University of the Highlands and Islands
Oilthigh na Gàidhealtachd agus nan Eilean

Primary Care Transformation in the Highlands and Islands

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By the end of the workshop attendees will be able to:

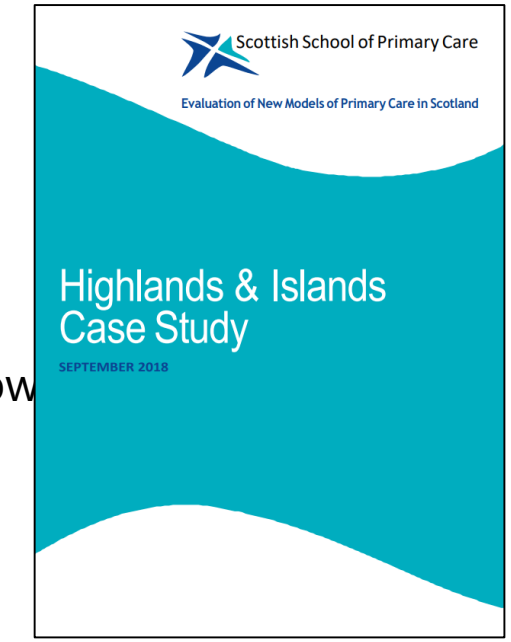
- Describe the evaluation of new models of primary care in the Highland and Islands.
- Report on the key findings of the four Deep Dives selected.
- Identify the key learning from the four Deep Dives selected.
- Discuss the implications of primary care transformation in remote and rural contexts.

Highlands & Islands Case Study

Phase 1: 20 Tests of Change

Intervention Theory & Expectations of Impact

- What are the tests of change?
- What are their **key components**?
- What are the **expected impacts**, how achieved, and what evidence?
- Who are the **key stakeholders** in terms of future sustainability and spread and what **evaluation information** do they require?



Phase 2: 4 Deep Dives

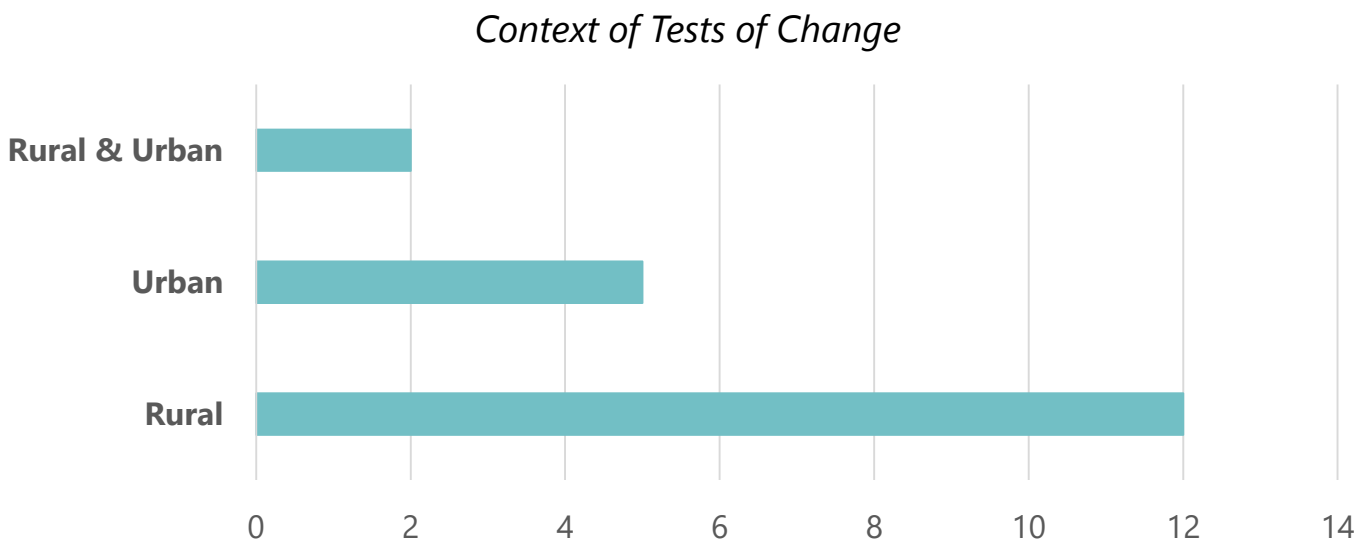
Impacts, Learning, Spread & Sustainability

- What **impact**(s) has the test of change had and have these **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 **sustainable** are these likely to be in the long-term?

Phase 1: March-December 2017

20 primary care tests of change across **4** NHS Health Board areas (Highland, Western Isles, Orkney & Shetland).

Status:13 were Green, 6 Amber,1 Red.



