demonstrators'
- 56 practices with evening and weekend primary care access
- NIHR CLAHRC Demonstrators evaluation



2015

- GM H&SCP announce primary care strategy
- Plans to rollout 7-day primary care across GM



2016/2017

- GM H&SCP rollout 7-day primary care across GM
- 7 CCGs without GPAF funding
- NIHR CLAHRC 7-Day Access evaluation

Aims

- To present key learnings from evaluations of extended access (7-day general practice access) schemes
  - Explore issues surrounding cost-effectiveness of the service
  - How should we deliver the service?

Importance of health economics

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- Healthcare commissioners have set budgets
  - –Demands for resources > resources available
    - •Require rationing with regards to what should and shouldn't be provided by the NHS

- Cost-effectiveness analysis requires comparisons of
  - –Costs of delivering the service and impacts on wider sector
  - –Effects of service on health
  - –These enable us to calculate cost per health gained and compare against a threshold (cut-off point) of expenditure (£20,000 per Quality Adjusted Life Year, QALY)

Costs of delivering the service

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- Costs of delivering service
  - Mott MacDonald & SQW
    - £18m (wave 1, includes set-up costs), delivered 540,000 appointments (average cost £34)

- NHS England and NHS Improvement propose funding of £6 per head ~£324m per year (54m patients)

Costs to other healthcare services

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- Costs to other healthcare services
  - –Secondary care: A&E activity

Study	Location	A&E effect	Cost effect
Demonstrators (NIHR CLAHRC, 2015)/ Whittaker et al (2016)	Greater Manchester (56 practices)	-3% (all) -26.39% (minor self-referrals)	-£767,976
Dalton & Pathania (2016)*	Central London CCG	-9.9% (all)	-
Mott MacDonald & SQW (2016)**	National PMCF (wave 1) pilots (1,100 practices)	-14% (minor self-referrals)	-
7-Day Access (NIHRC CLAHRC, 2018)**	6 CCGs in Greater Manchester (249 practices)	+3% (all) +3% (minor self-referrals)	-

*hub v non-hub
** no comparator

Lessons for delivering 7-day services

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- System wide effects
  - –Service appears to reduce A&E activity but only a small proportion of total A&E activity (minor, self-referrals)
    - •Service is unlikely to be cost-effective if commissioners provide the service to reduce secondary care activity alone

Effects of the service on health

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- Effects of service on health
  - –No study evaluated implications of service on health
  - –Major gap in the evidence

- Inference on likely impacts on health
  - –Use of appointments – some benefit
  - –Users of appointments – impacts on inequalities and unmet need

Effects: Uptake over time (GM)

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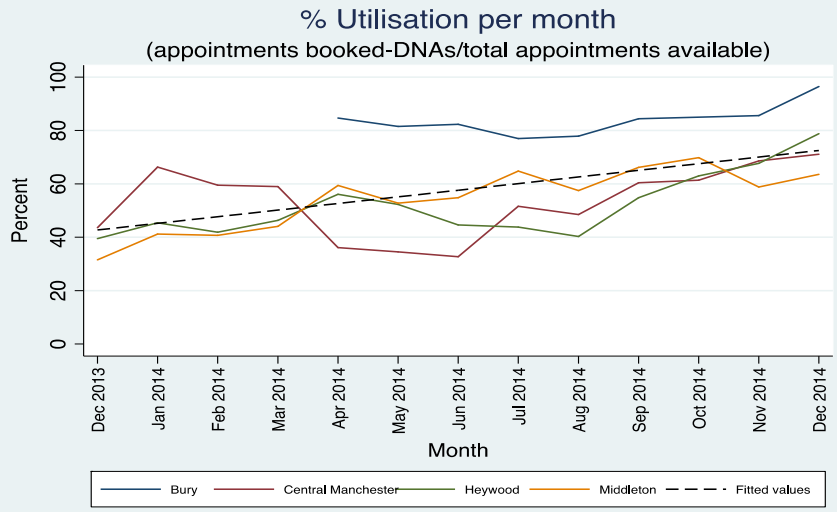
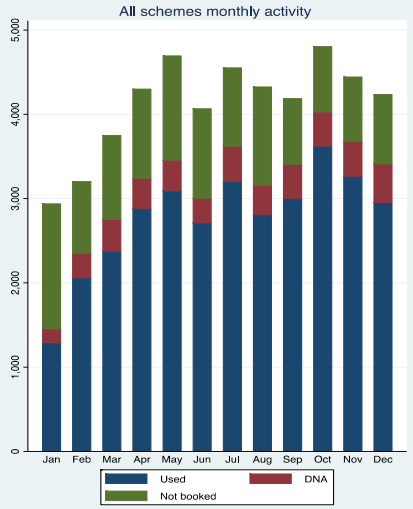
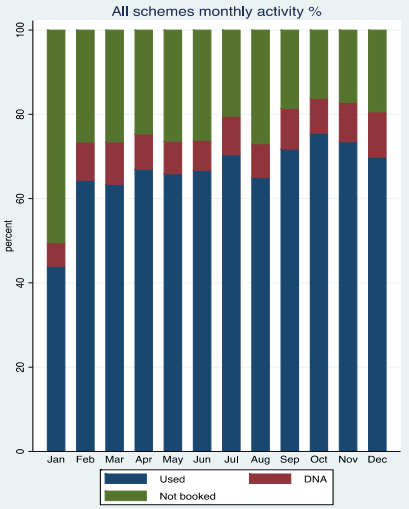
- Use of appointments: uptake improved over time for both waves of provision

