



Scottish School of Primary Care

Evaluation of New Models of Primary Care in Scotland

Tayside Case Study

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This study was led by the University of St Andrews

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Disclaimer

The views, information, or opinions expressed in this report are solely those of the authors and do not necessarily represent those of the University of St Andrews or the study funder, the Scottish Government. They are based on information provided by the identified key informants who participated in this case study, and may not necessarily represent potential key informants who were either not identified by the study recruitment strategy or who declined the invitation to participate in the case study.

KEY MESSAGES

NHS Tayside Case Study

Key Findings:

Eight 'test of change' programmes of work were identified in NHS Tayside: 1) Recruitment and retention projects, 2) Development of the multidisciplinary community hub model, 3) Mental health and wellbeing, 4) Multidisciplinary team working, 5) Pharmacy, 6) Community transport scheme, 7) Technology-enabled care (TEC), 8) GP engagement with integrated joint board (IJB) priorities. Within these programmes, 23 individual projects were identified. Of these 23, 14 projects were implemented, 8 projects were partially implemented, and one project was not implemented by the end of the evaluation period. Of the 14 projects that have been implemented, 3 were selected for 'deep dive' exploration: 1) Community leg ulcer clinic, 2) Welfare rights in primary care, and 3) Primary care staff wellbeing.

The main findings of the report were:

- Detailed documentation of the rationale for the project and the steps undertaken to develop and implement the project were essential for implementation and future sustainability.
- In addition to strong local leadership and project management experience, motivation, determination and perseverance to change the status quo was necessary to transform care.
- Implementation of the tests of change was facilitated by the dedicated funding. However, the short time-scale of funding created problems for achieving the expected impact. Uncertainty regarding future funding also impacted negatively on willingness to embrace change and the likelihood of sustainability.
- The lack of time, skills, and expertise of service providers to evaluate the new ways of working created difficulties in generating the necessary evidence. There was an expressed need for support in designing evaluations, in identifying outcome measures, and in establishing systems for collecting data.

Key Recommendations:

- Tests of change should be recognised by funders and those seeking to implementing change as **distinct projects** which require a clear documented rationale, implementation process, **project management team**, initial dedicated funding, the ongoing motivation of implementers, ongoing feedback process for monitoring and an evaluation process with agreed outcomes.
- Project management teams and stakeholders need clarity at outset on the nature and **process of monitoring feedback and learning processes** for iterative change, if any, during the test.
- Project management teams and stakeholders need clarity at outset what **conditions** would need to be met for **further funding for sustainability or roll out**, and the possible sources of such funding.
- Project management teams and those implementing change should seek appropriate support in designing **evaluations**, identifying **outcome measures** and in establishing **systems for collecting data**; where such support is not readily available should have clear processes to alert the stakeholder organisations.

Abbreviations

ABPi	Ankle Brachial Pressure index
FG	Focus Group Discussion
GP	General Practitioner
HSCP	Health and Social Care Partnership
IJB	Integration Joint Board
IT	Information Technology
MCHM	Multidisciplinary Community Hub Model
MDT	Multidisciplinary Team
MFE	Medicine for the Elderly
MH	Mental Health
NHS	National Health Service
OPFC	Outcomes Framework for Primary Care
OOH	Out of Hours
P	Participant
PCTF	Primary Care Transformation Funds
PLT	Protected Learning Time
QoL	Quality of Life
SG	Scottish Government
SIGN	Scottish Intercollegiate Guidelines Network
SOP	Standard Operating Procedure
SSPC	Scottish School of Primary Care
TEC	Technology-enabled care
VBRP®	Values Based Reflective Practice
FG	Focus Group Discussion
GP	General Practitioner
HSCP	Health and Social Care Partnership
IJB	Integration Joint Board
IT	Information Technology
MDT	Multidisciplinary Team
MH	Mental Health
NHS	National Health Service

OOH	Out of Hours
P	Participant
PCFMH	Primary Care Funds for Mental Health
PCTF	Primary Care Transformation Funds
PLT	Protected Learning Time
P&K	Perth and Kinross
QoL	Quality of Life
SG	Scottish Government
SIGN	Scottish Intercollegiate Guidelines Network
SSPC	Scottish School of Primary Care
VBRP®	Values Based Reflective Practice

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EXECUTIVE SUMMARY

Regional Context

Tayside represents approximately 7.7 % of the total population of Scotland. It incorporates both urban and rural settlements, and its population is distributed across the three local authority areas of Angus, Dundee, and Perth & Kinross. There are pockets of both significant deprivation and geographic isolation within Tayside. For example, 36 % of Dundee city's population reside in the most deprived areas, more than five times that compared to their Tayside counterparts. NHS Tayside is comprised of three health and social care partnerships: Dundee, Perth & Kinross, and Angus. Regional health services are managed either by individual partnerships, jointly by all three partnerships, or by NHS Tayside. In the case of primary care services for Tayside, the service is managed by Angus, although executive and clinical accountability remain with NHS Tayside. In recent years, NHS Tayside has experienced significant financial difficulties and has been subject to special measures.

To complement Scotland's 2020 Vision, NHS Tayside developed local strategies to guide primary care service development and transformation. These include a Five-Year Transformation Programme 2016-2021 (2), NHS Tayside Draft Clinical Services Strategy (2015) (3), and A Strategic Framework for Primary Care (2017) (4). The Tayside Strategic Framework for Primary Care focused on five integral areas, which were benchmarked against Scotland's 2020 Vision:

1. Service planning
2. Working across the interface
3. Infrastructure development to deliver new types of integrated care in the community
4. Workforce crisis
5. Leadership required to support and develop new models of care

A Transformation Programme Board was established (2015) to oversee implementation of the transformation programme, and subsequently an Assurance and Advisory Group was established (2017) to assess the deliverability of the programme.

Aims and Objectives

The overall aim of this report is to determine, in relation to implementation of primary care tests of change in Tayside, what works, for whom, why and in what circumstances.

The specific objectives in relation NHS Tayside primary care tests of change were to explore:

- experiences of their development
- their anticipated impact, and the theories of change underpinning these
- actual impacts and how these were measured
- facilitators and challenges to their development, implementation and evaluation
- their likely sustainability and potential spread

Methods

This case study was carried out as part of a 15-month research grant (March 2017 to May 2018). The approach adopted was based on the SSPC Evaluation Framework agreed with Scottish Government (Appendix 1). The principal means of data collection were review of national and local documents relevant

to primary care transformation in NHS Tayside, and interviews with key informants involved in the development, implementation and evaluation of primary care tests of change in NHS Tayside.

The case study comprised two distinct but complementary phases:

Phase 1: the tests of change in NHS Tayside were identified and scoped in terms of their individual components, anticipated impacts and theories of change underpinning the anticipated impacts. The ‘status’ of each test of change was described using an implementation staging system. Tests were classified as: ‘implemented’; ‘in the planning stages/ not yet fully implemented’; ‘not got off the ground/ has been stopped’.

Phase 2: focused on exploring in more depth (‘deep dives’) three tests of change, and sought to determine their actual impact, key learning, and likely sustainability and spread/roll-out.

Findings

We identified 8 ‘test of change’ programmes in NHS Tayside: 1) Recruitment and retention projects, 2) Development of the multidisciplinary community hub model, 3) Mental health and wellbeing, 4) Multidisciplinary team working, 5) Pharmacy, 6) Community transport scheme, 7) Technology-enabled care (TEC), 8) GP engagement with integrated joint board priorities.

Within these, we identified 23 individual projects (Appendix 2), funded by various funding streams, including the Primary Care Transformation Fund and the Primary Care Mental Health Fund. Using the staging system, we classified 14 projects ‘implemented’, 8 ‘partially implemented’, and 1 ‘stopped/not started’.

Together with Scottish Government, we selected three ‘implemented’ projects for ‘deep dive’ exploration:

- Community Leg Ulcer Clinic- anticipated to shift work from GP practices and secondary care to a community service, improve patient care and quality of life; and reduce wastage/costs.
- Welfare Rights in Primary Care- anticipated to shift work from GPs, reduce stress-related illness in patients and improve patient quality of life, empower patients by ensuring access to advice and information on appropriate benefits, and improve the interface between primary care and social care.
- Primary Care Staff Wellbeing- anticipated to improve the culture in primary care, improve primary care staff mental health and wellbeing, improve primary care staff resilience and absence from work, and improve recruitment and retention in primary care.

Community Leg Ulcer Clinic

This 6-month pilot project was implemented in September 2015 in 5 GP Practices in Dundee City. The Clinic was a bespoke nurse-led service that provided optimal, evidence-based treatment for venous leg ulcers. Implementation was overseen, managed and evaluated by a local project team comprising dermatology and community nursing representatives.

Positive outcomes from this small pilot scheme (16 patients) included better adherence to guidelines and improved healing rates. The main facilitators reported were strong leadership and project management. As well, the project team’s motivation, determination and perseverance to change the status quo was

considered essential. The main perceived challenges to implementation were the management effort and time needed to develop new channels of communications and protocols for sharing clinical information, difficulties with IT systems, and a need for increased capacity in the bandaging clinics. Further funding was also identified as a necessity to roll out the Community Leg Ulcer Clinic to other areas of NHS Tayside.

Welfare Rights in Primary Care

The first welfare right advisor in Tayside joined Taybank Medical Centre (Dundee) in January 2015. Over the next three years, the programme was rolled out to eight GP practices. The service extends the Welfare Rights advice provided in a council setting to a primary care setting. Implementation was overseen, managed and evaluated by a local project team comprising members of the Dundee City Council Welfare Rights Team.

Examples of positive outcomes from this scheme included patients reporting that they were advised in a non-judgmental way, patients' stress and anxiety levels were reduced, a way of working with vulnerable groups without stigmatising them was demonstrated, and response times from the Department for Work and Pensions had become faster. The scheme also provided a useful example of how primary care and social care services can be integrated. As well, a forecast analysis employing a moderately rigorous design of the social return on investment of the co-location of advice workers found that every £1 invested would generate approximately £39 of benefits (where 'benefits' refers to the social, economic, and environmental outcomes) (5). The main facilitators to implementation were clear rationale, careful consideration of project components, and detailed documentation of all the aspects of work, such as existing evidence. Implementation was reported to have been initially challenging, as access to GP practices and patients' medical records were perceived to be difficult. The project was perceived to be sustainable. However, sufficient numbers of permanently funded advisors would be required to ensure continuity and ability to deliver the service. Mainstream funding would also be required for an expanded roll-out.

Primary Care Staff Wellbeing

This scheme was implemented in all 66 GP practices in NHS Tayside in February 2016. It involved extending the existing NHS Tayside Staff Wellbeing Service to target primary care staff in particular. Implementation was overseen, managed and evaluated by a local project team comprising staff from the NHS Tayside Staff Wellbeing Service.

Limited evidence of positive outcomes includes encouraging participant experience feedback indicating that the project was very well-received, increased awareness of Staff Wellbeing amongst primary care staff, and provided primary care staff with coping strategies and relaxation techniques. However, it is not yet clear whether or not this scheme leads to improved mental health and wellbeing, resilience; reduced absence from work; improved recruitment, and improved retention. A challenge to implementation was reported to be that primary care is quite different to other areas that the Staff Wellbeing Service works in. Therefore, it was found more difficult to make contact and build relationships with primary care staff to facilitate engagement. The scheme was thought to be sustainable if additional funding was available for the Staff Wellbeing Service to reflect the added workload. As well, sustainability would require GP practices to make time for staff to participate in group sessions.

Summary

Detailed documentation of the rationale for the project and the steps undertaken to develop and implement the project was essential for implementation and sustainability. In addition, to strong local leadership and project management experience, motivation, determination and perseverance to change the status quo was necessary to transform care. This required a belief that the test of change would be more likely to improve care.

Implementation of the tests of change was facilitated by dedicated funding. However, the short time-scale of funding created problems for achieving the expected impact. Uncertainty regarding future funding in some cases led to an unwillingness to change, and in other cases, impacted negatively on future planning and the likelihood of sustainability beyond the existing, dedicated funding period.

The lack of time, skills, and expertise of service providers to evaluate the new ways of working created difficulties in generating the necessary evidence of clinical effectiveness and cost effectiveness. Those charged with overseeing the implementation and evaluation of the tests of change expressed a need for support in designing evaluations, in identifying outcome measures, and in establishing systems for collecting data.

Key Recommendations:

- Tests of change should be recognised by funders and those seeking to implementing change as distinct projects which require a clear documented rationale, implementation process, project management team, initial dedicated funding, the ongoing motivation of implementers, ongoing feedback process for monitoring and an evaluation process with agreed outcomes.
- Project management teams and stakeholders need clarity at outset on the nature and process of monitoring feedback and learning processes for iterative change, if any, during the test.
- Project management teams and stakeholders need clarity at outset what conditions would need to be met for further funding for sustainability or roll out, and the possible sources of such funding.
- Project management teams and those implementing change should seek appropriate support in designing evaluations, identifying outcome measures and in establishing systems for collecting data; where such support is not readily available should have clear processes to alert the stakeholder organisations.

1. INTRODUCTION

1.1 National Context

The driver for primary care transformation in Tayside is the Scottish Government's 2020 Vision for Health and Social Care in Scotland. The 2020 Vision, published in 2011, provides the strategic narrative and context for achieving sustainable quality in healthcare services delivery across Scotland, taking account of challenges in Scotland's public health record, changing demography and economic environment.

"Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting. We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission" (1)

Other national strategies, such as the National Clinical Strategy (6), further underpinned NHS Tayside's approach to develop and transform primary care. The National Clinical Strategy sets out a framework for developing health services across Scotland for the next 10-20 years, and has envisaged the range of reforms to achieve a more coherent and sustainable health service across the country. The strategy aims to strengthen primary and community care so that services can be planned and delivered around individuals and their communities, with a focus on prevention, anticipation and supported self-management:

"Our aim is a Scotland with high quality services that have a focus on prevention, early intervention and supported self-management. Where people need hospital care, our aim is for day surgery to be the norm, and when stays must be longer, our aim is for people to be discharged as swiftly as it is safe to do so" (6)

The Outcomes Framework for Primary Care (7) maps out the changes that need to happen to deliver the Vision for Primary Care transformation over the next ten years. It consists of: 1) a Strategic Level outcomes framework (or 'logic model'), with three nested frameworks for: 2) 'People' (the public who use primary care); 3) 'the Workforce'; and 4) 'the System'. It outlines why there needs to be change (situation); the changes needed to realise the Vision in the form of six high-level Primary Care Outcomes; and the inputs, activities and intermediate outcomes that need to happen along the way. The Framework aids those responsible for primary care policy and delivery in mapping out and understanding how activities and inputs contribute to the Primary Care Outcomes at different levels and at different points in time.

The National Health and Social Care Delivery Plan (8) provides the framework for integrating health and social care, and has defined actions to achieve this goal. From the primary care perspective, these include shifting resources from acute care into primary and community care, improving links between secondary,

primary and community care, addressing workload and recruitment challenges, and supporting the development of new models of care.

To address more specific questions related to workforce, a National Health and Social Care Workforce Plan has been developed. Part one (9) sets out the new approaches towards health care workforce planning and emphasizes the importance of multidisciplinary team working in General Practice:

"MDTs are the right approach because they enable better health outcomes, more efficient use of resources and enhanced job satisfaction for team members. These teams consist of a range of professionals whose core members already exist in Primary Care - including GPs, Practice Nurses, Practice Managers and Receptionists. New roles (clinical, non-clinical, social care and Third Sector) are already evolving and others will need to be introduced to ensure teams meet patient needs" (9)

Part two of the National Health and Social Care Workforce Plan provides the framework for improving workforce planning for social care in Scotland (10); and part three - Improving workforce planning for primary care in Scotland - outlines the principles to improve workforce planning for primary care (11).

In June 2015, the Scottish Government announced a £60 million investment in primary care transformation, and invited Scottish Health Boards to submit project proposals for funding by the Primary Care Transformation Funds (£50 million) and Primary Care Funds for Mental Health (£10 million). £20 million of these funds were dedicated to projects testing new models of primary care (Tests of Change).

In February 2016, the Scottish School of Primary Care (SSPC) was commissioned to carry out an evaluation of primary care transformation projects, irrespective of funding source. In March 2017, researchers from the University of St Andrews agreed to undertake the evaluation of primary care transformation in NHS Tayside. This report is one of seven reports contributing to the SSPC National Evaluation. For the purposes of this report, SSPC defined primary care transformation as:

"any project, which may be a new initiative or one that builds on previous or existing work, that is testing a new way of delivering, or facilitating the delivery of, primary care services or improving the integration or interface between primary care and other services (such as other health sectors, social care and third sector)"

1.2 Regional Context

1.2.1 Overview

Tayside represents approximately 7.7 % of the total population of Scotland. It incorporates both urban and rural settlements, and its population is distributed across the three local authority areas of Angus, Dundee, and Perth & Kinross. There are pockets of both significant deprivation and geographic isolation within Tayside. For example, 36 % of Dundee city's population reside in the most deprived areas, more than five times that compared to their Tayside counterparts. Further reflecting this, life expectancy in the rural areas of Tayside is higher than the Scottish average, whereas life expectancy in Dundee City is lower than the Scottish average.

1.2.2 Strategic Vision

To complement Scotland's 2020 Vision, NHS Tayside developed local strategies to guide primary care service development and transformation. These include a Five Year Transformation Programme 2016-2021 (2), NHS Tayside Clinical Services Strategy (2015) (3), and A Strategic Framework for Primary Care (2017) (4).

The Five Year Transformation Programme emphasises the need to build strong local partnerships and tackle health inequalities through targeted community programmes.

"Everyone has the best care experience possible" (2)

This strategy puts people at the heart of every decision and aims to facilitate the local delivery of services:

"We want everyone to have a positive experience of healthcare. Person-centred, safe and effective care is our priority for communities across Tayside" (2)

Primary care is a component of four strategic themes within the Transformation Programme which underpin the organisational strategy of NHS Tayside. Theme four, titled "Improving care through collaboration and partnership" focuses on integrating patient care across the different settings of primary, community, mental health (MH), hospital and social care. The aim is for patients to feel supported in managing their own conditions, with a focus on prevention. NHS Tayside's 2020 vision (Figure 1.1, reproduced from (3)), shows the importance of working with partners to deliver services. The partnerships that were created to implement health and social care integration have also published their own strategic plans to fulfil their health services planning and delivery obligations (12–14).

The NHS Tayside Clinical Services Strategy (2015) outlined the need to develop integrated pathways across primary and secondary care. It also recognised the need to reshape services so that both balance and investment shift from acute care to primary and community care (3). The focus on prevention, enhanced community provision alongside with suitable infrastructure, and workforce and organisational culture supports the delivery of the 2020 vision.