Phase 1: Findings

Built on previous work

Stakeholders supported

Local solutions

Short lead in time

Recruitment

Competing workload

Lack of time

Leadership

Phase 2 (Deep Dives): January-May 2018

NHS Highland — Computerised Cognitive Behavioral Therapy

NHS Highland — Investigation Treatment Room (ITR)

NHS Eileanan Siar Western Isles — Staying Well Programme

NHS Eileanan Siar Western Isles — Self-Management Programme

Deep Dives: Context

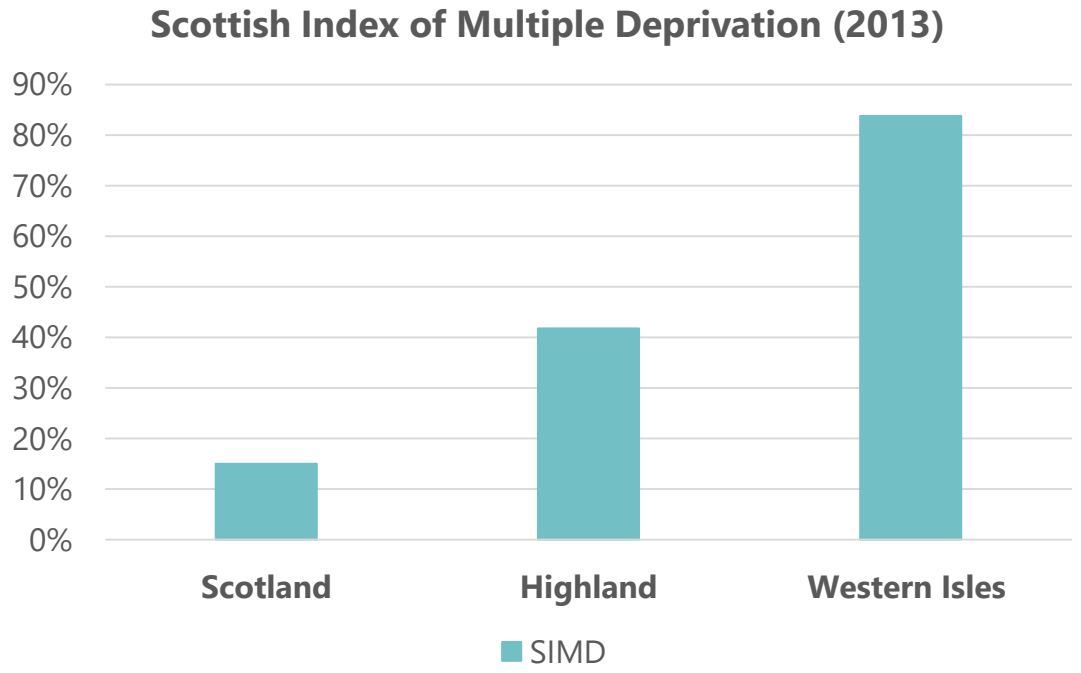
Population:

NHS Highland: pop. 321,990 spanning 41% of Scotland's land mass.

NHS Western Isles: pop. 26,950 spanning 100+islands,15 inhabited.

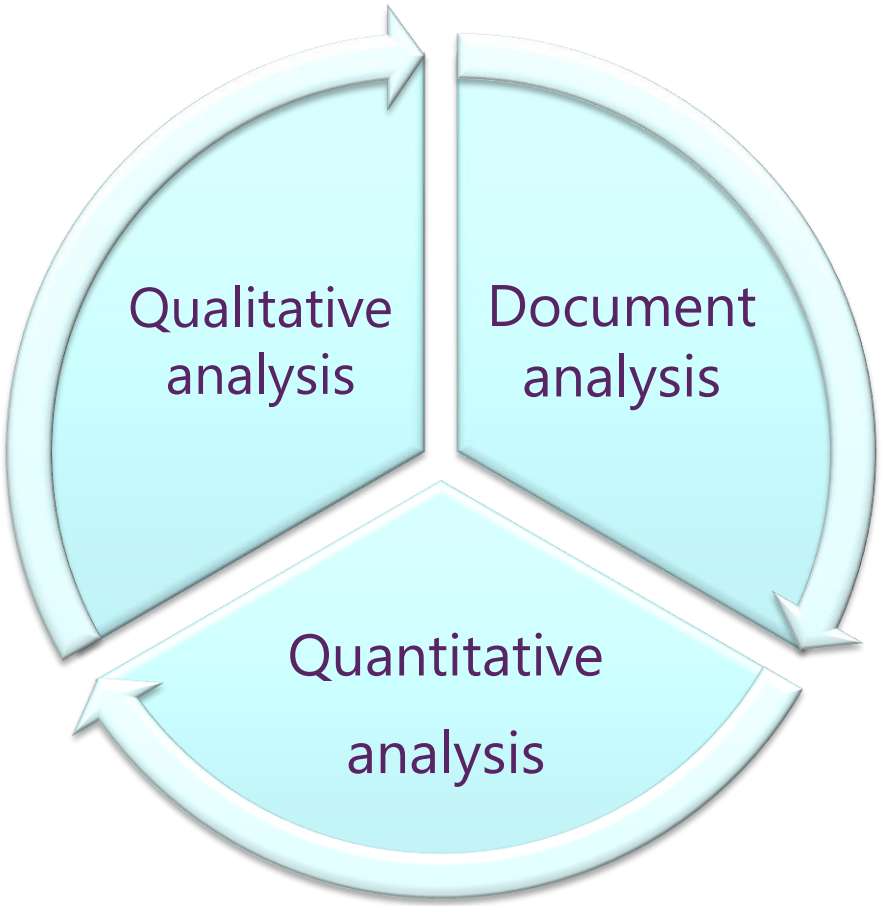
Access:

Centralisation of services to urban centres has been highlighted as an example of inequitable access to health services.