Demonstrators (NIHR CLAHRC, 2015)	7-Day Access (NIHR CLAHRC, 2018)
51,438 appointments	49,491 appointments
65% uptake	67% uptake







Effects: Uptake by week day (GM)

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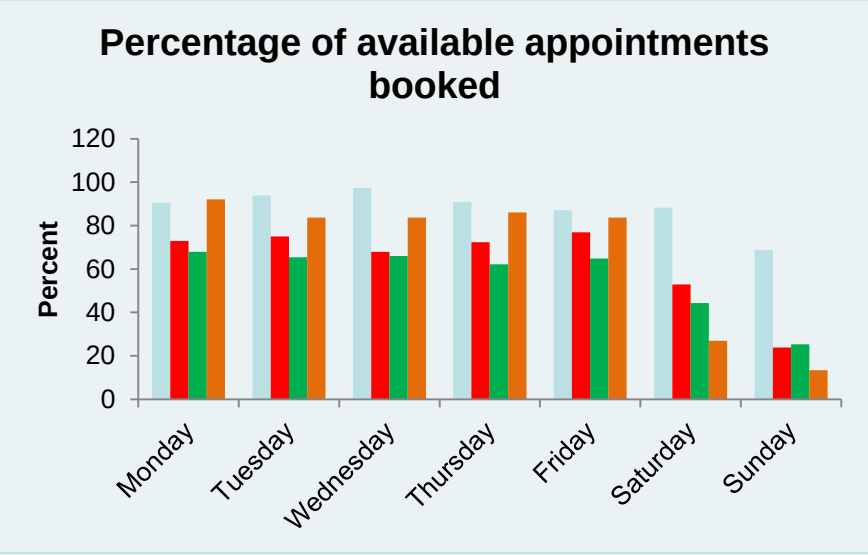
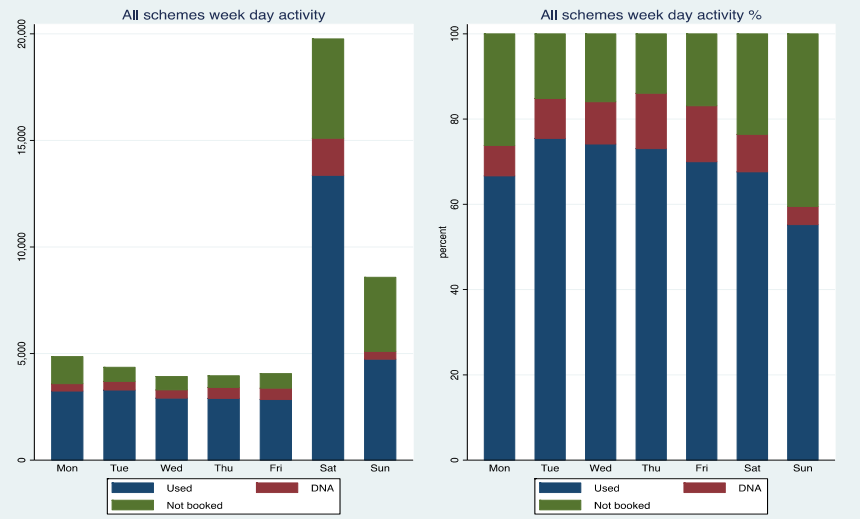
- Use of appointments: uptake varies by day of week