The Tayside Strategic Framework for Primary Care has a strong emphasis on general practice, and GPs as clinical leaders in primary care with a pivotal role around other developments (4). Also, frameworks for Older People and Mental Health (MH), and particularly strategic plans of new integration joint boards (IJBs) were developed to enhance community services around the new models of care.

To support the 2020 Vision, NHS Tayside defined three processes which underpin the new models of care:

"In an attempt to bind strategic thinking strongly with primary care ethos of delivering safe, person centred and effective care in our community at the right time, in the right place and the right person, our golden thread of the 'Prepared Patient, -Prepared Process, -Prepared Professional' runs throughout this paper. Ensuring these three processes underpin our models

of care will enable sustainable change, with a workforce and systems able to adapt, and more importantly setting the patient firmly at the heart of everything we do ...” (4)



Figure 1.1 NHS Tayside's 2020 vision (reproduced from (3))

The NHS Tayside 2020 Vision was developed to show the importance of working with a wide range of partners to deliver services in the future. NHS Tayside has built strong partnerships with a diverse range of local partners, and continues to develop these further, as well as build a co-production approach with communities. Partners include: local authorities and other public sectors, universities, the Academic Health Science Partnership, third and voluntary sectors, community planning partners, and patients, public and communities.

The Strategic Framework for Primary Care also set out five integral areas (Appendix 3), which were benchmarked against Scotland's 2020 Vision:

“... five key integral areas around: service planning; working across the interface; the infrastructure we will need to deliver new types of integrated care in the community; the workforce crisis we currently face; and the leadership required to support and develop new models of care. None of these areas can be developed in isolation, and indeed it is their interdependence and mutuality which contributes to the challenges and opportunities currently facing us” (4)

A Transformation Programme Board was established (2015) to oversee implementation of the transformation programme, and subsequently an Assurance and Advisory Group was established (2017) to assess the deliverability of the programme.

Progress in implementing the five priority areas has been variable, but all priorities are in keeping with the new General Medical Services contract (15). For example, Dundee Health and Social Care Partnership (HSCP) has outlined the progress and challenges related to each of the priority areas (16). Also, each IJB set out a Primary Care Improvement Plan to facilitate establishing the multidisciplinary team (MDT) model and to address the five priority areas. These plans were developed in mid-2018 in conjunction with NHS Health Boards and GP Subcommittees (17,18).

1.2.3 Infrastructure

NHS Tayside is comprised of three health and social care partnerships: Dundee, Perth & Kinross, and Angus. Regional health services are managed either by individual partnerships, jointly by all three partnerships, or by NHS Tayside. In the case of primary care services for Tayside, the service is managed by Angus, although executive and clinical accountability remain with NHS Tayside.

NHS Tayside had been operating under significant financial pressure since 2012/2013. As it had been unable to operate within its allocated resources, NHS Tayside had been under scrutiny by Audit Scotland and the Scottish Parliament's Public Audit and Post-legislative Scrutiny Committee.

NHS Tayside has established the Transformation Programme Board to oversee transformation work. Set up in October 2015, the Board is accountable for the Transformation Programme. An overview of the Transformation Programme is illustrated in Figure 1.2 below.

In March 2017, an Assurance and Advisory Group was established to look at the deliverability of NHS Tayside's¹ Five Year Transformation Programme (2). The report highlighted that NHS Tayside has undertaken significant work to achieve transformational change. However, it also concluded that the Programme, and its underlying plans, were not sufficiently well developed to achieve timely financial balance. While the governance structure to implement the Transformation was found to be in place, concerns were expressed about the need for better internal stakeholder engagement in partnership working.

The Assurance and Advisory Group Report also looked at areas of overspend. The main factors contributing to overspend were prescribing (£6.7M in 2016/2017), and nursing and midwifery staff costs (£6.2M in 2016/2017). Prescribing costs in Tayside were 9.4 % higher per weighted patient than the Scottish average (20).

¹ <http://www.gov.scot/Publications/2017/06/8615/3>



Figure 1.2 Overview of the Tayside Transformation Programme. Adapted from (19).

Areas highlighted by the Assurance and Advisory Group included the lack of evidence of involvement of individuals to support the operational service delivery plan; insufficient engagement of different stakeholders (GPs), and lack of project planning documents (project initiation documents, timescales, risk management, etc.). The review of the structures which supported NHS Tayside’s Transformation Programme was carried out by Ernst and Young (21); who highlighted that the level of resources invested was not different from other similar programmes. However, seven of the roles in the Project Management Office had fixed end dates, which could potentially impact upon morale and continuity.

1.3 Aims and Objectives

The overall aim of this report is to determine, in relation to implementation of primary care tests of change in Tayside, what works, for whom, why and in what circumstances.

The specific objectives in relation NHS Tayside primary care tests of change were to explore:

- Experiences of their development
- Their anticipated impact, and the theories of change underpinning these
- Facilitators and challenges to their development, implementation and evaluation
- Actual impacts and how these were measured
- Their likely sustainability and potential spread

2. METHODS

For a full description of the methodology used on this report, please refer to Appendix 4. These contain details on the case study design, data collection, data analysis and ethical approval.

In summary, this case study was carried out as part of a 15-month research grant (March 2017 to May 2018). The approach adopted was based on the SSPC Evaluation Framework agreed with Scottish Government (Appendix 1). The principal means of data collection were review of national and local documents relevant to primary care transformation in NHS Tayside, and interviews with key informants involved in the development, implementation and evaluation of primary care tests of change in NHS Tayside.

The case study comprised two distinct but complementary phases:

Phase 1: the tests of change in NHS Tayside were identified and scoped in terms of their individual components, anticipated impacts and theories of change underpinning the anticipated impacts. The ‘status’ of each test of change was subjectively described using an implementation staging system. Tests were classified as: ‘implemented’; ‘in the planning stages/not yet fully implemented’; ‘not got off the ground/has been stopped’.

Phase 2: focused on exploring in more depth ('deep dives') three tests of change, and sought to determine their actual impact, key learning, and likely sustainability and spread/roll-out.

Data collection: The research team collected data from national and local sources. The main sources of data employed were:

- national and local documents pertaining to primary care transformation in general and/or specific new ways of working
- interviews with key informants in Tayside.

Data analysis: Data were analysed using framework and thematic analysis (see appendix 4 for details).

Ethical approval:

The study was approved by the University of St Andrews Research Ethics Committee on 29 August 2017, and registered as external Quality Improvement Work or Service Evaluation Project on the NHS Tayside Clinical Governance and Risk Management Database in September 2017.

3. PHASE 1 FINDINGS

3.1 Primary Care Transformation Programmes in NHS Tayside

This chapter is based on analysis of data derived from the review of 97 national and local documents and interviews conducted with 24 key informants. Eight programmes of work to transform primary care within NHS Tayside were identified, comprising 23 individual projects (Table 3.1). Appendix 2 contains further detail on each programme, individual projects, and the resultant expected transformational change.

These projects were funded by several funding streams, including the Primary Care Transformation Funds, the Primary Care Funds for Mental Health, the Integrated Care Fund, and out-of-hours, recruitment and retention, and pharmacy funding streams.

Table 3.1 Tayside primary care transformation programmes

	Programme Name	Programme Overview
1	GP Recruitment and Retention (3 projects)	Creating new positions to recruit Career Start GPs, peripatetic salaried GPs, and encourage experienced GPs to stay.
2	Multidisciplinary Community Hub Model (MCHM) (4 projects)	Establishing care and treatment centres to reduce GP practice workload by shifting work to specialised services.
3	Mental Health and Wellbeing (4 projects)	Locating welfare rights advisors in GP practices, supporting the introduction of social prescribing, supporting the introduction of mental wellbeing services for NHS staff, and promoting a listening service for patients.
4	Multidisciplinary Team Working (5 projects)	Extending the multi-disciplinary approach to patient care to ensure the right mix of expertise and services provides the most appropriate treatment for patients.
5	Pharmacy (2 projects)	Utilising community pharmacists to support people to better use and manage their medication to reduce wastage and to free community nursing and social care staff time.
6	Community Transport Scheme (2 projects)	Providing transport for less mobile elderly patients and for those who do not have access to transport in order to improve access to healthcare services, and to reduce loneliness, social isolation and inequalities.
7	Technology-enabled care (TEC) (2 projects)	Embracing new technology in order to improve primary care through the national funding allocated to boards.
8	GP Engagement with IJB priorities (1 project)	Providing extra capacity for GPs to engage with IJB priorities in order to support the transformation of care, particularly in the area of prescribing.

We used the Outcomes Framework for Primary Care (OPFC) (7) to understand the focus of the 23 individual projects. The OPFC is comprised of a strategic-level outcomes framework, and within this

overarching strategic framework sit three nested frameworks. These nested frameworks map out the specific changes needed at three different levels: People; Workforce; and System. Our findings of this analysis are summarised below:

1. No projects were aimed to change only ‘System’
2. Two projects focused on change in ‘People’
 - Community transport scheme (Community Transport Scheme programme)
 - Listening service “Do you need to talk” (Mental Health and Wellbeing programme)
3. Four projects focused on change in ‘Workforce’
 - Career Start GP (GP Recruitment and Retention programme)
 - Flexible Career GP (GP Recruitment and Retention programme)
 - Leadership GP (GP Recruitment and Retention programme)
 - Primary Care Staff Wellbeing (Mental Health and Wellbeing Programme)
4. One project focused on change in ‘System’ and ‘Workforce’
 - GP engagement programme, Perth and Kinross HSCP (GP Engagement with IJB Priorities programme)
5. Two projects focused on change in ‘People’ and ‘Workforce’
 - Locality pharmacy (Pharmacy programme)
 - Community pharmacy (Pharmacy programme)
6. Seven projects focused on change in ‘People’ and ‘System’
 - Multidisciplinary community hub in out-of-hours, Angus (MCHM programme)
 - Multidisciplinary community hub in out-of-hours, Dundee (MCHM programme)
 - Multidisciplinary community hub in out-of-hours, Perth (MCHM programme)
 - Community leg ulcer clinic, Dundee (MCHM programme)
 - Technology enabled care, Perth & Kinross HSCP (TEC programme)
 - Telephone technology Florence (TEC programme)
 - Welfare rights in primary care (Mental Health and Wellbeing programme)
7. Six projects focused on change in all three levels of ‘People’, “Workforce” and ‘System’
 - Social prescribing (Mental Health and Wellbeing programme)
 - Enhanced community support: Frail elderly (Community Transport Scheme programme)
 - Mental health and wellbeing nurses in Links Health Centre, Angus (Multidisciplinary Team Working programme)
 - Neighbourhood Care, Angus HSCP (Multidisciplinary Team Working programme)
 - Developing sustainable models of general practice, Angus (Multidisciplinary Team Working programme)
 - Extended social prescribing, Brechin Medical Practice, Angus (Multidisciplinary Team Working programme)

The number of projects aimed at the change across three areas of people, workforce and system are illustrated in Figure 3.1 below.

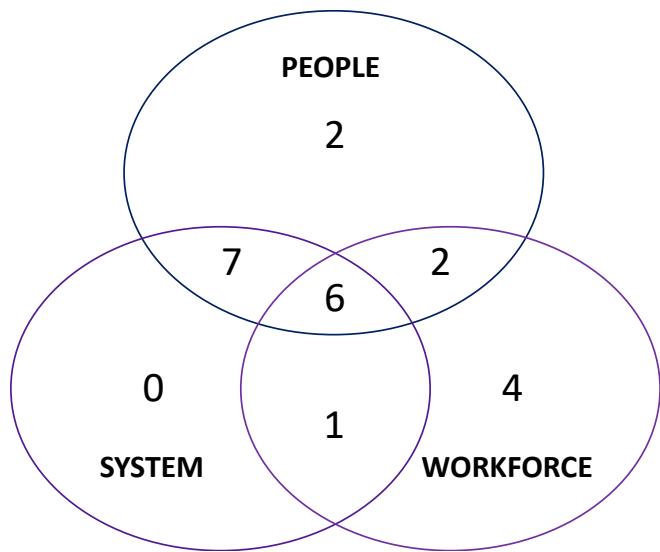


Figure 3.1 Project distribution across the three nested frameworks of the Primary Care Outcomes Framework: People, Workforce, System.

3.2 Implementation Progress

Using the implementation staging system, 14 projects were classified as ‘implemented’, 8 projects were classified as ‘in the planning stages or not yet fully implemented’, and 1 project was classified as ‘stopped’. A summary is provided in Table 3.2, and further detail can be found in Appendix 2.

Table 3.2 Stage of implementation of primary care transformation projects

	Programme	Project name and implementation stage
1	GP Recruitment and Retention (3 projects)	Career start GP implemented Flexible career GP partially implemented Leadership GP implemented
2	Multidisciplinary Community Hub Model (MCHM) (4 projects)	MCHM in out-of-hours, Angus partially implemented MCHM in out-of-hours, Dundee implemented MCHM in out-of-hours, Perth partially implemented Community leg ulcer clinic, Dundee implemented
3	Mental Health and Wellbeing (4 projects)	Listening service “Do You Need to Talk?” implemented Primary care staff wellbeing implemented Welfare rights in primary implemented Social prescribing implemented
4	Multidisciplinary Team Working (5 projects)	Mental health and wellbeing nurses, Angus implemented Neighbourhood Care, Angus partially implemented Developing sustainable models of general practice, Angus implemented Extended social prescribing, Brechin Medical Practice, Angus implemented

Table 3.2 continued -

	Programme	Project name and implementation stage
5	Pharmacy (2 projects)	Locality Pharmacy implemented Community Pharmacy partially implemented
6	Community Transport Scheme (2 projects)	Community transport scheme-pilot implemented Community transport scheme-rollout stopped Enhanced community support: Frail elderly implemented
7	Technology-enabled care (TEC) (2 projects)	Technology-enabled care, Perth & Kinross partially implemented Telephone technology Florence partially implemented
8	GP Engagement with IJB priorities (1 project)	GP Engagement Programme Perth & Kinross HSCP partially implemented

3.3 Concerns Raised in Phase 1 Interviews

The short time-scale of the funding was considered problematic for both achieving the expected impacts of the new way(s) of working and evaluating the new way(s) of working:

“... we’re going to see out of all of these work in all the boards where they’re doing the truly transformational stuff, they have to recognise that it costs more money. In the short- term. But the population health outcomes as a consequence of what we’re doing, you know, do we measure that, you know, and what’s the impact of that as well. So from a political perspective, we threw all these money at it and everybody’s quiet, but in two, three years’ time, if you haven’t got anything to show for it, then politically, your task was moving on to the next big thing, when truly transformation, you know, transformational change is going to take 5, 10, [years] you know. And one of the big things around the Nuka model and its success is, it’s had the same CEO for 30 years. You know, it takes that long” P4

The perception was that the uncertainty regarding future funding could lead to unwillingness to change due to perceived unsustainability of the new programmes beyond the end of the funding:

“a fund that has a time limited lifetime is not, you know, it’s difficult to have exit strategies for things like this and also not know when the new contract is going to set, you know, so people were reluctant to really engage in how to do that and also it’s mentally complex. It’s really complex to do, so we have not been too successful I think of being able to allocate all our funds to projects in the way that was perhaps originally envisaged” P12

Funding uncertainty was also thought to complicate the development and implementation of the new programmes:

“And it’s a usual thing with funding coming out. I know as a researcher you’re absolutely used to this because you work on short-term contracts all the time, but that’s slightly different because it’s a time limited piece of work that you’re often doing when you’re actually trying to

change and transform how services work, it's so difficult when you're getting one year's funding and then another year's funding and then... I mean, keep well eventually had 10 years funding, I think the initial pot was for two years... If we'd been known at the beginning we were going to have 10 years, we would've planned everything so differently because we wouldn't have been concerned about sustainability in the way we were. ... But actually, there's so much of what we're changing that just can't be sustained without resource from somewhere. So it is challenging and the process has made that more difficult, or the lack of processes made that more difficult" P13

It was also thought that it could create problems sustaining the new programmes that were implemented:

"But this is all creating extra work and if it's not funded...because we've all got other things to do" P6

The ability of service providers to undertake evaluation to provide adequate evidence for effectiveness and cost-effectiveness of the new programmes has been documented:

"Evaluation that is done inadequately, or not done at all, can render an intervention... a wasted effort" (22)

Key stakeholders recognised the importance of evaluating the new programmes:

"And I think it's very, very important that we evaluate not just the impact of the new service but the cost and the cost benefits around a lot of what we're doing" P4

However, key informants highlighted a lack of time, skills and expertise in evaluating new programmes of work as a problem:

"that's [evaluation] the bit we struggle with... I think as nurses... is how to evidence" FG1

"one of the areas we're not so hot at is looking at the cost-effectiveness... we certainly don't have the skillset... couldn't we have a template that had...? Could we agree some common denominators that we all try and measure regardless of the project because that mass must be worth something?" P23

3.4 Summary of Phase 1 Findings

We identified eight programmes of work to transform primary care within NHS Tayside, comprised of 23 individual projects. These projects were funded by several funding streams, including the Primary Care

Transformation Funds, the Primary Care Funds for Mental Health, the Integrated Care Fund, and out-of-hours, recruitment and retention, and pharmacy funding streams. Using the implementation staging system, we classified 14 projects as ‘implemented’, 8 projects as ‘in the planning stages or not yet fully implemented’, and 1 project as ‘stopped’. Through our interviews with key informants, we identified three areas of concern relating to the implementation of primary care transformation projects:

1. Short time-scale of the funding.
2. Uncertainty regarding future funding.
3. Lack of ability of service providers to undertake an evaluation and provide adequate evidence for effectiveness and cost-effectiveness.

4. PHASE 2 FINDINGS

This chapter is informed by our Phase 1 work, as well as analysis of data derived from the review of 56 national and local documents, and interviews conducted with 28 key informants. Phase 2 focused on exploring in more depth ('deep dives') three tests of change, and sought to determine their actual impact, key learning, and likely sustainability and spread/roll-out.

4.1 Selection of Phase 2 'Deep Dives'

Of the 23 'tests of change' projects that we identified, 14 projects have been fully implemented. Together with Scottish Government, we selected three of these projects for 'deep dive' exploration. Selection was based on the project's potential to be transformational, and whether there was evidence of attempts at evaluation.

