

Scottish School of Primary Care
National Evaluation of New Models of Primary Care in Scotland
Executive Summary

Background

Over recent years, the Scottish Government (SG) has progressed a raft of major new policy developments that aim to transform health and social care, with primary care being at the heart of these changes. In 2015, SG established a Primary Care Development Fund (<https://news.gov.scot/news/primary-care-investment>), which included £30 million to test new models of care through a Primary Care Transformation Fund (PCTF) and the Primary Care Fund for Mental Health (PCFMH). ‘Tests of change’ began in every territorial health Board in April 2016, funded until March 2018. The Scottish School of Primary Care (SSPC) – a multidisciplinary consortium of Scottish universities with expertise in academic primary care (www.sspc.ac.uk) - was commissioned by SG to evaluate the progress of these tests of change funded by the PCTF and PCFMH, plus any other innovative primary care projects identified that had the potential to be transformative.

Aims and Objectives

The overall aim of the evaluation, as requested by the SG, was to ‘tell the story of primary care transformation in Scotland’ in terms of the tests of change that were being piloted over the period funded. The specific objectives of the evaluation were to:

1. Identify the location and types of tests of change carried out across Scotland and their progress during the funding period (national scoping).
2. Using a case study approach, conduct in-depth investigation (deep dives) of what was working well and why, in selected case sites (Health Boards) and across Scotland in two professional groups – Advanced Nurse Practitioners (ANPs) and Musculoskeletal (MSK) Physiotherapy.
3. Integrate the findings from the case studies to inform the key overall learning relating to successful implementation.

In this overview report, we present a set of recommendations for future work based on learning from the research which was undertaken to meet the above objectives.

Approach

We used a ‘hub and spokes’ approach, with the SSPC core team leading the national scoping and coordinating the case studies, which were led by senior academics in five of the SSPC member Universities. These were:

- University of Glasgow (NHS Ayrshire & Arran, NHS Lanarkshire, and MSK Physiotherapy case studies)
- University of the Highlands and Islands (NHS Highland, NHS Eileanan Siar, NHS Orkney and NHS Shetland case studies)
- University of Stirling (ANP Case study)
- University of St Andrews (NHS Tayside case study)
-

The main overall report, which draws together the findings from the case studies is available here (www.sspc.ac.uk/reports/) along with the six full case study reports (www.sspc.ac.uk/reports/), which including detailed reviews of the international evidence on primary care transformation,

and factors influencing implementation of ANP and MSK Physiotherapy.

The evaluation involved a two-phase approach, the first exploring the planning and expected impacts of the tests of change, and the second exploring actual or perceived impacts, learning, spread and sustainability. This included any unintended negative consequences. The key sources of data were (a) interviews with key informants and (b) national and local documents.

In phase one, we interviewed 155 key informants, and reviewed 661 national and local documents. In phase two, we interviewed a further 191 key informants and reviewed additional documentation relevant to the selected deep dives. Full details of the approach and methods employed are given in the main report (www.sspc.ac.uk/reports/). We also conducted international literature reviews on primary care transformation, and ANP and MSK Physiotherapy implementation, and reviewed the findings of recent UK reports on new models of primary care which are available here (www.sspc.ac.uk/reports/). A quantitative evaluation using routine NHS data was planned as part of the current evaluation, but due to considerable delays in accessing the data, is now being taken forward as a separate study by the University of Edinburgh, which will report in Spring 2020.

Findings

Objective 1: National Scoping. In total, 204 tests of change in primary care were identified across Scotland during the scoping phase, of which the majority (137) spanned a wide range of different types of tests of change. The remainder involved MSK Physiotherapy (36) and ANPs (31). Most of these tests of change had received PCTF/PCFMH funding, though Health Boards differed in how they used the funds. Some funded a large number of new small projects entirely from these funds, others pooled the funding from various sources to focus on a smaller number of larger, often ongoing projects.

When classified according to the SG's Primary Care Outcomes Framework (<https://www2.gov.scot/Topics/Health/Services/Primary-Care>), 54 of the 204 tests of change focused on the People level (e.g. informed patients), 159 on Workforce level (e.g., new or changed roles), and 144 on System level (e.g., new ways of organising care). Seventy-three focused on one level only, 105 on two levels, and 24 on all three levels. In terms of the expected impacts, in relation to the SG's Primary Care National Outcomes (*as above*) most tests of change focused on improving and integrating the workforce and enhancing the public experience. Only one in 10 projects included reducing health inequalities as an intended outcome, despite this being a key focus of the funding call.

By the end of the scoping exercise of the 204 tests: 118 were implemented as planned; 70 were partially implemented; 12 had not started or had been stopped, and 4 could not be assessed.

Around half of the tests of change that focused on only one or two of the three levels (People, Workforce and System) had been implemented by this time, whereas three-quarters of tests that focused on all three levels had been implemented.

