Scottish School of Primary Care

GP Clusters

Briefing

Paper 15

Evaluation of Primary care Transformation

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Improvement Topic Series

The improvement topic series is a set of briefing papers about areas of quality and safety on which general practice clusters could usefully focus improvement activity. They summarise research, guideline and other evidence about areas of care which can be improved, and improvement methods and interventions.

Improvement Topic 15 — Transforming Primary Care

In 2015, the SG invested £60 million in a Primary Care Development Fund, which included £30 million to test new models of care through the Primary Care Transformation Fund (£20 million) and the Primary Care Fund for Mental Health (£10 million). The Scottish School of Primary Care (SSPC) was commissioned by the SG to carry out an independent evaluation of the new models of primary care being tested (tests of change throughout Scotland) during 2016-2018, the key findings of which are reported in this Briefing Paper.

Background

Primary Care in Scotland

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 [1-5]. In 2015, SG established a Primary Care Development Fund which included £30 million to test new models of care through a Primary Care Transformation Fund (PCTF) and the Primary Care Funding for Mental Health (PCFMH) (https://news.gov.scot/news/primary-care-investment). 'Tests of change' began in every territorial health Board in April 2016, funded until March 2018.

The Scottish School of Primary Care (SSPC) was commissioned by the SG to carry out an independent evaluation of the new models of primary care being tested (tests of change throughout Scotland). SSPC is a collaboration between nine Universities in Scotland with expertise in academic primary care (www.sspc.ac.uk). The overall aim of the evaluation was to 'tell the story of primary care transformation in Scotland' over the period funded. The specific objectives 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.

The evaluation took a 'hub and spokes' approach, with the SSPC core team forming the hub, and senior academics from different University members being responsible for the case studies and deep dives.

An early evaluation by the core team of primary care transformation in Inverclyde [6] established an agreed method for the subsequent main evaluation in which there were six case studies, listed below :

- Tests of change in areas served by the following territorial Health Boards:
  - NHS Ayrshire & Arran (SSPC evaluation led by Professor Kate O'Donnell, University of Glasgow)
  - NHS Highland, NHS Western Isles, NHS Orkney and NHS Shetland (SSPC evaluation led by Professor Gill Hubbard, University of the Highlands and Islands)
  - NHS Lanarkshire (SSPC evaluation co-led by Professor Frances Mair and Dr Bautesh Jani, University of Glasgow)
  - NHS Tayside (SSPC evaluation led by Professor Frank Sullivan, University of St Andrews)
- Two themed tests of change across the whole of Scotland:
  - Advanced Nurse Practitioners (ANPs) (SSPC evaluation led by Dr Gaylor Hoskins and Dr Heather Strachan, University of Stirling)
  - Musculoskeletal (MSK) Physiotherapy (SSPC evaluation led by Dr Barbara Nicholls, University of Glasgow

The main sources of data in both phases of the evaluation were (a) interviews with key informants involved in the planning and implementation of primary care tests of change across Scotland and (b) national and local documents relevant to primary care transformation. The empirical research was complemented by three scoping reviews of the published international peer-reviewed academic literature (Primary Care Transformation; Advanced Nurse Practitioners (ANPs), and Musculoskeletal (MSK) Physiotherapy.

Analysis of data from all sources used a thematic approach. The main overall report and the six full case study reports are available here (hyperlink), which include the 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. In phase one, 155 key informants were interviewed, and 661 national and local documents reviewed. In phase two, 191 key informants were interviewed.

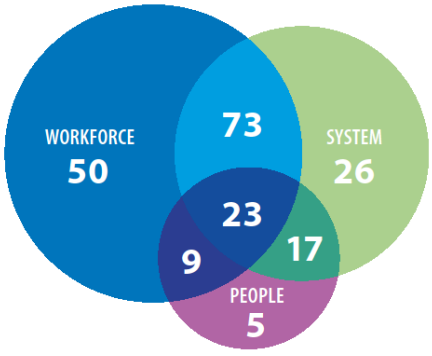
Findings

National scoping study (phase one)

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.