Table 4.1 Overview of three tests of change projects selected for deep dives

Project Name	Project Overview
Community leg ulcer clinic	<p>This project showed potential to: 1) shift work away from GP practices and secondary care into the community; 2) improve patient care; 3) improve patient quality of life; and 4) reduce wastage or costs. Based on results of the local evaluation, the project team reported that this test of change already had positive outcomes, e.g. better adherence to guidelines and increased healing rates. It was therefore likely to provide valuable learning for other nursing services and geographical areas.</p>
Welfare rights in primary care	<p>This project showed potential to: 1) shift work away from GPs; 2) reduce stress-related illness in patients; 3) improve patient quality of life; 4) empower patients by ensuring access to advice and information on appropriate benefits; and 5) improve the interface between primary care and social care.</p> <p>Based on results of the local evaluation, the project team reported that this test of change already had positive outcomes, e.g. increased efficiency of benefit claims. It was therefore likely to provide a useful example of how primary care and social care services can be integrated.</p>
Primary care staff wellbeing	<p>This project showed potential to: 1) improve culture in primary care; 2) improve primary care staff MH and wellbeing; 3) improve primary care staff resilience; 4) reduce primary care staff absence from work; 5) improve recruitment in primary care; and 6) improve retention in primary care.</p> <p>The project lead reported that this project had been very well-received by participants and there was significant interest in the Wellbeing Service amongst primary care staff.</p>

4.2 ‘Deep Dive’ Findings

4.2.1 Community Leg Ulcer Clinic

Context

This test of change was proposed as a solution to a multi-faceted problem concerning venous leg ulcer care in NHS Tayside. The main issues were: 1) the less-than-adequate healing rates or standard of care being provided to some patients; 2) the higher-than-necessary cost of care provision; and 3) the lack of clarity regarding responsibility for care provision.

An audit conducted in NHS Tayside in 2006 found that the healing rates for straightforward venous leg ulcers was less than one tenth (6 % instead of ~60 %) stated in the Scottish Intercollegiate Guidelines Network (SIGN) guidelines (23). Reasons for this included practice nurses not having time to assess and provide adequate care for leg ulcer patients, and not having the skills to treat leg ulcer patients due to a lack of training or deskilling. Use of expensive bandages instead of basic bandages in conjunction with compression therapy, which is more economical and effective, have also been identified as a source of wastage. Furthermore, GPs started to highlight that leg ulcer care was not part of their remit, with some practices ceasing to provide leg ulcer care. This resulted in both a need for district nursing to provide care for patients who were not housebound, and a need for secondary care to see non-complex leg ulcer cases as patients were told to go to hospital to have their wounds assessed and dressed.

The scale of the problem of venous leg ulcer care is set to increase given the ageing population as the prevalence of such leg ulcers increases with age (24). Some key informants also highlighted the following:

“And we know that venous leg ulcers are very common. It will get more common as you get older ageing population. They’re predicting an explosion in next 10, 20 years. So it’s going to get more and more demanding. Unless we can do it well at a very early stage, then it’s going to get overwhelming” P20

Project Development

To address the suboptimal healing rate and standard of care, and the higher than necessary cost of service provision, healthcare professionals skilled in leg ulcer care provided training for practice and ward nurses. However, this did not successfully address the problems. Therefore, a team of key stakeholders, including representatives from general practice, dermatology and community nursing, developed the Community Leg Ulcer Clinic. This clinic used a whole systems approach to provide:

“[evidence-based] treatments to the patient at the right time, given by the right person” [P20]

Such a specialist leg ulcer clinic is viewed as the optimal service for community treatment of venous leg ulcers (25). The key components of the Tayside Community Leg Ulcer Clinic are summarised in Box 4.1.

Box 4.1 Key components of the Community Leg Ulcer Clinic

Service initiation:

- Identified and adapted suitable space for pilot clinic
- Installed equipment (Doppler, foot baths) in pilot clinic
- Developed robust referral criteria from GP and dermatology
- Developed patient pathways across hospital and community
- Developed Standard Operating Procedures for:
 - Leg ulcer assessment
 - Ankle Brachial Pressure index (ABPi) assessment
 - Leg ulcer treatment
 - Record keeping in the leg ulcer clinic
 - Criteria for specialist vascular assessment
- Developed a Patient Specific Directive for patients referred to the clinic
- Developed and implemented an education pathway and competency framework for district nursing staff working in the clinic to equip them to work with this patient group
- Identified an initial cluster of GP practices upon which to trial the model
- Recruited and trained clinic staff
- Piloted the model for all non-housebound patients (those who are housebound continue to be treated by district nursing) with newly-diagnosed leg ulcers in Dundee Cluster 3
- Modified staffing model – recruited and trained new clinic staff
- Extended the model to Dundee Cluster 4 and also extended to all non-housebound leg ulcer patients, not just those with newly-diagnosed leg ulcers
- Identified and adapted a second suitable space for clinic
- Installed equipment (Doppler, foot baths) in second clinic
- Extended the model to Dundee Clusters 1 and 2, thus to all GP practices in Dundee

Patient care:

- Assessment clinic: 90-minute appointment with experienced nurse, full holistic assessment (including Doppler assessment) undertaken, care plan developed
- Bandaging clinic: 30-minute appointment with nurse, leg stripped down, washed and re- bandaged
 - patient to attend until ulcer is healed

Anticipated Impact

The Community leg ulcer clinic had four primary aims to demonstrate impact: (1) Improve patient care

and therefore healing rates; (2) Improve patient quality of life (QoL); (3) Reduce wastage and costs; (4) Reduce GP practice workload; (5) Reduce secondary care dermatology workload.

In the shorter term, the strategy to achieve improvement in patient care and patient quality of life, and reduce wastage and costs was to increase adherence to the SIGN guidelines for optimum management of leg ulcers. This included compliance with the wound care formulary, completion of Doppler assessments and providing compression therapy. The reduction in GP practice workload and secondary care dermatology workload would be achieved by providing a specialist leg ulcer service based in the community to which GP practices could refer patients.

In the longer-term it was intended that the Community Leg Ulcer Clinic would provide a model and foundation for the development of community hubs in Tayside. At the time of reporting, the plan for such hubs was unclear, but it appeared that they would deliver specialist nursing services, e.g. wound management. The would also cover some work generated by secondary care, e.g. blood tests, and include some social care services, e.g. Welfare Rights Advisors.

Implementation and Progress

The Community Leg Ulcer Clinic became operational in September 2015 with the implementation of a 6-month pilot for all non-housebound patients with newly-diagnosed leg ulcers in Dundee Cluster 3. The clinic was located in the West of the City within Westgate Health Centre. It consisted of one assessment clinic (on Thursdays) and two bandaging clinics (on Tuesdays and Fridays). The clinic was staffed by district nurses who showed an interest in leg ulcer care. They were already trained in compression bandaging and Doppler assessments, and were given further training as part of this project.

Referrals came directly from the secondary care dermatology clinic, or indirectly from GP practices. GP referrals were made to the secondary care dermatology clinic in the first instance, where staff then referred non-complex leg ulcer patients onto the Community Leg Ulcer Clinic. This was due to issues with IT systems in NHS Tayside as a whole, the Community Leg Ulcer Clinic referral process not being a priority for IT support, and difficulties in determining the communication pathways. There was uncertainty over who was responsible, for example, for reviewing test results and adjusting medication, as there was not a doctor present at the Community Leg Ulcer Clinic. It was also unclear what IT systems could be used once such pathways were developed – the project team was reluctant to establish and communicate a referral process until it was finalised.

Following the 6-month pilot, the next phase was implemented in March 2016. This involved extending the Community Leg Ulcer Clinic to Dundee Cluster 4 and also to all non-housebound leg ulcer patients, not just those with newly-diagnosed leg ulcers. The clinic remained based in Westgate Health Centre and continued to comprise one assessment clinic and two bandaging clinics. The staffing model was modified for this phase. District nursing staff viewed the Community Leg Ulcer Clinic as additional to their core role and therefore did not fully integrate the service or take ownership of it. The new model was attached to the anticoagulation service – where nurses with an interest in leg ulcer care were asked to come forward. This enabled those nurses to develop skills in more than one specialist area, providing a flexible resource in which staff absence could be covered without disrupting patient care. A second modification in this phase was the adjustment of the 24-hour after-assessment patient check recommended in the SIGN

Guidelines from compulsory to optional. The compulsory check was not well-received by patients as they viewed it as unnecessary.

In phase 2, patients were contacted by clinic staff to ask how they were, and if necessary, they returned to the clinic to be checked. Referrals were made in the same manner as in phase 1. Following the location of a second site for the Leg Ulcer Clinic, a third phase was implemented in January 2018. It comprised extending the Community Leg Ulcer Clinic to Dundee Clusters 1 and 2, therefore to all GP practices in Dundee, with the opening of a second clinic in the east of the city, within the Crescent, Whitfield. This also consisted of one assessment clinic (on Wednesdays) and two bandaging clinics (on Mondays and Thursdays). The referral route was the same as before. The timeline of the implementation of the Community Leg Ulcer Clinic project is displayed in Figure 4.1.

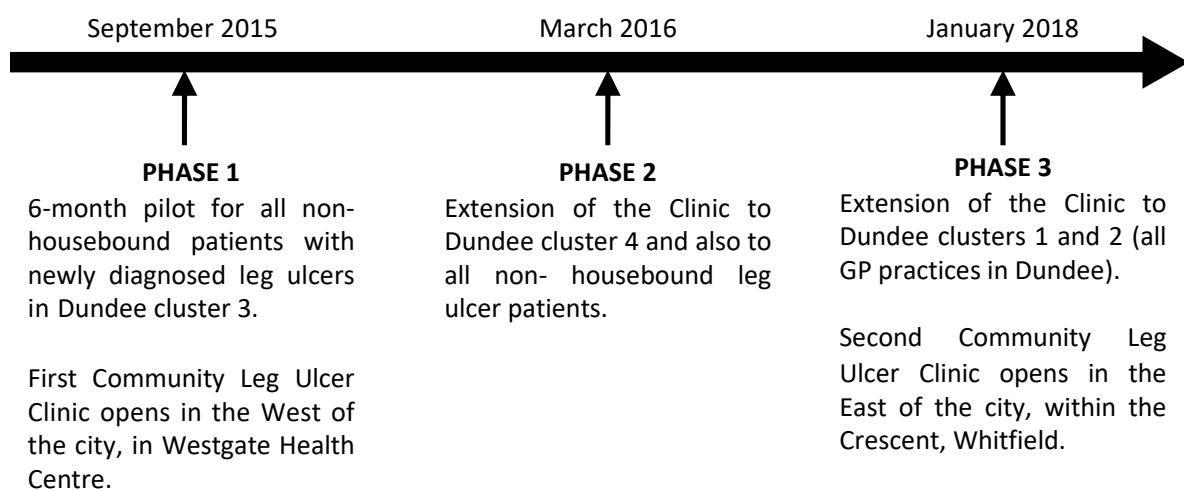


Figure 4.1 *Implementation timeline of the Tayside Community Leg Ulcer Clinic.*

Facilitators and Challenges

Implementation of the Community Leg Ulcer Clinic was reportedly difficult for the following reasons:

1. The inability to set up a direct referral process from GP practices to the clinic. This was burdensome for dermatology and it also generated some confusion amongst GP practices about the role of the Community Leg Ulcer Clinic.
2. Non-engagement of GPs, despite efforts by the project team to engage them, in setting up the clinic and the associated processes. This caused difficulties as it was unclear what GPs needed from the service, and whether or not the service and the pathways developed were useful or beneficial for GPs.
3. Problems with the original district nursing staff model
4. Problems with securing premises for the second clinic in the East of the city.

The Community leg ulcer clinic had four primary aims to demonstrate impact: (1) Improve patient care and therefore healing rates; (2) Improve patient quality of life (QoL); (3) Reduce wastage and costs; (4)

Reduce GP practice workload; (5) Reduce secondary care dermatology workload.

Local Evaluation

The local NHS-Tayside project team was uncertain if they could evaluate the Community Leg Ulcer Clinic, as they were not experienced in conducting project evaluations. However, they endeavoured to perform an evaluation for the first phase of the project to demonstrate impact in two areas (improve patient care and therefore healing rates, and reduce secondary care dermatology workload). For this, the following data were collected from the Clinic:

- patient experience feedback
- percentage of compliance with the NHS Tayside Wound Care Formulary
- percentage of patients receiving Doppler assessment prior to treatment
- percentage of patients treated with compression therapy
- percentage of patients referred to secondary care
- percentage of patients healed within twelve weeks of assessment

The project team also collected the same data from five GP practices in Dundee in December 2014 to use as a comparison for evaluating impact from the Community Leg Ulcer Clinic.

For the second and third phase of the project, the same data set was collected as in phase 1. An additional data set on improving patients' quality of life (QoL) was also collected for these phases, as it was found that chronic leg ulcers are less likely to heal within 12 weeks than venous leg ulcers. Therefore, a more appropriate outcome measure for patients with chronic leg ulcers is improvement in their quality of life (e.g. improved mobility, improved sleep, reduction in social isolation).

There was some disagreement amongst key informants about the best time to collect QoL data. Some advocated that they should first be collected at baseline, i.e. prior to or upon first visit to the Community Leg Ulcer Clinic. However, some believed that this would not generate accurate data as patients would be unwilling to reveal the full impact of their leg ulcers until they feel comfortable and have built a rapport with the staff:

"what they put in the paper doesn't reflect what they say during the assessment or actual treatment... initially what they'll say is no, no, not really... So it doesn't give us anywhere to go with it if there's been not at all... whereas further on in the conversation, they start to open up, tell you that they're conscious of the odour, they're, so all of these thing. We're not sure how effective, a true account they're going to be but we have nothing else at the moment so we have to use something... Over an hour, their information changes" FG5

At the time of writing this report, the project team was discussing potential methods and the timing for collecting QoL data in order to address this issue.

The project team was also unsure how to best-evaluate wastage and cost savings. The team was keen to

evidence the cost-effectiveness of the Community Leg Ulcer Clinic:

"in this day and age everything's in pounds, shillings and pence. So, what does, what we're saying, you know, we've improved this, we've improved that, we've improved the next thing...what does that mean in monetary value? So that can be taken to somebody and say, this is why the investment should be made in this clinic to keep it going" FG1_A

The team was considering asking a medical student or somebody employed in public health to revisit the original baseline data collected to identify a small number of patients treated for venous leg ulcers and explore in-depth the care they received, and the cost of that care compared to the cost of treating patients in the Community Leg Ulcer Clinic.

The project team did not appear collect data to evaluate the reduction on GP practice workload. However, following the pilot phase of the project, the team carried out an audit of all Dundee GP practices to establish the number of venous leg ulcer patients treated in the previous 12 months, and asked if GPs would like a Community Leg Ulcer Clinic. The collection of comparable data following the third phase of the project would enable the evaluation of the impact on GP practice workload.

Impact

During the first phase of the project, 20 patients were referred to the Community Leg Ulcer Clinic, and 18 attended the Clinic for assessment (two cancelled their appointments). Two did not meet the clinic criteria and required specialist dermatology assessment. Sixteen were treated in the Community Leg Ulcer Clinic. The results of the local evaluation for the pilot phase are displayed in Box 4.2.

Box 4.2 Results of the local evaluation of the Community Leg Ulcer Clinic pilot phase.

- Positive patient experience feedback
- 100 % compliance with NHS Tayside Wound Care Formulary as compared to ~84 % at baseline
- 100 % of patients receiving Doppler assessment prior to treatment as compared to 41 % at baseline
- 100 % of patients treated with compression therapy as compared to 60 % at baseline 11 % of patients referred to secondary care as compared to 53 % at baseline
- 85 % of patients healed within 12 weeks of assessment compared to 29 % at baseline

The positive patient experience feedback collected as part of the evaluation was corroborated by key informants:

"I think the patients' experiences that I've spoken to have...they've spoken really positively about the Leg Ulcer Clinic" FG10

"they definitely go away pleasantly surprised. And I think they're probably relieved because they know they're going to be looked after in a specialised way...we get plenty of chocolates!"

FG5

The findings that the project has reduced the secondary care dermatology workload were also substantiated by key stakeholders:

"patients coming in to see us in hospital are now much more appropriate. They are the complex ones that don't heal with standard treatment... [Prior to the establishment of the Community Leg Ulcer Clinic] we were seeing probably about 85% of our patients coming up to the hospital had a straightforward venous leg ulcer. Should never have got to us. And our clinic's overwhelmed by straightforward patients. And now we're getting much more appropriate mixed arteriovenous ulcers that are difficult to manage in the community, diabetic ulcers, vasculitis, skin cancer, things that are difficult... complex patients that we should be seeing"

P20

The interview and focus group discussion findings also provided evidence that the Community Leg Ulcer Clinic has been well-received by dermatology, and was viewed as cost-effective:

"Dermatology are well on board. They love the service, yeah, and what we're able to provide"

FG1_A

"We're [the Community Leg Ulcer Clinic] sticking to very, very basic dressings. And so, I'm sure unfortunately we couldn't measure that because we couldn't see... what was being... done before, but we know that there was lots of inappropriate dressings... being used and it wasn't healing in a quick time, so the... expense of that one leg being treated was going to be... so I'm sure we've saved a fair bit of money"

FG1_A

The local project team carried out an audit of all Dundee GP practices to which 10 responded, and 9 of the respondents indicated that they wanted a Community Leg Ulcer Clinic. Key informants highlighted the unmanageable workload for GP practices if they must treat several leg ulcer patients concurrently:

"Unfortunately, we did... well, at one point we were doing across the board about four or five at once, I mean, that was a huge burden... It's all right if there's one you can cope but there's more than one, that's enormous. Because they're coming sometimes more than once a week"

FG10

At the time of writing this report, no analysis had been undertaken of the data collected during the second and third phases of the project. As well as providing further evidence of impact on improving patient carer and therefore healing rates, and reduction on secondary care dermatology workload, these analyse should also enable evaluation of impact on improving patients' quality of life.

Sustainability

The project team believed that the Community Leg Ulcer Clinic was sustainable due to the following:

- 1) The project team and clinic staff had the necessary expertise and skills
- 2) The clinic staffing resource was flexible – staff members were trained in more than one specialist area; thus, clinics could be extended if necessary and extra workload could be absorbed
- 3) The processes had been established and set up (exception is the referral system, which was anticipated to be in place in the not-too-distant future)
- 4) The clinic had received permanent funding from the Dundee HSCP IJB

At the time of reporting, all bandaging clinics were at capacity. Therefore, the project team wished to expand the clinic to include another two full-day bandaging clinics. However, this would require additional funding.