Demonstrators (NIHR CLAHRC, 2015)	7-Day Access (NIHR CLAHRC, 2018)
51,438 appointments	49,491 appointments
65% uptake	67% uptake





Effects: Uptake, DNAs, Hub (GM)

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- Uptake varied by CCG and Hub. Hub dominance effect (NIHR CLAHRC, 2018)

Provider	Appointments	Appointments available	Appointments booked*	% appointments available	Booked DNAs**	% appointments DNAs	Appointments booked and used	% appointments available	% of booked appointments by Hub practice (Hub population)
Hub 1	3,597	3,597	2,899	80.59					
Hub 2	3,422	3,422	2,620	76.56					
Total	7,019	7,019	5,519	78.63					
Hub 1	7,971	7,475	5,220	69.83	567	10.86	4,649	62.19	
Hub 2	8,414	8,206	6,435	78.42	1,006	15.63	5,429	66.16	
Hub 3	8,131	7,357	5,229	71.08	577	11.03	4,650	63.21	
Hub 4	8,177	7,744	6,461	83.43	809	12.52	5,652	72.99	
Total	32,693	30,782	23,345	75.84	2,959	12.68	20,380	66.05	32% (19%)
Hub 1	3,053	3,053	1,806	59.15	185	10.24	1,621	53.10	
Hub 2	584	584	244	41.78	17	6.97	227	38.87	
Total	3,637	3,637	2,050	56.37	202	9.85	1,848	50.81	28% (14%)
Hub 1	2,270	2,270	1,878	82.73	338	18.00	1,538	67.75	
Hub 2	1,296	1,296	1,060	81.79	181	17.08	877	67.67	
Hub 3	2,034	2,034	1,525	74.98	239	15.67	1,284	63.13	
Total	5,600	5,600	4,463	79.70	758	16.98	3,699	66.05	13% (6%)
Hub 1	1,429	1,226	1,094	89.23	178	16.27	916	74.71	
Hub 2	1,428	1,227	1,089	88.75	184	16.90	904	73.68	
Total	2,857	2,453	2,183	88.99	362	16.58	1,820	74.19	46% (6%)
	51,806	49,491	37,560	75.89	4,281	11.40	33,266	67.22	

Effects: Type of appointments (GM)

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- Range of services varied by discipline (GP/Nurse) and pre-bookable/same-day appointments (NIHR CLAHRC, 2018)

Provider	Appointments available	% GP	% Nurse	Appointments booked	% Pre-booked	% Same-day
Hub 1	3,597	82.15	17.85	2,899	100.00	0.00
Hub 2	3,422	82.29	17.71	2,620	100.00	0.00
Total	7,019	82.22	17.78	5,519	100.00	0.00
Hub 1	7,475	79.01	20.99	5,220	39.85	60.15
Hub 2	8,206	78.80	21.20	6,435	49.48	50.52
Hub 3	7,357	83.69	16.31	5,229	35.26	64.74
Hub 4	7,744	73.90	26.10	6,461	41.74	58.26
Total	30,782	78.79	21.21	23,345	42.00	58.00
Hub 1	3,053	100.00	0.00	1,806	24.70	75.30
Hub 2	584	100.00	0.00	244	31.97	68.03
Total	3,637	100.00	0.00	2,050	25.56	74.44
Hub 1	2,270	93.79	0.00	1,878	61.98	38.02
Hub 2	1,296	93.60	0.00	1,060	65.38	34.62
Hub 3	2,034	94.05	0.00	1,525	39.54	60.46
Total	5,600	93.84	0.00	4,463	55.12	44.88
Hub 1	1,226	58.16	41.84	1,094	100.00	0.00
Hub 2	1,227	59.09	40.91	1,089	99.72	0.00
Total	2,453	58.62	41.38	2,183	99.86	0.00
	49,491	81.54	17.77	37,560	54.55	45.44

Effects: Patient demographics (GM)