Objective 2: Case Studies/ Deep Dives. Thirty-four tests of change were selected for in-depth investigation. Most of the tests of change were not based on a specific 'theory of change'; interviewees generally referred to the SG's own high-level vision for primary care. Almost all respondents regarded a main outcome as being a reduction in GP workload, though few

expected this to happen within the life of the funded projects. In most cases, successful implementation of the test of change itself was considered the key goal within the funding period.

As indicated above, the (small number) of tests of change that included *all three* levels of People, Workforce and System, appeared to be more successfully implemented, and examples were described in the deep dives. However, in general, there was limited patient or public involvement or consultation in the planning, design, and delivery of tests of change. Similarly, very few of the deep dives had a focus on health inequalities, though there were notable exceptions to this. Although most of the projects selected for the deep dives were successfully implemented, a ubiquitous view was that sustainability depended on future funding. Most tests of change were too small to be considered for spread and roll-out, and many felt unsupported in terms of evaluation. There was no clear pattern of particular types of tests of change being more successful than other. Unintended consequences included a perceived increase in GP workload due to the need for training and clinical supervision of new members of the multidisciplinary team, such as ANPs.

Objective 3: Key Learning. By comparing the key findings of each deep dive, ten overall themes were identified.

1. **Short-term funding is a double-edged sword.** The availability of such funding facilitated the tests of change but the short-term nature impacted negatively on forward planning and sustainability and in some cases led to a reluctance to embrace change.
2. **Building upon or starting anew?** Tests of change that built on previous work and where pre-existing relationships were functional, were implemented more effectively than those that were entirely new.
3. **Top down versus bottom up.** Tests of change that involved front-line staff in the design of new services and had good project leadership were implemented more effectively than those that were 'imposed' from above.
4. **Forward planning.** Tests of change that had a clear rationale and documentation of the steps taken to develop and implement the project were implemented better, and were more likely to become sustainable in the future.
5. **Time to train.** Staff training and clinical and managerial management from within GP practices facilitated implementation, but this was challenging due to current workload pressures on GPs and practices.
6. **Leadership and governance.** National leadership was important in establishing criteria for new roles and responsibilities (e.g. ANPs), but local governance issues regarding clinical supervision, remuneration, and accommodation were also key issues that needed resolving.
7. **System, workforce, people.** Tests of change with perceived early impacts more commonly targeted all three levels: People (e.g., public information and/or engagement campaigns), Workforce (e.g., capitalised on previous relationships and/or developments and invested in staff engagement, training and support), and System (e.g., dedicated funding and protected staff time).
8. **Data and evaluation.** 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.

9. **Demonstrating impact.** This was hampered by the short-term nature of the tests of change and the limited support for data collection, extraction and analysis in order to monitor quantifiable impact.
10. **Core outcomes.** There is a need to identify a core set of outcome measures and to continue to evaluate primary care transformation journeys over the next five to ten years in order to evaluate their actual impacts, sustainability and spread.

As an additional output of the evaluation, the SSPC core team developed a **Primary Care-Implementation Framework** (www.sspc.ac.uk/reports/). Drawing on the data from the case studies this is a pragmatic framework and could be developed into a very useful online tool to guide those charged with implementing new models of care.


Conclusions and Recommendations

Since we started this evaluation of new models of primary care, there have been a number of further developments in primary care in Scotland. These developments include the memorandum of understanding (MoU) established between Scottish Government, The Scottish GPs committee of the BMA, integration authorities and NHS Boards in April 2018 which sets out how each party will work together towards supporting, enabling and delivering the new GP contract and the new models of primary care. This includes the development of locally agreed Primary Care Improvement Plans, and the use of the associated Primary Care Improvement Fund.

The rapid development of change in many different areas of primary care policy in Scotland over the last few years presents challenges to the implementation of these very policies. Embedding these changes within services, so that they can contribute in a cohesive way to future integrated primary care development, will be essential in the next phase of primary care transformation. Based on the findings and implications of our evaluation, and the developments alluded to above, we have identified a number of areas which appear to be priorities for future work on primary care transformation, which we hope will be of relevance to policy-makers, policy- implementers, and clinicians tasked with embedding change at the front-line of the NHS.


Planning, Funding and Time


The lead in time from the SG's initial call for proposals for PCTF and PCFMH funding, to submission, decision, and project commencement was too short. This, plus the differing approaches taken by different Boards, is likely to have encouraged a '*let a thousand flowers bloom*' approach and probably limited the quality of submissions and projects. The duration of the funding (24 months maximum) was also too short, and for some acted as a deterrent rather than an incentive. It also limited the ability of project leads to plan and share experiences and learning, before, during and after the completion of the tests of change.


-  **Recommendation 1:** Although the approach taken in the PCTF/PCFMH fund led to some useful learning, the findings suggested that the next phase of primary care transformation should take a more 'mission-oriented approach', with a focus on a smaller number of larger projects, conducted over a longer period of time, with agreed goals and outcomes and sufficient support for robust evaluation. Decisions on committing future resources in this area should take into account the ten themes identified in the current evaluation. The SSPC-Implementation Framework can provide pragmatic support on the 'nuts and bolts' of planning and implementing such projects and should be made available as an online resource.