Overall, the project team believe that the Community Leg Ulcer Clinic should continue to operate because some believe that the new GP contract will result in the withdrawal of leg ulcer care from more GP practices, and due to the increasing numbers of venous leg ulcer patients resulting from the ageing population.

Rollout and Potential Spread

The Community Leg Ulcer Clinic had been rolled out to the whole of Dundee City, with one clinic (consisting one assessment clinic and two bandaging clinics) in the west and one clinic (consisting one assessment clinic and two bandaging clinics) in the east. All GP practices within Dundee could refer to the clinic. The plan was to roll out the Community Leg Ulcer Clinic across the whole of NHS Tayside, with Clinics operating within Angus, Perth and Kinross and North-East Fife. At the time of reporting, the project team had shared its Standard Operating Procedures (SOPs) and reports with colleagues in Perth and Kinross. Within Dundee City, the plan was for the Community Leg Ulcer Clinic to form a basis for a Community Hub, providing specialist services such as surgical dressings, vaccinations, suture removal and catheter care in the community. Those leading this work were discussing the services to be included in the Community Hub and exploring potential locations for the Hub.

The project team have also continued work in several other areas:

- finalising and operationalising the referral system to enable direct referrals from GP practices
- collecting data regarding patient satisfaction to strengthen evidence of benefit
- pursuing additional funding to expand the Community Leg Ulcer Clinic by providing another two full day bandaging clinics
- developing after-care for patients once their ulcers are healed, e.g. a stocking clinic based on the Lindsay Leg Club model (26), in which patients meet as a group to provide each other with social support, and healthcare professionals provide some input, such as reviewing education and advising on problems.

Summary:

- Integrating leg ulcer care across community, hospital and general practice teams was complex and required the development of new channels of communication for sharing protocols and clinical information. This required considerable management effort and produced time lag in the roll-out.
- IT systems and communication with IT support about the needs of the project were challenging.
- Leadership and project management experience was essential.
- Detailed documentation of the rationale for the project, the steps undertaken to develop and implement the project, etc. was essential for sustainability, and to provide resilience from staff turnover.
- Motivation, determination and perseverance to transform the status quo was necessary – it required a belief that the new way of working would improve care.

4.2.2 Welfare Rights in Primary Care

Context

Placing welfare rights advisors in GP practices (co-location model) was developed to mitigate the well-documented relationship between poverty and health (27,28), as well as the increasing number of patients whose circumstances have been adversely affected by the welfare reform (29). The SG is committed to achieving a fairer Scotland (30), and published nine National Health and Wellbeing Outcomes which provide guidance on what health and social care partners must aim to achieve². Similarly, the priority of NHS Scotland is to deliver better health and care, and increase healthy life expectancy for all (31). To facilitate achievement of these aims, local governments' welfare rights services and different voluntary organisations advise people on their welfare rights and available services. However, evidence shows that many people do not claim benefits to which they are entitled, and the most disadvantaged groups may not access these services at all (27,32).

Co-locating welfare rights advisors in GP practices has been trialled in many parts of the UK. In Scotland, 'Building Connections' had three projects in the most deprived parts of Glasgow, which aimed to improve social and economic outcomes for people (33). One of these, the Deep End Advice Worker project, aimed to improve social and economic outcomes for people, and reduce the time that clinical staff spend on non-clinical issues by embedding an advice worker into two GP practices. The advice worker provided advice on finance, debt, social security and housing, and was able to access medical records for supporting evidence.

Dundee City Council's Welfare Rights Team was established in the 1980s. Its key goal was to empower clients by helping them make informed decisions relating to the benefits and services available to them:

² <http://www.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration/National-Health-WellbeingOutcomes>

"So, from my point of view as a Welfare Rights Manager and formerly as an advisor, it's... it's all about client empowerment. It's all... about ensuring that people get access to... about which routes to take, which options and strategies to take, in terms of both their... their benefit income... their personal... their personal circumstances..." P9

Project Development

The co-location model in Dundee originated from meetings in 2014 to develop Dundee's strategy to respond to welfare reform from a multi-departmental point of view. During these meetings, the co-location model established in Edinburgh in 2001 - which included welfare rights advisors' ability to access patients' medical records - was discussed:

"And that... I suppose, I heard that and I thought, that's amazing. I saw from a practice point of view... from a welfare rights practice point of view... that that would hugely help clients who are accessing disability and sickness benefits. ... if we were to replicate that in Dundee" P9

Dundee's team established a good working relationship with their Edinburgh counterparts, and spent 2014 studying their model, which had been running in partnership between Edinburgh City Council, the local Community Health Partnership and the Health Promotion Service. In Dundee, however, their working relationship with GP practices was suboptimal. A large portion of the workload of welfare rights' advisors come from clients who present with disability (74 % in 2014). To apply for Employment and Support Allowance, Disability Living Allowance and Attendance Allowance, advisors frequently had to approach GPs to obtain letters of supporting medical evidence. The ability to access medical records would be a way to reduce GP workload and improve the efficiency of welfare rights advisors' work:

"When I heard them at Edinburgh I thought to myself, well, this is great. If we could... directly access that information... and help to take some of the burden away from the GP practices... then that would make a huge difference. And it's a win-win for both the GPs... and for us" P9

In preparation to implement the co-location model in Dundee, the team briefed colleagues within the welfare rights team and Dundee HSCP about the rationale behind enacting the co-location model. The team also developed the core project documentation, including: 1) Principles document; 2) Objectives document; 3) Process map outlining the stages of the co-location; and 4) Briefing note.

The key components of the project are outlined in Box 4.3. These were consistent across all GP practices with the access to medical records being perceived as central to the success of working:

"We go into a practice looking for the model that we've adopted. ... if we go into a practice and they say to us, well, we are fine with everything else, but you can't have access to medical records ...we would say, well, we're not interested" P9

Box 4.3 Key components of the Co-location of Welfare Rights in Primary Care project

- Co-location of Welfare Rights Advisors into GP practices
- Advisors provide free confidential advice on appropriate benefits and services
- Advisors have direct access to patients' medical records - this enables them to choose relevant medical evidence to support benefit's claim
- Patients sign a consent form which is put into their medical record
- Experienced advisor is dedicated to each GP practice with a backup worker being in place
- Simple referral process for GPs - advisors are included in the booking system so patients can easily book an appointment
- Patients can self-refer
- Welfare rights advisors can use private room in the GP practice
- Strong relationship between practice staff and welfare rights advisor – the aim is that advisors are accepted as practice members

Anticipated Impact

The expected impacts for the patients were to reduce stress-related illnesses and to improve patients' quality of life. This would be achieved by empowering patients by giving them free and confidential advice on appropriate benefits and services. Advisors would also support clients' claims by compiling relevant evidence from their medical records, which was expected to translate into an increased number of positive benefit decisions. Addressing clients' socio-economic problems was expected to result in reduced stress, reduced stress-related health problems and improved quality of life.

The co-location model also aimed to improve access to the welfare rights services among the population groups who find it difficult to access in the council setting. This was achieved by creating easy access to the service (patients are used to going to their GP practice), and by reducing the stigma which is associated with accessing benefits in the council setting. The GP practice being a trusted location and the ease of booking an appointment through their system were the main facilitators for this. The resultant increase in access to free and confidential advice is anticipated to lead to a reduction in health inequalities.

GP workload was expected to be affected in a number of ways. First, GPs ability to refer patients with underlying socio-economic problems to the welfare rights advisors would leave them with more time to concentrate on medical issues. Second, advisors with direct access to relevant medical records could compile medical evidence without GP input. Third, as advisors address patients' underlying socio-economic problems, reduced GP visits for stress-related health problems would be expected:

"We've got this model which we think, you know, reduces health inequality, improves people's health and wellbeing. ... We've known this for years, but it's just that this project has kind of highlighted it in terms of not just, you know, the simple cash terms, in terms of what we actually generate for our patients, but in terms of how it can potentially just boot someone out of that socio-economic hole and improve their life in so many other ways. You know, in order to manage the social inclusion side of things you need money..." P9

Implementation and progress

The Welfare Rights in Primary Care project was implemented in Dundee in January 2015, when the first Welfare Rights Advisor began work in Taybank Medical Centre. By the end of 2017, welfare rights advisors were present in 5 practices, covering approximately 26,000 Dundee residents. By April 2018, the service was rolled out in eight GP practices, covering approximately 40,000-50,000 Dundee residents. In all practices welfare rights advisors worked one day per week and the service was always fully booked. The timeline of the implementation of the project is displayed in Figure 4.2.

2014	Jan 2015	Jun 2015	Apr 2016	Jul 2016	Nov 2016	Jan 2018	Feb 2018	Mar 2018
Contact with Edinburgh Evaluate Edinburgh's model Discussions with local stakeholders	Taybank Medical Centre	Lochee Health Centre	Wallace-town Medical Centre	Douglas Medical Centre	Whitfield	Erskine	Mill Practice	Maryfield Medical practice

Figure 4.2 Implementation timeline of the Welfare Rights in Primary Care Project.

Facilitators and Challenges

Implementation of the co-location model was reported to have been challenging because access to the GP practices was perceived to be difficult. The complicated relationships amongst patients, advisers and members of the practice teams were a contributing factor to this, and were underpinned by the view from GPs that welfare rights advisors were creating additional work for them by asking for corroborating evidence for benefit applications:

"And we, kind of... we didn't have a great relationship with many GP practices... because they saw us as... as an irritant, you know" P7

To introduce the model in the first GP practice, an existing positive working relationship between one of the practice managers and the welfare rights team was used. The welfare rights team used this opportunity to demonstrate how GP practices would benefit from taking part:

"She also sees people... she also hears from the GPs that, you know... you know, I've had six patients in today looking for letters, looking for evidence or... worried that their... their benefits have been taken away from them. So she saw the... the... the huge benefit in being able to say to those customers... the GPs being able to say to those clients, those patients... right, I can't help you, but advisor, in the other room, can help you to do that" P7

Existing evidence and an outlined working model were used when new GP practices were approached. This was considered useful when other third sector service providers were present, as it enabled the team to demonstrate how they could complement other work streams. To provide an overview of existing partners, the team had developed a document which included all involved GP practices and outlined the

services provided in those practices:

"... she [practice manager] was at the initial meeting as well and alongside two of her social prescribers. So I can outline the model and it was good to be able to go back and say well, this is the model. This is what we're here for. Anything else that's maybe related to another service supporter then that can be done through the social prescribers. So... I know that... and the social prescribers have worked incredibly well in... this GP practice to work out between themselves who does what and when" P7

The team also addressed emerging problems. For example, the referral strategy was modified in one health centre after the number of referred patients remained relatively low. The welfare rights advisor suggested using adverts in the waiting areas to increase awareness of the service:

"So we just thought, well, it's not quite working the way that [named practice] did. So we put banners up, just in the practice, saying you know, if you need an appointment, see the receptionist." P9

To facilitate the work and future spread of the co-location model “word of mouth” was perceived to be important. Also, new GP practices started to get involved as information about the positive experiences spread:

"And then it's to do with just taking off and you get folks that are new to the services, you get folks that are happy with the service... come back to you time and time again, and word of mouth. It's not just the GP that will refer as well could be word of mouth from other patients..."
FG6

"But yeah, I think. They said, "Oh what you're doing here?" And I think the next protocol for the welfare rights people was next door anyway. So as far as I'm aware, they're up and running" FG4

Patients using the service were required to consent to welfare rights advisors looking at their medical records. To gain patients' trust, only experienced welfare rights advisers were placed in GP practices -as they had to select relevant information from records and explain to clients what they were looking for and why certain pieces of information were important:

"but I haven't come across a single case of a patient saying, "Oh no, you're not looking at my medical records," so like anecdotally, certainly, like 100% of patients are in favour of that for our purposes, so which is quite surprising I think. But maybe they're not aware of what they're truly opening up" FG4

Local Evaluation

The local project team undertook two evaluations or report. First was a report written to the Dundee

Integrated Care Fund (34). This report focused on the development of a referral pathway within primary care through the linking up: 1) social prescribers; 2) Keep Well team; 3) Listening Service; 4) the 'Improved Cancer Journey' model; and 5) the 'Shelter' GP service. The report discussed the use of 'read codes' from patients' electronic health records to facilitate this process by mapping the patient journey, including tracking referrals and identifying attrition. The report also highlighted financial gains between January 2015 and March 2017 of £1,627,557.42.

The second report on the evaluation of the integrated care fund was submitted to the Dundee HSCP in December 2017 (35). This report evaluated the project implementation. The data collected for this is summarised in Table 4.2.

Table 4.2 Total gains from benefits applications in Dundee between April 2017- December 2017.

GP Practice	# of appt.	Attended appt.	Attendance rate (%)	Total gains (£)
Taybank Medical Centre	435	372	86 %	£780,916
Lochee Health Centre	275	200	73 %	£412,035
Wallacetown Medical Centre	318	265	83 %	£534,008
Douglas Medical Centre	108	83	77 %	£160,533
Whitfield Health Centre	130	101	78 %	£146,007
Total	1,266	1,021	81 %	£2,033,500

From April 2016 to December 2017, advisors made 1,266 appointments in total with 1,021 of these appointments being attended, representing an 81 % attendance rate (varying across practices from 73 % to 86 %). The total financial gain (income for the clients from successful benefit applications) was just above £2 million pounds (£2,033,500) for this period. The local project team did not appear to collect data to evaluate the impact of the service on GP workload and improved quality of life on patients. The difficulty of doing this was raised by key informants and the potential impact of the lack of measurable evidence was highlighted:

"... I have... spoken to a few GPs independently. Mixed views on effectiveness and benefits to appointments... but happy to have a trial period for... assessment and take things from there. So I'm not sure where that mixed views has come from..." P7

"But that's been difficult because the only thing we can really measure properly is financial gain and as you say, you can only be guessing part of that" FG6

"Yeah, it's just more of a general feeling, perception of what's going on" FG4

Although the report did not collect data on the impact on GP workload, it included evidence from GP practices reporting a reduction in the re-attendance of patients in relation to problems with anxiety, depression and physical manifestation of the symptoms. GPs perceived the presence of welfare rights

advisors particularly beneficial in areas of high deprivation:

"Accessing help with claims for appropriate benefits and empowering patients who are otherwise disenfranchised by illiteracy, social phobia, panic, anxiety, depression and addiction is a valuable and time saving resource for practices such as ours. Not only does this help patients identify medical problems which attract appropriate benefits, it helps them live less wretched lives, and also helps GPs in formulating a more effective management plan for their problem which is consequently less likely to be scuppered by financial concerns. I would like to develop better communication with our welfare rights workers to engender a more coordinated MDT management plan" P45

National Evaluation

Dundee's welfare rights co-location into GP practices has been included in two national evaluations. First, a report to Scottish Government on Third Sector Approaches to Community Link Working (36) included Dundee City Council Advice Services or GP surgery co-location in Dundee as one case study. This evaluation included reports from patients that they had been advised in a non-judgmental way and as a result their stress and anxiety levels had reduced. Also, the outcomes for benefit claims and appeals had improved, and response times from the Department for Work and Pensions had become faster. From the community's point of view, the co-location model was found to have increased the support available for residents and demonstrated an effective way of working with vulnerable groups without stigmatising them.

Second, a forecast social return on investment analysis of the co-location of advice workers in medical practices has been carried out (5). Taybank Medical Practice in Dundee and two sites in Edinburgh were included in this evaluation. This analysis provided evidence of multiple benefits of the co-location model. In financial terms it estimated that every £1 invested generated approximately £39 of benefits (where 'benefits' refer to the social, economic, and environmental outcomes of the activity). Factors at the health systems level that were taken into account in calculating this impact include improved ability to target resources at priority groups, and cost savings of mental health services as a result of earlier intervention. Factors taken into account at the practice/advisor level include time savings for GPs, increased job satisfaction for GPs and advisors, improved delivery of cost-effective services, and improved productivity. From the patients'/clients' perspective, co-location of welfare rights services enhanced resilience, employment outcomes, and patient-reported health and wellbeing.

Impact

The local project team measured patients' satisfaction with the service using a questionnaire (Appendix 5). This included questions on accessibility of the service, whether or not expectations were met, and if the information provided was understandable. To evaluate the impact service made to the client's life, the questionnaire also asked "*Has the help provided by the Welfare Rights Team made a positive difference in your life?*". A comments box was also included at the end of the questionnaire to allow for additional information about how the service was perceived and if it has made any difference to the client's life. Administration of the questionnaire started in January 2018 and, at the time of this report, the data had not yet been analysed.

Measurement of the co-location model's impact on the prescribing budget had also been initiated. This

was taken forward in cooperation between Dundee's Welfare Rights Team, University of St Andrews' evaluation team, University of Dundee's evaluation team and an Information Services Division Local Intelligence Support Team data analyst. To date, the list of medications prescribed for stress-related illnesses has been established, and work is ongoing to look at practice-level prescribing data from the beginning of 2015 onwards. We do not anticipate that there will be a clearly measurable change in prescribing due to the small scale of this project. However, this is one step forward in identifying and establishing objective outcome measures.

The local project team was unsure of how to measure the effectiveness of the co-location model and its impact on GPs. Although the forecast social return on investment analysis indicated that the service offered financial value (5), the evidence on reduced GP workload was less clear. Limited evidence suggests that there was a perception that the co-location model reduced GP visits by signposting patients with socio-economic matters to the welfare rights advisors. Advisors and practice managers reported comments relating to this, for example:

"... because of his benefit situation, he's had to go to doctor for antidepressants so that shows the mess that people are in with their benefits that are having to go to the doctor for these things, if you take away that benefit problem, they might not have had to go to the doctor for antidepressants" FG6

"I think in some of our frequent attenders come to see the doctor which isn't necessarily medical issue and having that service as a way of with clinicians to point them, signpost them to that..." FG4

The co-location project was well received in the GP practices which were involved, to the extent that it was viewed as well embedded in the practice culture:

"I think, hopefully this project will carry on. And now it's so embedded... general culture is the thing (Overlapping Conversation) and that's the sort of, that seems to be the default for a lot of things so. So, to take that away would be not so good I don't think" FG4

The co-location model also facilitated improved understanding of the respective areas of work of welfare rights advisors and practice staff, and facilitated more efficient referrals from GPs to the welfare rights service:

"So basically it should involve less visits to the GP and also a better understanding of the system for the medical staff as well which is sometimes a bit... it doesn't really make sense sometimes, but we do understand it" FG6

The ability of welfare rights advisors to directly access medical records increased their efficiency, as demonstrated by a quicker turnaround of cases and increased success in benefit applications. Advisors also noted that direct access to medical records allowed them to assess cases where it was not appropriate to proceed with an application, and they could then explain this to their clients.