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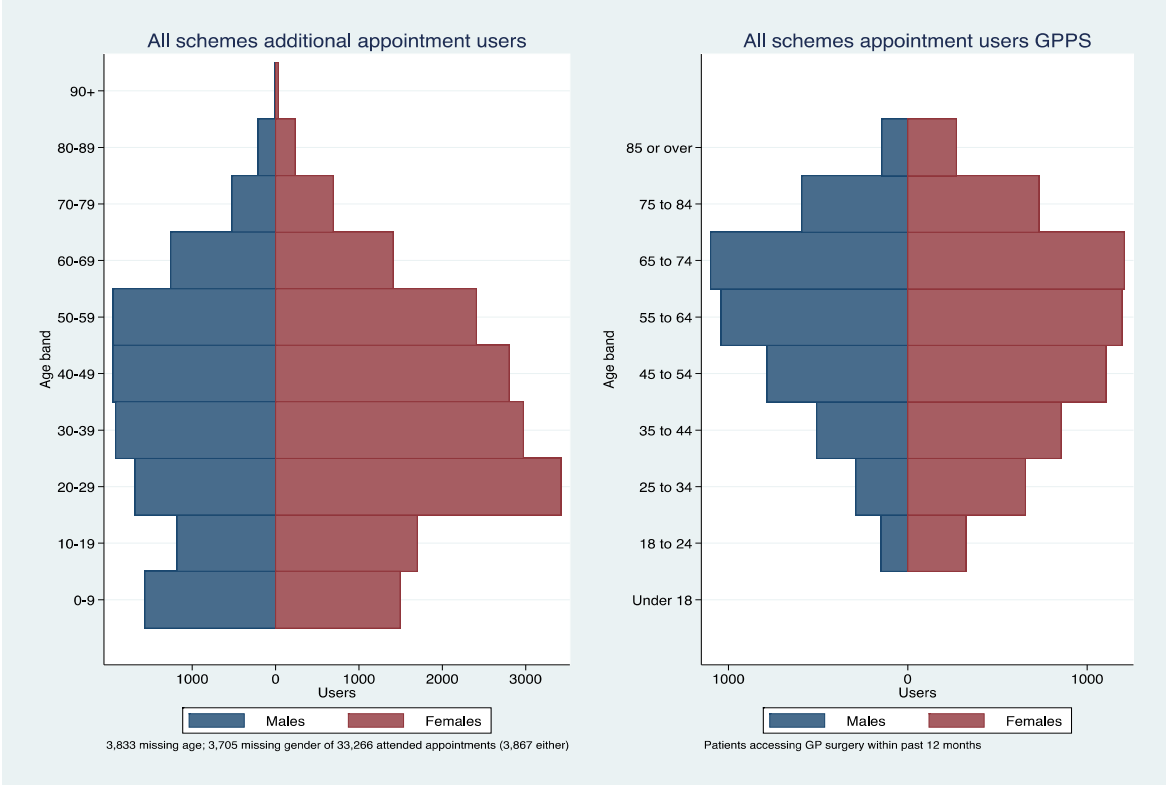
- Users of appointments: patients are typically younger and female compared to core hour patients (NIHR CLAHRC, 2018)



Cost-effectiveness of extended access

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- Costs
  - –£6 per patient proposed
  - –Effects on secondary care unlikely to offset cost
- Health effects
  - –Largely unknown
  - –Service is used and improved over time
    - •Use likely to have some benefit to the patient
  - –Users of the service suggest may meet unmet need for those younger and female
  - –But gains could potentially be unequally distributed – hub practices dominate use

Lessons for delivering 7-day services

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- Cost-effectiveness can be improved by providing the service efficiently: Provide service in ways that reduce low uptake
  - –Uptake improves over time:
    - •Provide accordingly, enable system to embed, promote
  - –Uptake varies by day of week:
    - •Vary provision accordingly
  - –Hub choice is important:
    - •Locate where access is constrained
  - –Patient type may influence appointment type:
    - •Consider nurse appointments, booking structure, anticipate DNAs

Acknowledgements

NHS National Institute for Health Research

- Partners
  - GM Health and Social Care Partnership
  - GM Academic Health Science Network

This project was funded by the GM Health and Social Care Partnership and the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care (NIHR CLAHRC) Greater Manchester. The NIHR CLAHRC Greater Manchester is a partnership between providers and commissioners from the NHS, industry and the third sector, as well as clinical and research staff from the University of Manchester. The views expressed in this article are those of the authors and not necessarily those of the NHS, NIHR or the Department of Health and Social Care.

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Provision by day of week (GM)

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- Availability varied in volume and days of appointments (NIHR CLAHRC, 2018)