Relationships, Roles and Engagement

The complexity of the landscape in integrated primary care grew considerably during the period of the evaluation as the GP contract evolved and Integration Authorities were established. Moving forward, relationship development and maintenance within and between teams and sectors will be crucial. This was notably absent in some tests of change. Engagement and involvement of patients and communities is also a vital aspect of this. In addition, the limited number of tests of change that focused on health inequalities, despite a clear request to do so by the SG, strongly suggests that this is an area of great challenge. Rural proofing of health services has been proposed as a systematic approach to ensure the needs of rural populations are considered in the planning and delivery of health services. This involves a four stage process: ‘what are the direct or indirect impacts of the policy on rural areas?’; ‘what is the scale of these impacts?’; what actions can you take to tailor your policy to work best in rural areas?’; ‘what effect has your policy had on rural areas and how can it be further adapted?’ (<https://www.gov.uk/government/publications/rural-proofing>).

-  **Recommendation 2:** Role clarity, role support, governance, and clear communication channels are required as the primary care landscape becomes more complex. Strengthened support for collaborative leadership and multidisciplinary team-working is required at all levels.

-  **Recommendation 3:** Involvement and participation of patients and communities in the future development of new ways of working in primary care is essential, especially for projects or service developments that directly affect patient care, and should be a condition of funding being granted. The aim should be to include patients, carers, and families in the co-design of projects and service developments, rather than ‘information campaigns’ after the changes have been made.


-  **Recommendation 4:** Further work is required on how primary care can best address, or mitigate the effects of, health inequalities. This should build on existing evidence. Learning should be shared from the experience of the ‘GPs at the Deep End’ group, which should be regarded as an important asset and resource for broader work in inequalities, including vulnerable patients with complex needs living in less deprived areas,(for example, in remote and rural areas, where ‘pocket deprivation’ is common).

-  **Recommendation 5:** The needs of remote and rural populations require that transformation be addressed in a way that reflects rural geography, population sparsity and distances from secondary and tertiary services. Rural proofing of health services should be considered as a systematic approach to ensure the needs of rural populations are considered in the planning and delivery of health services.

Training and Environment


As set out in the Health and Social Care workforce plan part 3, high quality training, with local and national leadership, and adequate clinical supervision is required to develop the multidisciplinary primary care workforce further. This requires a supportive learning environment and suitable physical and digital environments within and beyond GP practices. The environment also includes broader issues including support for staff wellbeing. Current


GP workload pressures are limiting the time available for teaching and clinical supervision, and also making it harder for staff who wish to undertake training for new roles to get the required protected time. The SG overview of Primary Care Improvement Plans highlights the weakness of local workforce planning across PCIPs, as well as suggesting the need for further national efforts on workforce capacity, capability and leadership .

 **Recommendation 6:** The success of primary care transformation over the next few years will require a step change in the development of national and local efforts in workforce planning, capacity, capability and leadership to address workforce and capability challenges across all clinical disciplines. The forthcoming SG integrated workforce plan represents an opportunity to move these areas forward at pace.

Data, Evaluation and Outcomes

A clear message from the current evaluation was the need for more data and evaluation support at a local level. Crucial elements include data availability, collection, analysis, and interpretation. Expansion of the Local Intelligence Support Teams (LIST; NHS National Services Scotland), progress of the Scottish Primary Care Information Resource (SPIRE), the launch of ‘Improving Together Interactive (iTi)’ website, and the establishment of a Primary Care Evidence Collaborative, are all welcome developments. The SG is also currently developing a ten-year Primary Care Monitoring and Evaluation Strategy. In addition to evaluation and monitoring, a focused academic programme of applied research is also required to fill the many evidence-gaps identified in the current evaluation and related literature reviews. Without this, future primary care policy is likely to be poorly evidenced and therefore potentially both less effective in improving patient care and more wasteful. Many of these issues, particularly data availability for planning development and evaluation across primary, secondary and social care, are linked to the need to develop better national digital infrastructure for primary care.

 **Recommendation 7:** A strategic, integrated approach to the generation, dissemination, and implementation of the evidence required to guide the ongoing transformation of primary care is required. The SG’s Primary Care Monitoring and Evaluation Strategy should be accompanied by a Scottish Primary Care Research Strategy, with dedicated funding for high priority applied research in primary care in Scotland. Such research should be co-designed and co-produced by academics, Integration Authorities, practices, patients and the third sector.

 **Recommendation 8:** The rapid development of a national digital platform, as set out in Scotland’s Digital Health and Care Strategy enabling, connecting and empowering (<https://www.gov.scot/publications/scotlands-digital-health-care-strategy-enabling-connecting-empowering/>) has the potential to address many of the issues of data availability and use as well as evaluation and the generation of evidence. This could help to speed up transformation. Consideration should be given to a large-scale demonstrator digital primary care transformation project with clear co-designed and co-produced outcomes and rigorous evaluation. This could be established in both a rural and an urban area, to ensure that the differing contextual needs of both are addressed.