"we're getting decisions right, first time of asking, has definitely increased within the client-base that's within these surgery. In terms of our expectation of the whole project from day one, I think it's far exceeded" FG6

Perceptions on the benefits for patients have also been positive. GP practice staff and welfare rights advisors perceived that the service had been well received by patients. They believed that having advisors in GP practices had improved access to welfare rights services. Improving access to the service was important for empowering clients. This was particularly the case for the most vulnerable people who would not access the service in the council setting:

"I think the patients like it... And having it here, actually, I think it's probably helped some to know and they have to come to anyway rather than go in the town or having a walk... people are coming frequently anyway so having embedded with them the GP practices I think is a good thing" FG4

"A lot of people we see are very vulnerable and they stick to what they know and they wouldn't know to come into town and they don't know different services and... say something to the GP and the GP says we've got somebody in our surgery. I've got one yesterday who I saw she would never come in... and she's... even though I met her twice, she... she's too comfortable at her surgery, but she was aware of all these services" FG6

The following client' case (Box 4.4) illustrates the theory of change for the co-location model, and provides an example of the impact of socio-economic problems on patients' health and GP workload. It also demonstrates how the model facilitates co-operation between medical and social care staff.

The co-location of welfare rights advisors in primary care model has also been recognised by two awards. First, the service was the winner of the Chairperson's Award at the COSLA Excellence Awards in 2017. COSLA awards recognise projects that set new standards of excellence and help to spread creativity and impact.

Second, the service was a shortlisted finalist for the Dundee City Council 2017 OSCAS within the category of Achieving Fairness and Reducing Inequalities.

Box 4.4 Example of a GP practice welfare rights client's case

Client's GP had referred him to me due to his Employment Support Allowance dispute. He had an assessment and had been found fit for work, due to this he was cut off Employment Support Allowance. He then made a claim for Universal Credit and began handing in fit notes. These were refused by his work coach and he nor his GP could understand why. His GP approached me about this and I had advised that as he was found fit for work, he could not be signed off with the same condition and asked if she thought his condition had deteriorated - it had. She then provided him with a fit note which the Department for Work and Pensions would accept.

I met with him and he had explained that the requirements of being on Universal Credit and being made to look for work were causing him to have an increase in his seizures as they are brought on by

stress. I assisted him with requesting a mandatory reconsideration and with him signing a subject access request, I used relevant information from his medical records to dispute the original Employment Support Allowance decision. During this time, his fit note had expired so I had spoken with his GP and she issued him another one for him to pick up.

Several weeks after asking for the reconsideration, the decision was overturned and the client was found unfit for work. He is no longer needing to take part in 20 hour work searches per week and does not have to go in to the Job Centre, which was causing him a lot of stress.

Being in the surgery meant he was able to access our service and we were able to discuss concerns directly with his GP. His GP and I worked together to resolve the issues he was having and with having access to his medical records meant the client did not have to go to Tribunal and the process was far quicker and smoother.

Sustainability

The project was perceived to be sustainable due to the 1) availability of experienced welfare rights advisors; 2) patients' demand; 3) acceptance of the service among GP surgeries which take part in the project. However, in terms of future expansion, there is a need to secure mainstream funding. Permanent funding would also be required to maintain sufficient staffing levels to ensure the project's continuity and ability to deliver project outcomes. At the time of writing this report, two members of the Welfare Rights staff were financed by the Integrative Care Fund:

"Yeah, so we need to convince the council management to employ more welfare rights officers because it's just about that capacity as it is I would imagine" FG6

It was believed that workload was likely to increase due to the changes in welfare provision which has an impact on peoples' financial security. However, the service was already reportedly stretched, particularly on days when it was being provided in multiple locations:

"But Wednesday is a particularly difficult day because we've got two, we got Maryfield and Taybank on a Wednesday... and we've got one in the central library... which is just a general clinic. So there's not often enough bodies to spread around, and that's probably a barrier" FG6

Rollout and Potential Spread

The Welfare Rights in Primary Care project has been rolled out to the eight GP practices in Dundee. At the time of writing this report, this entailed one advisor working in each practice for one day per week. One GP practice had asked if the service could be extended to two days per week in their practice.

Future rollout of the service was thought to depend on GP practice willingness to be involved in this work and their ability to provide advisors with office space. It was recognized that all practices would not be able to provide advisors with a dedicated room, and a mobile unit has been discussed.

The project team have also continued to develop several other areas:

- plans to roll out the service to all GP practices
- plan to link up with particular diagnoses, such as cancer.

(The intent is that new cancer patients would be referred to a welfare rights advisor for advice on available services and benefits to prevent the escalation of financial difficulties.)

- improve on the local evaluation plan by monitoring the impact on prescribing
- engage with localities to plan future development

Summary:

- It took time to build relationships with GPs and healthcare professionals, but once achieved, welfare rights advisors were seen as a trusted part of the practice.
- Practice staff perceived improvement in their workload given that they could directly refer to the advisor "in practice".
- Welfare rights advisors saw the benefits of being able to submit well informed cases on behalf of clients.
- Detailed project rationale, documentation and an implementation plan were essential when negotiating with local stakeholders, and for implementation and spread in Dundee.
- Direct access to patient medical records with client permission allowed for more informed decisions to be made regarding entitlement to benefits.
- GPs and health professionals learned more about the benefits system and its processes where they have had access to a Welfare Rights Advisor in practice. This improved the interface between primary and social care.
- This project provided an example of how to learn from interventions which have been implemented elsewhere (implementing the Edinburgh model in Dundee).

4.2.3 Primary Care Staff Wellbeing

Context

The need to improve primary care staff wellbeing is acknowledged by Bodenheimer and Sinsky (2014) in their article From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider (37). They argue that it is not possible to achieve the aims of improving patient experience, improving population health and reducing costs without improving the wellbeing of staff.

Additionally, following a survey conducted in 2016 with over 1000 NHS primary care staff, the UK MH charity *Mind* concluded that levels of stress among primary care staff are 'worrying' (38):

- 88 % of primary care workers found work life stressful (compared to 56 % of the wider workforce)
- 83 % reported that workplace stress affected their ability to sleep
- 54 % believed workplace stress impacted on their physical health

- 43 % resigned or considered resigning from their jobs because of workplace stress
- 21 % believed workplace stress had impacted on their MH
- 17 % had called in sick to avoid work because of workplace stress
- 8 % reported that workplace stress had led to suicidal thoughts

The NHS Tayside Staff Wellbeing Service was established in 2012 (and formally launched in 2013) following commitment from Scottish Government to introduce interventions to improve staff experience (39). This commitment was in response to the findings of the 2009 report *NHS Health and Wellbeing* (40) (also known as the Boorman Review), which found correlations between staff experience and wellness (in terms of physical, mental and social contentment) and patient experience and outcomes, levels of staff retention and rates of sickness absence.

As outlined in the Scottish Government's 2009 document *Spiritual Care and Chaplaincy* (41), the wellbeing of healthcare staff falls within the remit of spiritual care and chaplaincy. Accordingly, the Wellbeing Service is run by the NHS Tayside Department of Spiritual Care. However, the decision was taken not to include the terms 'spiritual' or 'chaplaincy' in the title of the service in order to remove any barriers to its use due to an association with religion. The service provides support for staff experiencing work-related or personal difficulties. It operates on a signposting, rather than a referral basis, and aims to respond positively and quickly (it strives to have no waiting lists) where there is need. It offers both reactive support (support to help people deal with problems or negative events that have occurred) and proactive support (support to prevent problems and negative events and/or to give people the tools to deal with them as and when they arise). The support it provides takes the form of telephone support, one-to-one confidential conversations, information group support, group Values Based Reflective Practice (VBRP®) (a model to help staff deliver the care they came into the service to provide). As well, support is offered in the form of training and workshops in Mindfulness (the practice of focusing one's attention on the present moment and acknowledging and accepting one's feelings, thoughts and sensations), communication issues, bereavement, grief and loss and wellbeing and resilience. The service has received positive feedback from staff members receiving support. Examples of such feedback are contained in the information leaflet of the service, and include:

"I felt I would have exploded without this opportunity"

"My appointments gave me strength to keep going (and continue working)"

"It has helped me get back my usual professional perspective"

"We are much more cohesive as a team. Trust levels have increased ten-fold"

"I feel these wellbeing sessions have made a difference to the team. I feel the whole team are trying to think of each other"

Project Development

Historically, the service was not-accessed often by primary care staff, perhaps due to a lack of awareness of its existence or an assumption of irrelevance arising from the historical base of spiritual care and chaplaincy being in acute and larger hospitals, rather than in a primary care setting. Therefore, as part of

the work to transform primary care in NHS Tayside, the Staff Wellbeing Service was asked to target primary care staff in particular. Twenty-thousand pounds of the PCTF monies was allocated to this project. This supported half-time backfill for the Professional Lead for Staff Support to focus on primary care staff for the period 1 February 2017 to 31 January 2018.

Although the Staff Wellbeing Service was already well-established, one adaptation was made for this work: a greater amount of the Wellbeing Service support was delivered locally. Previously the service had been advertised as the *Wellbeing Centre*, which was located centrally in Dundee. However, in developing this project, it was recognised that staff in more remote locations may be disinclined to travel to Dundee and that this would therefore present a barrier to accessing the support offered by the Wellbeing Service. For example, staff based in Pitlochry would have around a 100-mile round trip to visit the Wellbeing Centre. In this project the Professional Lead for Staff Support travelled to GP practices in both urban and rural locations, across the three HSCPs in NHS Tayside. The key components of the Primary Care Staff Wellbeing project are displayed in Box 4.5.

Box 4.5 Key components of the Primary Care Staff Wellbeing project

- Raise awareness of the NHS Tayside Staff Wellbeing Service amongst primary care staff
- Run wellbeing and resilience group sessions
e.g. Mindfulness and Values-Based Reflective Practice for primary care staff (including within GP practices) to enhance team working, learning, development and support
- Raise awareness of how to access one-to-one counselling-style support for primary staff experiencing work-related or personal difficulties

Anticipated Impact

This project aimed to make a positive impact in four key areas:

1. Improve primary care staff mental health and wellbeing
2. Improve primary care staff resilience
3. Reduce primary care staff absence from work
4. Improve recruitment in primary care

The primary strategy for achieving progress in the key areas was to raise awareness of the support services available to primary care staff from the Staff Wellbeing Service, and to promote uptake of the service. In the longer-term, progress to improve the work culture of primary care was envisioned, making it a more attractive place to work.

Implementation and Progress

The Primary Care Staff Wellbeing project commenced on 1 February 2017 and ended on 31 January, 2018. The Professional Lead for Staff Support contacted by email all 66 GP practice managers and also the Cluster Leads in NHS Tayside to provide details of the Staff Wellbeing Service, and share positive feedback from colleagues who have already used the service. Managers were invited to share this information with practice staff and to organise a visit from the Professional Lead for Staff Support to meet staff, introduce the Service in person, run a group session in Mindfulness and inform staff about VBRP®.

The Professional Lead for Staff Support attended 12 GP practices to introduce the service, run a group

session in Mindfulness for practice staff and inform them about VBRP®. The Professional Lead for Staff Support would also run a group session in VBRP® if this was requested. Additionally, the service was introduced and sessions entitled ‘Values Based Reflective Practice’ and ‘Managing Stress and Finding Peace in a Busy Life’ were run at the Annual Conference of the Tayside Centre for General Practice in November 2017.

Facilitators and Challenges

Implementation of the Primary Care Staff Wellbeing Project was reported to have been difficult, with slow engagement of GP practices:

“It was a very slow burn, I have to say, to start with. How we work most effectively, because our work is really, really relational, it’s about interconnectedness between people, and that’s what works best is getting out, meeting people and then that’s the beginning of a relationship. That was quite difficult to be honest, the GP practices wanted written information which was fine, we could give them written information on what we’ve done in the past and the kind of feedback that people have given us about what their experience of our work with them was and how it helped them. But it took quite a while to begin getting invitations then actually getting out into GP practices...it’s all about getting your foot in the door” P6_A

“Because we’d done it in the kind of acute and the health board if you like... just taking off and become really successful and then word-of-mouth got out there, maybe we were naive in assuming the same would happen in primary care, but it’s a very different culture... primary care is difficult” P6_B

Local Evaluation

The Staff Wellbeing Service undertook only minimal evaluation, and collected data in five areas listed below. Comparable data was not collected prior to the start of the Primary Care Staff Wellbeing project.

1. number of GP practices responding to the invitation to participate in the project
2. number of GP practices organising subsequent group sessions following the introductory session
3. number of primary care staff participating in the group sessions
4. number of primary care staff referring themselves for one-to-one sessions
5. participant experience

The participant experience data was collected by means of feedback forms following GP practice group sessions and the sessions at the Annual Conference of the Tayside Centre for General Practice. The feedback forms asked questions about whether or not participants would be willing to access the Staff Wellbeing Service and whether or not they would recommend the service to others. At the time of writing this report, these data had not yet been analysed.

The findings began to address the expected impacts of the project. However, it was recognised that these data would not facilitate conclusions regarding achievement of any of the expected impacts and that a different approach to evaluation would be considered in future:

"I must say, reflecting on it all now, I am rather wishing we had taken a different approach... Perhaps the approach we took was not the best one to adequately test the product and to provide the right kind/quality of evidence" P6_B

Impact

Of the 66 GP practices contacted by the Professional Lead for Staff Support, 12 replied and arranged a visit to the practice to introduce the service and group sessions. Only two of these practices organised subsequent group sessions following the introductory session. A total of 268 primary care staff attended group sessions (this number includes those who attended in GP practices as well as those who attended at the Annual Conference of the Tayside Centre for General Practice). During the twelve months of the project, 33 primary care staff referred themselves to the service for one-to-one support sessions.

Key informants indicated that the service was not well-accessed by primary care staff prior to the project:

"I think all of it [primary care staff accessing the Service] will probably be from [the Primary Care Staff Wellbeing project] because otherwise they won't know that they can come, yeah... I think maybe I had one or two but the bottom line is they probably wouldn't have known about us... I think that's been a big change", "I've had some GPs come to me which I've never had. I've never seen GPs before in any area of my work" FG3

It appeared that primary care staff were unaware of the Staff Wellbeing Service:

"I didn't know the service was available until [the Professional Lead for Staff Support's] email"
FG7

"so I think the benefit that kind of came from it... was knowing what they had to offer" P21

"I just thought it was very reassuring to know that there was help available out there... it's just good to know that there's something out here if you do find you need them" FG7

Analysis of the participant experience data undertaken as part of this evaluation indicated that the project was very well-received:

"Very enjoyable session"

"Excellent session. Positive feedback from all team members. Thank you"

"Fantastic morning which was very refreshing to both myself and team. Helpful tips and advice given"

"Fantastic session... Loved addition of humour. Not felt so relaxed in a while!"

It revealed that awareness of the Staff Wellbeing Service increased amongst primary care staff:

"I was not aware of your service. Good to know it is available if needed"

"I did not realise the service was available"

"Useful to find out about the Wellbeing Centre or Service"

It also revealed that participants in the group sessions felt that they were provided with coping strategies and relaxation techniques:

"It helped put things into perspective. It's easy in life to get a bit lost – this helped with ways to get back on track easily"

"I particularly liked the 'STOP' technique and how it helps us to prioritise and clear adverse thoughts. I was also amazed at how long a negative thought, feeling or niggle can dwell in our minds. Very true!"

"It raised awareness of the benefits that practising Mindfulness can bring" "It gave me good tips to try and relax"

"It made me feel more relaxed, especially the breathing exercise"

There was indication that the Primary Care Staff Wellbeing project may have reduced absence from work:

"I had a member of staff say to me the other day 'If I wasn't seeing you I would not have been able to stay at work. I would've been off sick the whole of this time'" FG3

"I had an email from someone to say I'm now back at work... she said they were very fortunate to have such a supportive and caring Staff Support Service or she wouldn't have been back at work" FG3

The project was also viewed to have been worthwhile and value for money:

"there has been some really good work done which has positively impacted on the wellbeing of primary care staff. I think there's enough evidence to show that, with a more concerted, embedded, funded and supported effort, much more could be done which could positively transform the culture, and the resilience and wellbeing of staff in Primary Care, making it a more attractive environment in which to work and to stay" P6_A

"when they do [make time for the Staff Wellbeing Service sessions], they absolutely appreciate it... and I think it's been one of the most well-spent things that we could have done with that funding" P4

Sustainability

The project had limited impact due to low engagement and a short roll-out period, therefore it is not yet clear whether it would be sustainable. Some practices were able to, and wished to, integrate group sessions into protected learning time (PLT) and/or public holidays:

"It maybe, it maybe something that's a good thing to have once a year just to remind the staff that the service is there... I think it would be a good session, that would be a great thing for staff for like a, you know, protected learning afternoon" FG7

While other practices were unable to make time for the sessions, and managers did not believe that staff would to participate in their own time.

"I mean the logistics have fit in that into the daily sort of GP practice life is very, very difficult, because we do...PLT sessions now anyway, I think we're to get two for this year coming, and then next year the funding stopping all together so there won't be any more, so it would then require staff to come in in their evening or the weekend, and who then funds that because staff wouldn't come in in their own time to do it, they just wouldn't, they would want paid for it, and we paid the staff that attended on a development day and the Mindfulness, they got paid for that, but they still didn't come now, so it's down to them wanting to engage with things as well...maybe if it was mandatory training they had to go to you know, might be every once every quarter, that would might be justify so at least you would capture people, but how do you build that into an independent business like a GP practice, you can't, so I don't got an answer for that one" P22

Further funding would also be necessary for the project to be sustainable:

"the bottom line is the staff support work could grow and grow and grow... I don't think we can withdraw what we've already put out now for primary care only because our name's out there and people are going to be tapping into our service but it will impact what we do in our other services... So the project created more demand but... we may need extra resources to cover it..." FG3

Rollout and Potential Spread

This project does not appear to provide sufficient evidence for a wider rollout at this time. However, the Primary Care Staff Wellbeing project continue to provide support to existing and new primary care staff Service users, and continue to collect data on these to strengthen the evidence base for this service. Dependent on further funding, the team also plan to continue to target primary care staff and raise awareness of the Staff Wellbeing Service to increase engagement.