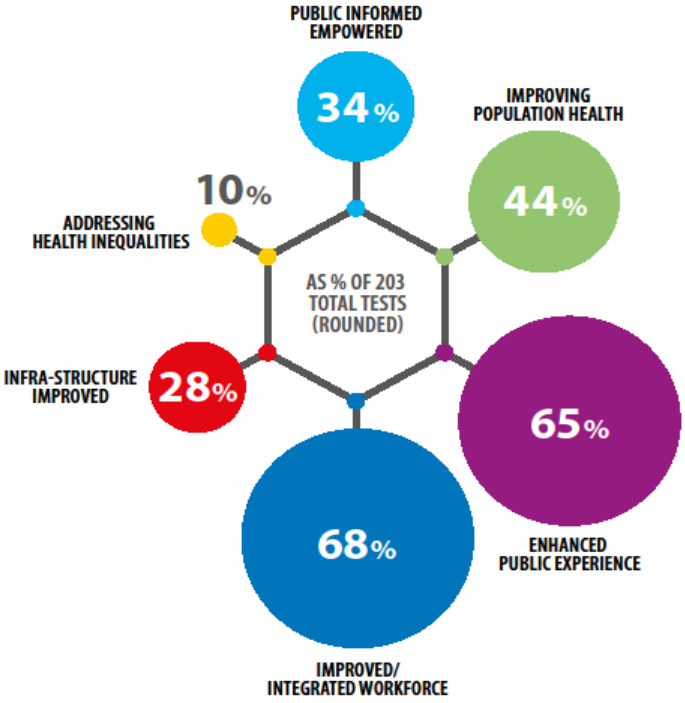
When classified according to the SG's Primary Care Outcomes Framework (https://www2.gov.scot/Topics/Health/Services/Primary-Care), 54 of the 204 tests of change focused on the People level (e.g. informed patients), 159 on Workforce level (e.g., new or changed roles), and 144 on System level (e.g., new ways of organising care) (Figure 1). Seventy-three focused on one level only, 105 on two levels, and 24 on all three levels.

Figure 1. Focus of tests of change



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 (Figure 2).

Figure 2. Anticipated Outcomes of Test of Change in relation to Scotland's Primary Care Outcome Framework



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.

Advanced Nurse Practitioners (ANP) were working across most of Scotland, but it was not possible to quantify the exact number of ANPs in primary care settings. In general, ANPs were reportedly undertaking clinical tasks traditionally undertaken by GPs and included telephone triage, diagnosis and treatment of minor illness, and management of long-term conditions, predominately in surgeries but in some cases by doing home visits. (See separate ANP briefing paper).

MSK Physiotherapy tests of change had two predominant approaches: (1) MSK Advanced Practice Physiotherapists (APPs) in GP practices, as an alternative to the GP as the first point of contact for patients with MSK problems, and (2) NHS24 MATS: Musculoskeletal Advice and Triage Service (MATS), which uses a nationally endorsed triage protocol to triage patients by telephone to either self-management advice or referral to local services. (See separate MSK Physiotherapy briefing paper).

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 that 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**. 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 going forward.

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. Support for GP clusters has been developed via the Healthcare Improvement Scotland ihub [7]. Realistic Medicine is now part of the policy and clinical landscape [8]

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 recommendation in a number of areas which appear to be priorities for future work on primary care transformation. We hope that these will be of relevance to policy-makers, policy- implementers, and clinicians tasked with embedding change at the front-line of the NHS.

Key Recommendations:

Recommendation 1: Primary care transformation should 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 quantitative evaluation.

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: Patient, carer, and community involvement is essential. The aim should be participation 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, and learning from the 'GPs at the Deep End', but include vulnerable groups living in less deprived areas.

Recommendation 5: 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 [9]

Recommendation 6: The success of primary care transformation requires a step change in workforce planning, capacity, capability and leadership to address workforce and capability challenges across all clinical disciplines.

Recommendation 7: A strategic, integrated approach to the evidence required to guide the ongoing transformation of primary care is required. Monitoring and evaluation should be accompanied by dedicated funding for high priority applied research in primary care in Scotland to fill the many evidence-gaps [10, 11].

Recommendation 8: 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.

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