Summary

- It was more difficult to make contact and build relationships with primary care staff than with staff in other health care departments. This created a challenge in engaging primary care staff with the Staff Wellbeing Service.
- The project team carried out a limited assessment, and through this process determined that other assessment approaches may be more appropriate for future similar projects.
- The demonstrated impact of the project has been limited in the 12-month rollout period- 12/66 practices engaged with an introductory session and 2/66 practices engaged with follow-up sessions. Overall, 268 staff engaged with the Service.
- Feedback from individuals who engaged with the Service has been positive.
- GP practices gave mixed feedback about the feasibility of rolling out the Service, with creating time in busy schedules being identified as a significant challenge.
- Further funding is required to continue the existing programme, and particularly when the hurdles experienced with low engagement are overcome, and more staff begin to access the Service.

Summary of Phase 2 Findings

Three ‘test of change’ projects were selected for in-depth analysis: 1) Community Leg Ulcer Clinic; 2) Welfare Rights in Primary Care; and 3) Primary Care Staff Wellbeing. All three projects showed promising results and appeared to have the potential to achieve their expected impacts. However, they all required further data collection and analysis to produce rigorous evidence about actual impact, particularly about cost-effectiveness. There were substantial unmet data support needs- all three project teams indicated that they would benefit from advice regarding evaluation of the new models of care. The Community Leg Ulcer Clinic and the Welfare Rights in Primary Care project had received funding to sustain their current model. However, in order to expand, something that both project teams believed would be beneficial, required further funding. The Primary Care Staff Wellbeing project was not sustainable without further funding.

5. KEY LEARNING FROM THE DEEP DIVE TESTS OF CHANGE

5.1 Key Learnings from the Community Leg Ulcer Clinic project

- Integrating leg ulcer care across community, hospital and general practice teams was complex and required the development of new channels of communication for sharing protocols and clinical information. This required considerable management effort and produced time lag in the roll-out.
- IT systems and communication with IT support about the needs of the project were challenging.
- Leadership and project management experience was essential.
- Detailed documentation of the rationale for the project, steps undertaken to develop and implement the project, etc. was essential for sustainability, and to provide resilience from staff turnover.
- Motivation, determination and perseverance to transform the status quo was necessary – it required a belief that the new way of working would improve care.

5.2 Key Learnings from the Welfare Rights in Primary Care project

- It took time to build relationships with GPs and healthcare professionals, but once achieved, welfare rights advisors were seen as a trusted part of the practice.
- Practice staff perceived improvement in their workload given that they could directly refer to the advisor "in practice".
- Welfare rights advisors saw the benefits of being able to submit well informed cases on behalf of clients.
- Detailed project rationale, documentation and an implementation plan were essential when negotiating with local stakeholders, and for implementation and spread in Dundee.
- Direct access to patient medical records with client permission allowed for more informed decisions to be made regarding entitlement to benefits.
- GPs and health professionals learned more about the benefits system and its processes where they have had access to a Welfare Rights Advisor in practice. This improved the interface between primary and social care.
- This project provided an example of how to learn from interventions which have been implemented elsewhere (implementing the Edinburgh model in Dundee).

5.3 Key Learnings from the Primary Care Staff Wellbeing project

- It was more difficult to make contact and build relationships with primary care staff than with staff in other health care departments. This created a challenge in engaging primary care staff with the Staff Wellbeing Service.
- The project team carried out a limited assessment, and through this process determined that other

assessment approaches may be more appropriate for future similar projects.

- The demonstrated impact of the project has been limited in the 12-month rollout period- 12/66 practices engaged with an introductory session and 2/66 practices engaged with follow-up sessions. Overall, 268 staff engaged with the Service.
- Feedback from individuals who engaged with the Service has been positive.
- GP practices gave mixed feedback about the feasibility of rolling out the Service, with creating time in busy schedules being identified as a significant challenge.
- Further funding is required to continue the existing programme, and particularly when the hurdles experienced with low engagement are overcome, and more staff begin to access the Service

6. DISCUSSION AND RECOMMENDATIONS

This chapter first discusses the key findings from both phases of this case study in relation to relevant policy. It then lists the key learning derived from the case study that may inform future primary care transformation.

Key Findings in relation to policy

The phase 1 scoping exercise identified a diverse range of programmes and component projects that had been undertaken to transform primary care within NHS Tayside. This work advanced the SG 2020 Vision for Health and Social Care in Scotland (1). The work was in line with the NHS Tayside Strategic Framework for Primary Care (4) which outlines five integral areas needed to deliver new types of integrated care in the community. We identified eight overarching programmes in NHS Tayside:

1. Supporting recruitment and retention of GPs
2. Development of the multidisciplinary community hub
3. Supporting mental health and wellbeing
4. Improving multidisciplinary team working
5. Improving ways of working in pharmacy
6. Developing a community transport scheme
7. Developing the Technology-enabled care (TEC)
8. Engaging GPs with IJB priorities

Within these eight programmes, 23 projects or ‘tests of change’ were identified. These tests of change were funded by the Primary Care Transformation Fund, the Primary Care Funds for Mental Health, the Integrated Care Fund, and out-of-hours, recruitment and retention and prescribing funding streams. By the end of phase 1 of this case study (January 2018), 60 % of these projects were fully implemented, and 40 % of the projects were not yet fully implemented. Key informants expressed three concerns relating to the implementation of the identified transformational projects: the short time-scale of the funding; the uncertainty regarding future funding; and the lack of ability of service providers to undertake evaluation and provide adequate evidence for effectiveness and cost-effectiveness.

Three tests of change were analysed in-depth in the phase 2 ‘deep dives’. These were: 1) Community Leg Ulcer Clinic; 2) Welfare Rights in Primary Care; and 3) Primary Care Staff Wellbeing. The Community Leg Ulcer Clinic followed the Healthcare Improvement Scotland SIGN Guideline for the management of chronic venous leg ulcers (25). This guideline recommends such specialist leg ulcer clinics as the “*optimal service for community treatment of venous leg ulcer*”. The Welfare Rights in Primary Care co-location model was in line with the SG nine National Health and Wellbeing Outcomes (42) and addressed the priority of NHS Scotland to deliver better health and care, and increase healthy life expectancy for all (31). The Primary Care Staff Wellbeing project advanced the commitment of the Scottish Government to introduce interventions to improve staff experience as outlined in its May 2010 publication Quality Strategy for NHS Scotland (39).

The Community Leg Ulcer Clinic and the Welfare Rights in Primary Care project had demonstrated positive outcomes. For example, the Community Leg Ulcer Clinic achieved better adherence to guidelines and

improved healing rates, and the Welfare Rights in Primary Care project increased the efficiency of benefit claims and provided a useful example of how primary care and social care services can be integrated. The Primary Care Staff Wellbeing Project had received positive participant feedback. However, the local evaluation did not enable conclusions to be reached about whether or not the project resulted in positive outcomes, i.e. improved primary care staff mental health and wellbeing, and improved retention of primary care staff.

The Community Leg Ulcer Clinic and the Welfare Rights in Primary Care project may be locally sustainable, however further expansion and roll out would require further dedicated funding. The Primary Care Staff Wellbeing project is sustainable only with further funding as it created additional work for the Staff Wellbeing Service.

We identified some important facilitators and challenges to the implementation of these new ways of working.

Facilitators to implementation included:

1. strong local leadership and project management experience (Community Leg Ulcer Clinic)
2. buy-in from the project team in terms of belief that the new way of working will improve care (Community Leg Ulcer Clinic)
3. detailed documentation of the rationale for the project and the steps undertaken to develop and implement the project (Community Leg Ulcer Clinic and Welfare Rights in Primary Care project)
4. starting small (Welfare Rights in Primary Care project as opposed to wide Primary Care Staff Wellbeing project)

Challenges to implementation included:

1. the effort and time required to develop new channels of communication of protocols and clinical information across different teams (Community Leg Ulcer Clinic)
2. difficulties in making contact and building relationships with service users (Primary Care Staff Wellbeing project and Welfare Rights in Primary Care project)
3. challenges with IT systems and IT support (Community Leg Ulcer Clinic)

Key Learnings

- Detailed documentation of the rationale for the project and the steps undertaken to develop and implement the project was essential for implementation and sustainability.
- In addition to strong local leadership and project management experience, motivation, determination and perseverance to change the status quo was necessary to transform care. This required a belief that the test of change will improve care.
- Implementation of the tests of change was facilitated by dedicated funding. However, the short time-scale of funding created problems for achieving the expected impact. Uncertainty regarding future funding in some cases led to an unwillingness to change, and in other cases, impacted negatively on future planning and the likelihood of sustainability beyond the existing, dedicated funding period.
- The lack of time, skills, and expertise of service providers to evaluate the new ways of working created difficulties in generating the necessary evidence of clinical effectiveness and cost

effectiveness. Those charged with overseeing the implementation and evaluation of the tests of change expressed a need for support in designing evaluations, in identifying outcome measures, and in establishing systems for collecting data.

Key Recommendations:

- Tests of change should be recognised by funders and those seeking to implement change as distinct projects which require a clear documented rationale, implementation process, project management team, initial dedicated funding, the ongoing motivation of implementers, ongoing feedback process for monitoring and an evaluation process with agreed outcomes.
- Project management teams and stakeholders need clarity at outset on the nature and process of monitoring feedback and learning processes for iterative change, if any, during the test.
- Project management teams and stakeholders need clarity at outset what conditions would need to be met for further funding for sustainability or roll out, and the possible sources of such funding.
- Project management teams and those implementing change should seek appropriate support in designing evaluations, identifying outcome measures and in establishing systems for collecting data; where such support is not readily available should have clear processes to alert the stakeholder organisations.

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Appendix 1 SSPC National Evaluation Framework Summary

The Primary Care Transformation Fund (PCTF) has £20 million designated to new models of care in primary care, which is part of a £60 million fund covering additional aspects of care such as MH, community pharmacy, and out-of-hours care. The SSPC has been awarded £1.25 million to help evaluate these new models of primary care. Four Health Boards across Scotland have already received funding over the last 1-3 years for specific projects on new models of care, and these have recently also received an additional year of funding (as from April 2016); a larger number of new projects that will be funded to start later this year on the basis of new bids put in by all the Health Boards in Scotland. In addition, Inverclyde has received funding to pilot new ways of working and the new GP Contract, including GP practice clusters, and this work is in progress.

Evaluation Framework

The evaluation framework proposed by SSPC consists of two phases; firstly the identification of the new models of primary care being funded by the SG across Scotland, what their components are, how they are expected to work (theory of change) and what the expected short, medium and long-term impacts or outcomes are. The second phase consists of identifying the impacts, learning, spread and sustainability.

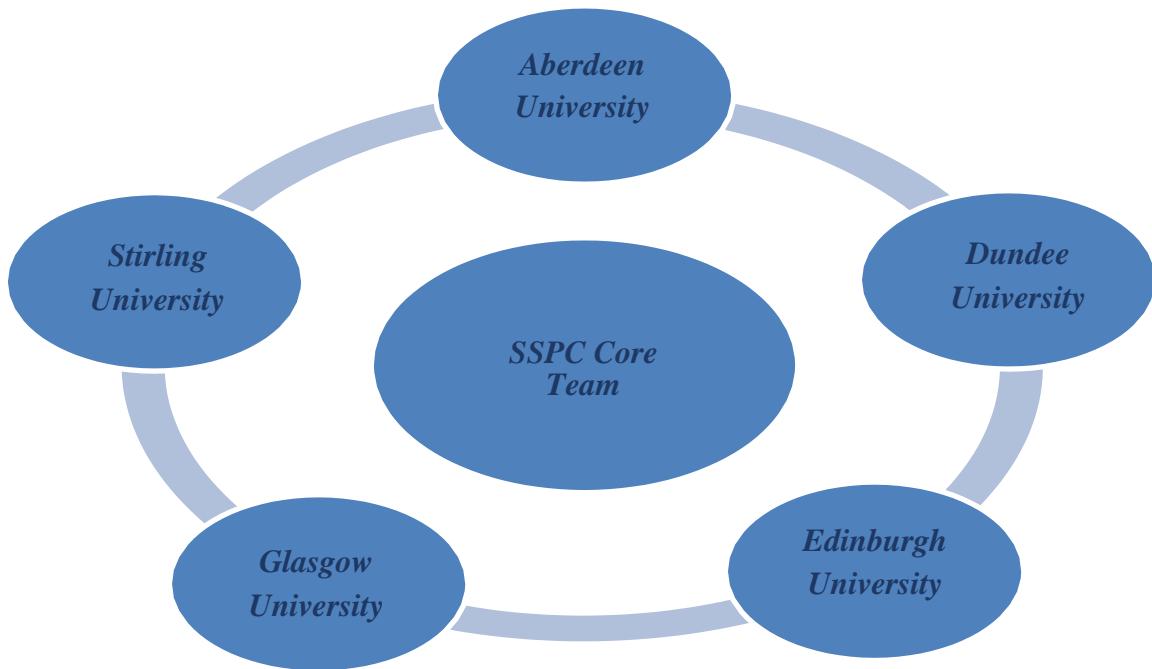


The evaluation will be carried out at two levels, national and local. The national evaluation will include the Scottish Governments own theories of change and expectations of impact, and those of the funded projects at Health Board level. Evidence of Impact, learning, spread and sustainability will be mainly gathered through a limited number of selected local in-depth case studies ('deep dives') carried out by SSPC member Universities in different Health Board regions, together with rapid literature reviews of the best evidence for key aspects of the interventions. This will be complemented with the available evidence from the other sites not selected for detailed case study. In this way, an integrated and detailed sharing of learning will be produced which will be of national as well as local relevance.

How it will work

SSPC works on a hub and spokes model. The small core SSPC team have already been scoping the remit of the renewed and new bids, drawing of evaluability assessment methodology. We will suggest to the SG sites for the 'deep dive' case studies, based on our assessment of evaluability. These will be distributed

across Scotland, and we will ask our SSPC members in different regions to bid for the evaluation of these local sites. The senior researchers in each academic unit will then lead the evaluation of their site with their own chosen team. However, the core team will ensure close co-ordination with the SSPC hub and also between evaluation sites, so that learning is shared and all members will contribute to the integration of findings to inform the national picture. SSPC core staff will additionally continually collect information and learning from the non-case study sites during the course of the evaluation, to complement the case study findings. Thus a fully integrated final national report will be produced, as well as the detailed reports from the chosen local sites. In addition, SSPC will contribute to the evidence-base for the components of the interventions by carrying out a series of literature reviews.



SSPC will also work collaboratively with other key organisations on available national performance data on patient satisfaction and 'big data' (such as unplanned hospital admissions), working in partnership with other key organisation such as central analytical services, NHS Health Scotland, and so on.

Appendix 2 Tayside Primary Care Transformation Programmes, Individual Projects, Components and Expected Transformational Change

Project Name	Project Components	Expected Transformational Change
GP Recruitment and Retention (3 projects)		
Career Start GP	<ul style="list-style-type: none"> Concept - innovative models are required to recruit and retain newly qualified GPs On offer to General Practices across Tayside Modular GP positions - 6 sessions per week in GP, 2 sessions in a specialty area and 2 sessions of CPD. Specialty areas: OOH, Medical Education, Palliative Care, Musculoskeletal, Medicine for the Elderly Funding model - salaried from the mix of transformation monies and pay from practices and specialties 	<ul style="list-style-type: none"> Improve recruitment and retention of GPs Create community-focused, more rounded GPs Improve patient care (due to specialist knowledge of GPs) Reduce hospital admissions (due to specialist knowledge of GPs) Improve GP job satisfaction
Flexible Career GP	<ul style="list-style-type: none"> Flexible GP positions FlexiTime (more security than locum posts) Salaried model Educational opportunities 	<ul style="list-style-type: none"> Improve recruitment and retention of GPs Increase GP job satisfaction
Leadership GP	<ul style="list-style-type: none"> GP positions with additional time to implement new models of care Advance Nurse Practitioner support 	<ul style="list-style-type: none"> Turn around struggling practices Improve GP job satisfaction Improve recruitment and retention of GPs
Multidisciplinary Community Hub Model (MCHM) (4 projects)		
General Model	<ul style="list-style-type: none"> Establishment of care and treatment centres or hubs in a locality Developed integrated community model to other areas of nursing care (e.g. anticoagulant management clinic and catheter clinic) Centralised service provision, information flow Flexible opening hours 	<ul style="list-style-type: none"> Reduce GP practice workload by shifting work to specialised services Reduce GP practice workload by picking up work from secondary care Improve patient care Improve patient experience Improve the accessibility of services

Project Name	Project Components	Expected Transformational Change
	<ul style="list-style-type: none"> Precise SOPs 	
Multi-disciplinary community hub model in OOH (Angus)	<p>3 different models are under consideration</p> <ul style="list-style-type: none"> Provide coordinated care and treatment services Include unscheduled and minor injuries type of work Development based on available workforce “Continuing Conversations” events for public engagement have been held 	<ul style="list-style-type: none"> Improve access to treatment and care Reduce the number of services provided by general practices Improve patient care Improve patient experience Improve the accessibility of services
Multi-disciplinary community hub model in OOH (Dundee)	<p>Paediatrics pilot</p> <ul style="list-style-type: none"> Extra GP shifts: 2-6pm and 7-11pm Saturdays and Sundays Paediatric assessment room provided Paediatric consultant present 2-6pm each Sunday Monitoring of service based on data collected from patients and staff 	<ul style="list-style-type: none"> Enhance GP knowledge in specialty areas Improve OOH recruitment Improve OOH service Improve patient care Improve patient access to services Reduce hospital referrals Improve communication with secondary care paediatric colleagues Enhance learning through on-the-job experience
	<p>Medicine for the Elderly</p> <ul style="list-style-type: none"> Extra GP shifts at weekends to see frail elderly GP able to consult with MFE team Link with the Enhanced Community Support to support people at home 	<ul style="list-style-type: none"> Improve patient journey Reduce hospital admission
	<p>Improving Clinical Leadership in OOH</p> <ul style="list-style-type: none"> Clinical Leads work OOH and unsociable shifts (e.g. Christmas Day) and they provide mentorship and discuss problems Clinical Leads ensure that everything needed for appraisal, e.g. patient satisfaction questionnaires, CPD sessions, they provide mentorship 	<ul style="list-style-type: none"> Improve quality of service Improve access to the services Improve recruitment and retention to OOH Improve OOH staff job satisfaction

Project Name	Project Components	Expected Transformational Change
	<ul style="list-style-type: none"> Clinical Leads give all new staff a one-to-one induction 	
	<p>Specialist Paramedic Input</p> <ul style="list-style-type: none"> Specialist Paramedic when working will base the ambulance in Kings Cross Health and Community Centre car park and consults patients with minor illnesses in OOH when not attending a call. Test of change in progression (as per January 2018) 	<ul style="list-style-type: none"> Improve OOH service Improve patient care Improve patient access to services
	<p>MH Community Triage</p> <ul style="list-style-type: none"> The MH Crisis team is working with Police Scotland Triage service is being offered for the patients known to the police The MH Team aims to extend this service to OOH Trial of direct referral or admitting of patients who are known to MH services 	<ul style="list-style-type: none"> Improve patient care Improve patient access to service
	<p>Listening Service</p> <ul style="list-style-type: none"> Provide support for patients who attend in crisis and would benefit from person centred listening GPs on duty are given contact details of the on call Chaplain 	<ul style="list-style-type: none"> Improve patient care Improve patient access to the relevant services
	<p>Pharmacy Input to OOH</p> <ul style="list-style-type: none"> Review of Pharmacy in OOH Team managed by the Clinical Pharmacy Technician commenced in Nov 2017 Pharmacy Assistant commenced Jan 2018 	<ul style="list-style-type: none"> Shift non-medical problems to appropriate service Improve pharmacy input and processes

Project Name	Project Components	Expected Transformational Change
Multi-disciplinary community hub model in OOH (Perth)	In-hours component <ul style="list-style-type: none"> • Project team established to align Future Community Care and Treatment Centres with Anti-Coagulation and MIIU Provision • Next stage planning - prepare options paper for EMT 	<ul style="list-style-type: none"> • Improve patient care • Improve patient access to the relevant services
	OOH component <ul style="list-style-type: none"> • Extend Roving GP project to cover all Tayside • Next stage planning – continue to offer additional shifts, monitor coverage and costs 	<ul style="list-style-type: none"> • Improve OOH service • Improve patient care • Improve patient access to services
Community Leg Ulcer Clinic, Dundee	System <ul style="list-style-type: none"> • Identified & adapted Westgate Health Centre • Installed equipment (Doppler, foot baths) • Developed referral criteria and patient pathways • Developed SOPs for assessment, treatment, record keeping • Developed criteria for specialist vascular assessment • Developed Patient Specific Directive for patients referred to the clinic • Developed and implemented education pathway and competency framework for district nursing staff • Identified cluster of GPs for trial Patients <ul style="list-style-type: none"> • Assessment clinic: full holistic assessment and care plan • Bandaging clinic: attend until discharged • Different skill mix of staff: assessment clinic staffed with more experienced nurses 	<ul style="list-style-type: none"> • Reduce GP practice workload • Reduce secondary care workload • Improve patient care • Improve patient quality of life • Reduce wastage Improve OOH service • Improve patient care • Improve patient access to services

Project Name	Project Components	Expected Transformational Change
Mental Health and Wellbeing (4 projects)		
Welfare Rights in Primary Care	<ul style="list-style-type: none"> • Co-location of Welfare Rights Advisors to the GP practices – in co-operation between Dundee City Council and GP surgeries • Advisors provide free confidential advice on relevant benefits and services • Advisors have direct access to patients' medical records - this enables them to compile medical evidence to support benefit's claim without GPs input • Patients sign consent form which is put into their medical records • Experienced advisor is dedicated to each GP practice with a backup worker being in place • Simple referral process for the GPs - advisors are included in the booking system as other healthcare professionals • Patients can self-refer • Advisors use private room in the GP practice • Good relationship between practice staff and advisor – the aim is that advisors are accepted as practice members 	<ul style="list-style-type: none"> • Reduce GP workload • Reduce stress-related illness in patients • Improve patient quality of life • Empower patients by ensuring access to advice and information on appropriate benefit • Contribute into the reduction of health inequalities • Improve the interface between social care and primary care
Primary Care Staff Wellbeing	<ul style="list-style-type: none"> • Raised awareness of NHS Tayside Staff Wellbeing Service • Wellbeing and resilience group sessions, e.g. Mindfulness and Values Based Reflective Practice run for primary care staff to enhance team working, learning, development and support • Awareness raised of how to access one-to-one 	<ul style="list-style-type: none"> • Improve primary care staff MH and wellbeing • Improve primary care staff resilience • Improve organisational culture

Project Name	Project Components	Expected Transformational Change
	<ul style="list-style-type: none"> counselling-style support for primary care staff experiencing work-related or personal difficulties • Next stage planning – explore funding options to continue beyond March 2018 	
Listening service: "Do You Need To Talk"	<ul style="list-style-type: none"> • Listening service for patients • Listeners are trained volunteers based in GP practices • GPs refer patients • Listeners invite patients to tell their story • Listener holds and reflects on patient's story; and uses assets- based approach • Listener and patient discuss possible next steps • Patients can make unlimited appointments • Patients can return without GP referral 	<ul style="list-style-type: none"> • Reduce GP workload • Provide another layer of service – gap between counselling and “nothing” • Improve patient care – quick access to the service • Reduce prescribing of antidepressants, analgesics and anxiolytics
Social prescribing	<p>Work evaluated by using PROM for Spiritual Care</p> <ul style="list-style-type: none"> • GPs refer patients with social, emotional or practice needs to Link Workers • Link Workers conduct initial interview to identify patients' needs and concerns • Link Workers help patients to access non-clinical sources of support within the community, e.g. physical activity programmes • Link Workers accompany patients to these sources of support when necessary 	<ul style="list-style-type: none"> • Reduce GP workload • Address social issues underlying health problems • Improve patient care • Improve MH and wellbeing of patients
Multidisciplinary Team Working (5 projects)		
Enhanced Community Support: Frail elderly Rolled out across 3 HSCPs of Angus,	<ul style="list-style-type: none"> • MDT approach around GP teams: MFE consultant, district nurses, occupational therapist, physiotherapist, pharmacist, pharmacy technician, 	<ul style="list-style-type: none"> • Enhance level of work done in primary care • Improve coordination of care • Adopt anticipatory care planning approach

Project Name	Project Components	Expected Transformational Change
Dundee and Perth and Kinross	<ul style="list-style-type: none"> locality geriatrician, etc. Weekly MDT meetings Care tailored to the individual's needs and priorities Dominant MDT member according to the patient's need Rolled out in Dundee and Perth Roll out finished in Angus in Spring 2018 Same core principles and values across 3 HSCPs Model varies according to the local population needs 	<ul style="list-style-type: none"> Keep people living healthier and independently longer Ensure that patient's voice is heard Reduce hospital admissions and length of stay Reduce costs
MH and wellbeing nurses in Links Health Centre, Montrose, Angus	<ul style="list-style-type: none"> Experienced, qualified nurses see patients with emotional distress and possible MH problems early in patient journey – they have time to assess patients Nurses signpost patients appropriately (including to third sector organisations) 	<ul style="list-style-type: none"> Reduce referrals to secondary care Improve patient care
Test of development: Neighbourhood Care in South West Locality (Angus HSCP)	<ul style="list-style-type: none"> Co-locate integrated MDTs System approach to assessment, information sharing and decision making Close liaison with 3rd and private sectors at locality level 	<ul style="list-style-type: none"> Support community resilience Empower patients Improve self-management
Developing sustainable models of GP in the context of integrated care and demographic changes (Academy Medical Centre and Ravenswood Surgery,	<p>General components:</p> <ul style="list-style-type: none"> Learning from Nuka model Family based care approach by teams (GP, practice nurse, healthcare assistant, receptionist, named community nurse) Community development worker to lead social prescribing Health psychologists work across two practices Steering group to support implementation, evaluation and 	<p>Improved patient:</p> <ul style="list-style-type: none"> continuity of care quality of care empowerment partners in their health and wellbeing ease of service use

Project Name	Project Components	Expected Transformational Change
Forfar, Angus HSCP)	<p>professional support</p> <ul style="list-style-type: none"> • Upgraded telecommunication <p>Academy Medical Centre</p> <ul style="list-style-type: none"> • 5 team model • Increased nursing WTE • Educational development of the nursing team <p>Ravenswood Surgery</p> <ul style="list-style-type: none"> • 2 teams led by 2 GP partners • Patients with minor illness access same day clinical assessment or treatment 	<p>Staff and system:</p> <ul style="list-style-type: none"> • Improved recruitment, retention, morale • Whole system redesign to maximize coordination of care • Organisational learning about new models of care • Reduced use of secondary care services
Brechin Medical Practice, Angus	<ul style="list-style-type: none"> • Extended social prescribing model – include volunteer drivers to reduce home visits • Practice-based physiotherapy service – rapid triage and management • MH and wellbeing nurse within the practice • Advance Nurse Practitioner within the practice 	
Pharmacy (2 projects)		
Locality pharmacy	<ul style="list-style-type: none"> • Locality pharmacy teams consisting of practice pharmacists and pharmacy technicians • Work at national level with universities – to engage earlier • Pharmacists attached to GP practices • Working relationships with community, specialist pharmacists and social care colleagues • Priority 2015-2017: focus on complex patients <ul style="list-style-type: none"> • Provide advice, conduct medication reviews (including on hospital wards), support medicines reconciliation, participate in multidisciplinary reviews 	<ul style="list-style-type: none"> • Reduced GP and Practice workload • Improved patient care and outcomes • Empower patients to self-manage • Provide patient-centred pharmaceutical care • Support people in managing/taking control of their health and medicines • Reduce hospital admissions • Improve quality of service • Reduce wastage of medicines • Reduce prescribing costs

Project Name	Project Components	Expected Transformational Change
Community pharmacy	<ul style="list-style-type: none"> • Upskilling, and better use of the skills, of pharmacy team members • Community pharmacists conducting reviews for patients with long-term conditions • Community pharmacists treating minor ailments, e.g. urinary tract infections, using algorithms 	<ul style="list-style-type: none"> • Support people in managing or taking control of their health and medications • Relieve pressure on GP practices • Improve patient care
Community Transport Scheme (2 projects)		
Pilot Community transport scheme	<ul style="list-style-type: none"> • Volunteer collect patients from their homes and take them to their appointments 	<ul style="list-style-type: none"> • Improve patient access to healthcare services
Community transport scheme for less mobile elderly population	<ul style="list-style-type: none"> • Volunteer collect patients from their homes and take them to their appointments 	<ul style="list-style-type: none"> • Improve patient access to healthcare services
Technology-Enabled Care (TEC) (2 projects)		
TEC Perth and Kinross HSCP	<ul style="list-style-type: none"> • Increase the availability and use of TEC • Develop training and awareness sessions for existing or potential users, staff and assessors of TEC • Develop a partnership approach towards the TEC • Expand digital inclusion programs in all localities • Implement trials to use the TEC 	<ul style="list-style-type: none"> • Increased independence of patients and carers • Increased support • Increased access to services • Increased self -management • Reduced need for care • Reduced hospital admissions • Delayed need for residential care
Telephone Technology Florence	<ul style="list-style-type: none"> • Florence sends out automatically programmed text messages • Messages provide tips, support, advice, and reminders to send readings 	<ul style="list-style-type: none"> • Support people with long term conditions • Support people in making positive lifestyle changes • Help people to understand their symptoms • Allow monitoring of the symptoms remotely by the healthcare provider • Reduce the number of appointments
GP Engagement with IJB priorities (1 project)		

Project Name	Project Components	Expected Transformational Change
GP engagement programme Perth and Kinross HSCP	<ul style="list-style-type: none"> • GPs work alongside locality pharmacists to address the Quality Prescribing Agenda • Different reporting measures developed to address prescribing variances 	<ul style="list-style-type: none"> • Fundamental shift in ways GPs work with IJB in delivering sustainable prescribing and transformation of care • GPs commit to work in partnership with P&K HSCP and locality pharmacists to address Quality Prescribing Agenda • GPs engage in the new model of locality working and Enhanced Community Support to reduce unplanned hospital admissions • Engage GPs in MDT approach

Appendix 3 NHS Tayside Primary Care Strategic Framework, Five Key Integral Areas

SERVICE PLANNING	INTERFACES
GPs should work increasingly as part of an extended multidisciplinary team of health and social care professionals, and increasingly the patient and their carers within a locality framework. NHS Tayside will support the formation and development of these localities.	Opportunities should be extended to developing more prospects for shared education and learning across the primary/secondary care interface. This should incorporate data for learning and improvement.
Support should be given to ensure that all practices in Tayside are engaged with the integration agenda, and have an active part in shaping it. This should be in accordance with the best available evidence and meet mutually agreed outcomes. They should help shape new and innovative models of care, supported by a new contractual framework which will have an emphasis on person centred care, safety and quality.	GP's working as integral members of an extended team (<i>similarly to 2. Service Planning</i>) must be willing and engaged partners in the developing agendas of the new Integration Joint Boards. All Boards should support contractor engagement and recognise the resource required to enable this.
There should be an established clear understanding of the roles and accountabilities of each member of the MDT, who will be expected to work "at the top of their licence" which needs to be underpinned by explicit professional governance arrangements.	Contribute to the development of a local information system to successfully introduce the single electronic patient record.
Local communities must be supported to contribute to the better management of their own care recognising and addressing inequity and being equal partners in co-producing services that meet their needs. They should "know who to turn to" and be offered alternatives to the traditional GP model.	Patient safety and quality in Primary Care is recognised as the bedrock to delivering services within the multi-disciplinary team, and should be a priority for investment and development, utilising local and national clinical and academic expertise. This should inform clinical and care governance and include resource and support to implement clinical and care governance support systems such as Datix with clarity around how Primary Care will contribute to both existing and emerging governance structures.
Pathways of care should be co-produced, address inequity and focus on the whole patient journey, beginning with prevention. To empower the "prepared patient" there should be investment in self management, and access to a wide range of information, including early person centred care planning conversations.	The opportunities and interfaces offered by new contractual frameworks are explored and actively developed. The opportunities offered by the new GP Contract and Prescription for Excellence must be explored, with a jointly agreed improvement agenda.
The locality hub model should be tested, and spread if evaluation positive.	Supporting the recommendations of the Ritchie Report: A Tayside wide Out of Hours Strategic and Implementation Plan incorporating all Ritchie Report recommendations should be supported.
Resource is made available to support the delivery of the new Scottish GP Contract.	

SERVICE PLANNING

The work to develop patient focussed, evidence based end to end pathways of care should be strengthened and made a Board priority. Initial pathways should focus on the areas of: frail elderly, dementia, management of complex or undifferentiated illness, and the deteriorating patient in the community. The economic and health impact of these pathways, and the shift into the community should be measured.

There must be a better understanding of access and demand across all parts of the system, supported by data and intelligence to inform and improve pathways of care. Service planning should be both whole system and supported at locality level, utilising integrated resources, and reflecting the needs of the local population. This should be reflected in locality level integrated resource frameworks.

In order to manage more complex care within the community, there must be rapid access to local diagnostics, named teams and readily available resources to support care at home.

There should be facilities and resource within each locality to support care within the local community - the current bed model should be reviewed as a priority, with resource freed to consider new and innovative models of providing step up and step down care supported by the whole MDT. This must include provision for end of life care.

National reviews and recommendations relating to health visiting and district nursing should be implemented without delay.

A new model of immunisation delivery must be developed and implemented as a strategic and public health priority.

Develop a Primary Care Out of Hours Service based upon an MDT model of care operating in-hours with the emphasis upon achieving seamless transitions to support episodes of unplanned care.

INFRASTRUCTURE

A long term strategic capital plan for Primary Care should be developed. This must take account of PFI buildings, and consider new contracting opportunities.

Services and facilities must develop in places where demographic demand is growing. These must be planned and designed in partnership.

The e-Health Strategy must take cognisance of not just the medical interface, but expand to consider the growing need for single record multiple interface freely mobile working. Patient access must be considered in this context. This will require significant and sustained investment and should be considered within the context of the Board's eHealth Local Delivery Plan.

IT systems should be developed to support maximum data set extraction and sharing, supported by robust data protection and governance arrangements. Data sets should support whole system planning, and should increasingly reflect the integrated resource available within each locality.

WORKFORCE & LEADERSHIP

A Tayside wide strategic package of initiatives should be put in place as a priority to support practices currently facing recruitment difficulties and to prevent other practices experiencing these difficulties. A specific Primary Care workforce plan should be considered.

Put in place arrangements to support effective medical leadership and management development.

Primary Care should play an active part in the Academic Health Science Partnership.

Models to support flow of staff and encourage learning and development across the interface should be developed. To support the patient journey across the interface, and support our staff to explore new ways of working, away from traditional models of hospital based to more community based care and prevention.

We must support an improvement culture, with quality and safety- underpinned by clinical and care governance, at the heart of everything we do.

Appendix 4 Methods

The NHS Tayside case study was conducted over a 15-month period (March 2017 to May 2018).

A4a. Case Study Design

The approach adopted for the Tayside case study was based on the SSPC Evaluation Framework agreed with the SG (Appendix 1). This comprises two distinct but complementary phases:

Phase 1 during which the tests of new ways of working in NHS Tayside were identified and scoped in terms of their individual components, anticipated impacts and theory of change underpinning the anticipated impacts. The ‘status’ of each test of change was assessed using an implementation staging system, within which they were classified as: ‘implemented’; ‘in the planning stages, not yet fully implemented’ or ‘not got off the ground or had been stopped’.

Phase 2 focused on exploring in more depth (‘deep dives’) 3 of the identified tests of change, and the key research questions sought to determine their actual impact, key learning, and likely sustainability and spread or roll-out.

Data Collection

The research team collected data from national and local sources. The main sources of data employed were:

1. national and local documents pertaining to primary care transformation in general and/or specific new ways of working
2. interviews with key informants in Tayside.

Document identification

Three strategies were used to obtain documents related to primary care transformation and new ways of working in NHS Tayside:

1. Documents were identified from relevant websites, such as the websites for NHS Tayside and the three Health and Social Care Partnerships (HSCPs) and Integration Joint Boards (IJBs).
2. *Google™* searches were conducted for pertinent documents – search terms included “NHS Tayside primary care transformation” and “NHS Tayside Transformation Programme”.
3. Interviewed key informants were invited to share any relevant documentation related to the overall transformation of primary care transformation in NHS Tayside and/or the specific new ways of working.

Key informant interviews

A snowball approach was used to identify potential key informants to provide information related to new ways of working in NHS Tayside. First, an NHS Tayside member of senior management was consulted to identify other potential senior management key informants. These individuals were then asked to identify

project leads who, in turn, were asked to identify further potential key informants, such as practice managers, General Practitioners (GPs) and practice nurses, who could add to the developing picture of primary care transformation in NHS Tayside.

Two separate interview schedules were developed: one for the key informants who were asked about the new ways of working at the level of NHS Tayside or HSCP, and one for the key informants for specific projects. These interview schedules were based on the SSPC Evaluation Framework.

Phase 1 interview questions included:

- What are the new projects and how do these build on previous work?
- Have the intervention or projects been designed, developed or adapted to the specific context of the local area? If so, how has this been done?
- What are the key components of the different interventions or projects?
- Are these likely to change over the life of the intervention?
- What are the expected impacts in the short, medium, and long-term?
- How do the stakeholders think these impacts are going to be achieved?
- What is the evidence to support this?
- Who are the key stakeholders in terms of future sustainability and spread and what evaluation information do they require?

Phase 2 interview questions included:

- What impact(s) has the intervention, project or programme had in relation to the expected impacts?
- Has the intervention and the expected impacts changed over time?
- Have there been any unintended negative consequences?
- What is the key learning that needs to be shared? Which interventions seem worth scaling up and spreading?
- How easily can these be implemented?
- How sustainable are these likely to be in the long-term?

In additional Phase 2 interview questions probed reach, efficacy, adoption, implementation and maintenance. To explore the mechanisms for successful implementation and integration of the new ways of working into routine work, the questions asked related to areas of: coherence, cognitive participation, collective action and reflexive monitoring.

Potential key informants were initially emailed an invitation to take part in the study – this included a Participant Information Sheet and Consent Form. Once agreement had been reached and arrangements made for the interview, participants were sent a copy of the interview schedule outline to facilitate the opportunity to obtain considered views.

Key informants were interviewed individually in face-to-face or telephone meetings, or in a focus group

discussion. When further information or clarification was required, key informants were followed up by telephone and/or email.

Prior to each interview, key informants signed the study consent form, and permission was sought to record the interview or group discussion. Audio-recordings were transcribed verbatim and depersonalised.

A4b. Data Analysis

Documentary analysis

Data from all documentary analysis were employed to gain a better understanding of the context of the primary care transformation in Tayside, and to complement the results of the interview data analysis. This resulted in evaluation findings being drawn from two sources of evidence as the documents provided corroboration for the interview findings and prompted the evaluation team to seek clarification if necessary. Additionally, during phase 2 more recent IJB documents enabled tracking of the development of some of the projects.

Interview data analysis

Phase 1 key informant interview data and collected documents were analysed in a mainly deductive ('top down') manner, while still allowing for unanticipated themes and subthemes to arise. The analytic framework was based on the phase 1 interview questions.

Interview transcripts were read and relevant data were extracted and coded in accordance with the analytic framework. New ways of working were identified and their key features summarised. This involved outlining the project components, expected transformational change and an example of transformational change where relevant. The 'status' of each project was assessed using an implementation staging system. Within this system, projects were described as: 'implemented'; 'in the planning stages/not yet fully implemented'; or 'not got off the ground/has been stopped'.

The 'status' of projects was a key consideration in the selection of the phase 2 'deep dives'. Analysis of these documents helped provide an understanding the context in which the new models of working were being tested and also a greater understanding of the individual projects. Phase 2 data from the key informants interviews and documents were similarly analysed i.e. mainly deductive ('top down') manner. The analytic framework was based on the phase 2 interview questions.

The interview data were analysed using thematic analysis with the additional 'Framework' step – commonly referred to as 'Thematic Framework Analysis'. To facilitate rigorous data analysis, interview transcripts were entered into NVivo 11. Interview transcripts were read and relevant data extracted and coded in accordance with the analytic framework. Data were then synthesized and interpreted in order to address the phase 2 questions regarding impacts, key learning, potential for spread and sustainability of the new ways of working.

A4c. Ethical Approval

The study was approved by the University of St Andrews Research Ethics Committee on 29 August 2017,

and registered as external Quality Improvement Work or Service Evaluation Project on the NHS Tayside Clinical Governance and Risk Management Database in September 2017.

A4d. Main Key Informant Interview Topic Guide (Tayside wide)

Thank you for agreeing to take part in this evaluation of the new models of primary care; and to interview to discuss your views and experiences of projects that are being tested in NHS Tayside. The interview is concerned with two broad phases of the development and implementation of projects in NHS Tayside.

The first relates to the **theory of change** underpinning each tested project and its **expected impact**. Specifically, we will aim to understand:

- The context of each tested project in NHS Tayside.
- How different projects have been planned and who has been involved in this process.
- What are thought to be the working mechanisms of the projects and what are they expected to achieve.

The second relates to **what has been learned over the lifetime of each project**; and the **perceived sustainability of the projects**.

As different projects are likely to be at different stages of planning and/or implementation, the interview questions will be tailored accordingly.

For information, the questions for each phase are:

1. Phase One: Intervention Theory and Expectations of Impact

- Could you tell me about the work going on to transform primary care in NHS Tayside?
- What projects are being planned/implemented in NHS Tayside that aim to transform primary care?
- Do the projects build on previous work? If yes, how?
- What are the key components of the projects; are they likely to change over the time?
- What are the expected impacts of the projects over the short, medium and long-term; and how are these thought likely to be achieved?
- What is the evidence to support expected impacts and ways of achieving these?
- Do you have plans in place of how to measure the success of the projects, if yes then what measures will be used?
- What information would you require from this evaluation; and how could we support the measurement of the performance of the Tayside programme of projects?
- Who are the other key stakeholders of the main project and its sub-projects?

2. Phase Two: Impacts, Learning, Spread and Sustainability

- What impacts have the projects had so far; and how do these compare to the expected impacts?
- Have the projects changed over the time? Have there been any negative or unintended

consequences?

- What is the key learning that needs to be shared?
- Have data been collected during the lifetime of the projects, and what are their support needs?
- Do any of the projects seem to be worth scaling up? If yes, how easily could they be implemented?
- How sustainable is the Tayside programme of projects in its current form in the long-term?

Is there anything we have not discussed and you would like to add regarding the new ways of working in primary care?

Estimated time for the interview: 45 minutes

Evaluation of Tayside Primary Care Transformation Project

A4e. Key Informant Interview Topic Guide (specific test of change)

Thank you for agreeing to take part in this evaluation of the new models of primary care; and to being interviewed to discuss your views and experiences of name of the project (this section will be updated for specific interviewee).

The interview is concerned with two broad phases of the development and implementation of projects in NHS Tayside.

The first relates to the **theory of change** underpinning *name of the project* and its **expected impact**. Specifically, we will aim to understand:

- The context of *name of the project* in NHS Tayside.
- How this project has been planned and who has been involved in this process.
- What are thought to be the working mechanisms of the project and what are they expected to achieve.

The second relates to **what has been learned over the lifetime of name of the project** and its perceived sustainability.

As different projects are likely to be at different stages of planning and/or implementation, the interview questions will be tailored accordingly.

For information, the questions for each phase are:

1. Phase One: Intervention Theory and Expectations of Impact
 - How was the *name of the project* initiated?
 - Does this project build on previous work? If yes, how?
 - Was the *name of the project* designed or adapted for this specific context?
 - What are the key components of *name of the project* and are they likely to change over the time?
 - Who are the target/participating groups of this project and how have they been involved?
 - Has the name of the project been well received by participating groups?
 - What are the expected impacts of name of the project over the short, medium and long- term; and how these impacts have thought to be achieved?
 - What is the evidence to support the expected impacts and ways of achieving these?
 - Do you have plans in place of how to measure the success of name of the project; if yes then what measures will be used?
 - At the current stage, what are your views on the sustainability of name of the project?
 - Who are the key stakeholders in terms of sustainability of this project?
 - What information would you require from this evaluation?

2. Phase Two: Impacts, Learning, Spread and Sustainability

- What impacts has name of the project had so far; and how does this compare to the expected impacts?
- Has the name of the project changed over the time?
- Are there any negative or unintended consequences of name of the project?
- What is the key learning about name of the project that needs to be shared?
- Has any data been collected during the project and what are the support needs?
- Does the name of the project seem to be worth scaling up? If yes, would it be easily implemented?
- How sustainable is name of the project in its current form in the long-term perspective?

Is there anything we have not discussed and you would like to add regarding the project? Estimated duration of the interview: 45 minutes

Evaluation of Tayside Primary Care Transformation

A4f. Participant Information Sheet

What is the study about?

We invite you to participate in an evaluation of the new models of primary care. Scottish School of Primary Care (SSPC) has been contracted by the Scottish Government to evaluate the new ways of working which aim to transform the delivery of primary care. Projects in five NHS Boards are being evaluated, with NHS Tayside being one of these. The evaluation of the NHS Tayside is being conducted by Professor Frank Sullivan, Ms Katrin Metsis and Dr Kathryn Cunningham at the University of St Andrews.

Our aim is to map and evaluate the progress of new models of care that are currently being tested in NHS Tayside. Evaluation of all projects follows the same framework by focusing on context, impacts and outcomes. Essentially, we aim to identify "***what works, for whom, and in what circumstances***"; and "***tell the story***" of how NHS Tayside is transforming primary care. We will utilise both quantitative and qualitative methods including individual interviews with key stakeholders, review of existing data and documentary analysis.

We will carry out a number of individual interviews with key stakeholders who are involved in planning and delivering projects testing new models of care. This is essentially a scoping exercise to enable us to map what is going on, what projects seem to be making progress as well as what projects have faced/are facing difficulties. We will complement the interview data with available existing local data (e.g. audit reports) and documents (e.g. reports or minutes of meetings). Data collection will be ongoing in order to monitor progress over time with a view to identifying perceived/actual impacts of the projects, barriers and facilitators to their implementation; and their impacts on patients, practitioners and NHS Tayside.

You have been identified as a key informant for reporting on plans and activities relating to primary care transformation in NHS Tayside. Your views are important in understanding the benefits and challenges of these tests of change; and in defining sustainable ways of working in primary care. The enclosed Interview Topic Guide provides more details of the questions we will ask during the interview.

Do I have to take Part?

The study is voluntary and this participant information sheet has been written to help you decide if you would like to take part. If you do decide to take part, you will be free to withdraw at any time without providing a reason.

What would I be required to do?

You will be asked to take part in an individual interview to discuss different aspects of the tested new models of care. This interview will take approximately 45 minutes. With your permission, we will audio record your interview so that we have an accurate account of it. Should you wish, we will send you a transcript of the interview so that you can check the accuracy of its content, and give you the opportunity to provide further comment or clarification on discussion points.

Depending on the timing of the interview, we may contact you later to ask about further developments regarding this project. We will also ask you to provide us with documents that have been used during the development and implementation of the project; these will be used for the documentary analysis.

Will my participation be anonymous and confidential?

We will seek your written consent before the collection of any interview or other data in the Coded Data Consent Form (also enclosed). The information you provide will be depersonalised before analysis and reporting. It will be used for the scholarly purposes only.

Researchers named at the end of this participant information sheet will have access to the data. We also have an agreement to share data across the SSPC Core evaluation team (in the Universities of Edinburgh and Glasgow) and the other SSPC case study teams (in the Universities of Glasgow, Highlands and Islands, and Stirling). This is to enable all the researchers involved to identify common themes in new ways of working throughout Scotland. Only anonymised data will be shared across research teams.

All researchers involved in this evaluation are bound to follow the same rules of data protection and confidentiality. All forms of the collected data will be kept strictly confidential.

Storage and Destruction of Data Collected

Collected data will only be accessible by the researchers involved in the SSPC evaluation, unless explicit, written consent for wider access has been sought from you. Recording devices that are used for recording of interviews will be kept in a locked storage cupboard. All data will be stored on password-protected files (accessible only to the researchers) on secure university servers. For data analysis purposes, all recorded interviews will be transcribed and depersonalised (care will be taken not only to ensure your anonymity but also the anonymity of anyone referred to during your interview). Paper versions of the data will be held in a locked storage cupboard, accessible only to the research team. After this study has finished, data will be stored for a period of ten years before being destroyed in line with good research practice and the University of St Andrews archiving policy.

What will happen to the results of the research study?

This case study will contribute to the evaluation of the new models of primary care at both a national and local level. At a national level, the results will feed into the SSPC national evaluation of the tested new models of primary care. At a local level, the results will provide feedback to local stakeholders. At both levels, the results of this study will contribute to the identification of the new and sustainable models of primary care.

We also aim to publish research results in academic journals and as working papers to share learning at national and local levels, and to enhance evaluation methodologies which support program development. Publication of the research finding will be coordinated with the SSPC and the Scottish Government.

Are there any potential risks to taking part?

The main risk is that a participant may be identified, particularly in a local report, by reporting an expressed view. To avoid this risk, we will not only depersonalise data before data analysis and reporting,

but will also take care to report all views in a generic way so that participants will not be identified by any particular role that they have.

These risks will be addressed through the careful depersonalisation of data and compliance with the data protection guidelines. The procedures which we undertake to ensure the compliance with data protection guidelines are outlined in the Coded Data Consent Form (enclosed).

Questions

You will have the opportunity to ask any questions in relation to this project before completing Coded Data Consent Form. We will also answer any of your questions during or after the completion of research.

Consent and Approval

This research has been considered by the Scientific Officer at the East of Scotland Research Ethics Service; and considered of being a survey seeking the views of NHS staff on service delivery.

Therefore it does not need NHS ethical review under the terms of the Governance Arrangements for Research Ethics Committees (A Harmonised Edition). This study has been granted Ethical Approval through the University of St Andrews' ethical approval process.

What should I do if I have concerns about this study?

If you have a concern or complaint about your participation in the study, you can speak to a senior member of the research team (Professor Frank Sullivan). If your concern cannot be solved at this level, you can contact the Ethics Committee of the School of Medicine at the University of St Andrews.

Professor Frank Sullivan

Professor of Primary Care Medicine
University of St Andrews
School of Medicine
Fm20@st-andrews.ac.uk

Julie Anderson

University of St Andrews
School of Medicine
School Ethics Committee
medethic@st-andrews.ac.uk

Full outline of the procedures governed by the University Teaching and Research Ethical Committee is available at <http://www.st-andrews.ac.uk/utrec/guidelinespolicies/complaints/>

Contact Details

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Evaluation of Tayside Primary Care Transformation

A4g. Participant Consent Form: Coded Data

Researchers

Principal Investigator: Professor Frank Sullivan Researcher: Ms Katrin Metsis

Researcher: Dr Kathryn Cunningham

The University of St Andrews attaches high priority to the ethical conduct of research. We therefore ask you to consider the following points before signing this form. Your signature confirms that you are happy to participate in the study.

What is Coded Data?

The term 'Coded Data' refers to when data collected by the researcher is identifiable as belonging to a particular participant but is kept with personal identifiers removed. The researchers retain a 'key' to the coded data which allows individual participants to be re-connected with their data at a later date. The un-coded data are kept confidential to the researchers. If consent is given to archive data, participants may be contacted in the future by the original researchers or other researchers.

Consent

The purpose of this form is to ensure that you are willing to take part in this study and to let you understand what it entails. Signing this form does not commit you to anything you do not wish to do; and you are free to withdraw at any stage, without giving a reason.

Material gathered during this research will be coded and kept confidential by the researchers involved in the SSPC evaluation of the new models of care. All electronic forms of the data will be kept in password-protected computers located in the University of St Andrews. Paper based materials will be kept in locked cabinets in the University of St Andrews that are accessible only to the research team. After the research has finished, electronic forms of data will be stored in the PURE for the period of ten years. PURE is the web-based Research Information System which brings together key information on research at the University of St Andrews. Physical records (such as paper based documents) will be archived for data verification purposes for the period of ten years in a locked cabinet in a locked room within the University of St Andrews.

Please answer each statement concerning the collection and use of the research data.

I have read and understood the Participant Information Leaflet (Version 1.0: 28.7.2017) Yes No

I have been given the opportunity to ask questions about the study. Yes No

I have had my questions answered satisfactorily. Yes No

I understand that I can withdraw from the study at any time without having to give an explanation. Yes No

I understand that my data/recording/transcripts will be confidential Yes No

I understand that my data will contain identifiable personal data but that will be stored with personal identifiers removed. Only the researchers will be able to decode this information as and when necessary. Yes No

Part of our research involves taking tape recordings. These recordings will be kept secure and stored separately from other records of relating to your participation such as consent forms and transcripts.

Recorded data are a valuable resource in ensuring the most accurate recording of information. In this evaluation, recorded interviews will be transcribed for the purpose of data analysis. Transcripts will be depersonalised before the analysis, and each will be assigned a unique code. We will have a separate file which links the personal details of participants with the unique codes; and this file is only accessible to Professor Sullivan, Ms Metsis and Dr Cunningham.

We have an agreement that data can be shared with the SSPC core team (Universities of Edinburgh and Glasgow) and the other SSPC case study teams (Universities of Dundee, Highland and Islands, and Stirling). All researchers involved in the SSPC evaluation of the new models of care are bound by the same data confidentiality rules. Data will be depersonalised before sharing; and we will use workbook encryption and password protection to share documents.

During reporting of research results, non-identifiable verbatim quotes will be used to provide evidence of the research findings. We will take care that views are reported in a generic way so that participants, or anyone else referred to during the course of an interview, will not be identifiable.

I agree to have my interview being tape recorded Yes No

I agree for my tape recorded material to be verbatim quoted as part of this research Yes No

I agree for my tape recorded material to be used in future studies Yes No

Participation in this research is completely voluntary and your consent is required before you can participate in this research. If you decide at a later date that data should be destroyed we will honour your request in writing.

Name in Block Capitals

Signature

Date



We want to make sure that we give you a good service. To help us do this, please tell us your answer to these questions. We want you to be as honest as you can. Please tick one box for each question, unless otherwise stated.

1) Where did you find out about our service?

- | | | | |
|-----------------|--------------------------|----------------------------|--------------------------|
| Friend/Relative | <input type="checkbox"/> | GP/Healthcare Professional | <input type="checkbox"/> |
| Hospice | <input type="checkbox"/> | Macmillan Nurse | <input type="checkbox"/> |
| Social Worker | <input type="checkbox"/> | Other (please specify) | _____ |

2) How easy was it to make contact with us?

- Very easy Easy Unsure Difficult Very Difficult

3) Did you get what you expected from your contact with the Welfare Rights Team?

- Yes No Don't Know

4) How well did the adviser understand you and your needs?

- Very well Quite Well Unsure Not Well Not at all

5) How well did you understand the information / advice offered by the adviser?

- Very well Quite Well Unsure Not Well Not at all

6) How useful was the information / advice you received?

- Very useful Quite useful Unsure Not very useful Not useful at all

**7) Which of the following did you receive information / advice about?
(please tick all that apply)**

- | | |
|-----------------------------------|----------------------|
| Disability Living allowance (DLA) | Attendance Allowance |
| Macmillan Grants | Social Fund |
| Money Advice/Debt Counselling | Tax Credits |
| Housing/Council Tax Benefit | Pension Credits |
| Carers Allowance | Bereavement Benefits |
| Other (Please specify) | _____ |