Phase 2 data analysis (deep dives): January-May 2018

- Qualitatively driven mixed methods approach, informed by the SSPC Evaluation Framework.



NHS Highland Deep Dives

Argyll & Bute - Computerised Cognitive Behavioral Therapy

Inner Moray Firth area - Investigation Treatment Room (ITR)

Beating the Blues in Argyll & Bute

- Mastermind is a European Commission project which provides CCBT for patients with mild to moderate depression and anxiety in Scotland.
- Mastermind uses the ‘Beating the Blues’ programme made up of eight online sessions which last approximately 50 minutes.
- Confidential and available online 24 hours a day and has been recommended for use in the NHS by NICE.
- Available in other health boards.

Beating the Blues in Argyll & Bute

- 5 key informants participated in individual interviews.
- Key informants included Cognitive Behavioural Therapists, Primary MH Care Workers, Project Coordinators, and Local Area Managers.
- Some GPs were using the Computerised Cognitive Behavioural Therapy programme but all declined to answer requests for evaluation participation or said that they were too busy to take part.

Key Findings

- Perceived to reduce MH staff workload alongside being used as a way of patients accessing immediate help for their MH problem whilst waiting for appointments.
- Perceived as advantageous for patients in rural areas who wish to keep their MH problems private and away from the public gaze.
- Perceived to improve access to care and reduce travel times - particularly important issue for people living in remote and rural areas.
- GP referrals to the programme could be higher; the online programme would benefit from further publicity.

Key Findings

Completion Rates of CCBT Program Users in A&B

Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Session 7	Session 8
75	52	39	32	25	17	14	12

Distress Level Scores of CCBT Users in A&B

Distress Levels

	1	2	3	4	5	6	7	8
Problem 1	6.67	4.80	4.47	3.93	4.47	4.27	4.20	4.13
Problem 2	6.07	4.93	4.20	4.93	4.20	3.73	4.20	3.33
Problem 3	6.17	4.25	4.58	4.75	4.17	4.08	3.58	3.42

Anxiety and Depression Scores of CCBT Users in A&B

Anxiety/Depression Levels

	1	2	3	4	5	6	7	8
Anxiety Score	3.47	3.20	2.47	2.80	2.93	2.73	2.73	2.40
Depression Score	5.93	4.60	4.20	4.40	4.13	4.20	4.07	3.60

Moray Firth Interface between Primary Secondary Care

- Investigation Treatment Room (ITR), sought to alleviate the pressures on GP practices associated with responding to increasing secondary care requests for blood tests and other procedures.
- Patients from 15 GP practices dispersed across the Inner Moray Firth area attending the ITR rather than own GP practice for procedures requested by hospital consultants.
- ITR clinic created within an existing NHS community hospital site in Inverness.

Moray Firth Interface between Primary Secondary Care

- 32 key informants participated in 4 focus groups and 7 participated in individual interviews.
- Key informants included GPs, hospital consultants, GP practice managers, GP practice nurses, community nurses and administration staff who work in the ITR, and members of the Inner Moray Firth Operational Unit management team.

Key Findings

- Introduction of the ITR model was divisive; a great deal of frustration and difficulty was reported from all stakeholders concerning this unanticipated change to a referral or treatment pathway.
- Perceptions of impact of the ITR differed between urban and remote and rural GP practices.
- Rural practices reported that it had a negative impact on access to care, patients would now have to travel longer distances, to a third site, for a procedure.
- It was reported that GP practices had received a number of complaints from patients about the introduction of the ITR.

Key Findings

Number of ITR Attendance per Month

YEAR	2017										2018	Total
Month	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Number of Attendances	32	162	349	440	472	569	530	480	516	396	525	4,472

- Perception that the ITR shifted how consultants and GPs worked together to treat a patient. Consultants referred directly to the ITR, removing the patient's General Practice from key aspects of their care; some GPs believed had a negative impact on the provision of generalist medicine.

Key Findings

- Nurses in both primary and secondary care perceived that their workload had increased as a consequence of the introduction of the ITR.
- Perceived impact on the district nurse team relating to staffing the ITR, particularly when required to provide holiday cover for ITR staff.
- Despite evidence that the ITR was divisive, there were plans to sustain the model and roll it out across Highland.
- Some of those with negative views appeared to be organising themselves to oppose these plans.


Caledonian MacBrayne

NHS Western Isles Deep Dives

Self-Management Programme
for patients with LTC, minor MH problems & physical symptoms

Staying Well Programme
at the Group Practice

Staying Well Programme

- To provide targeted clinical support from **Staying Well Advanced Nurses** (SWANs) to patients with long-term conditions to alleviate pressure on GPs; located in one GP practice (list size ~7, 900).
- Development post of 22.5 hours (Summer 2016) and thereafter one FTE post (Autumn 2016).
- Service demand led to a shift from **proactive** targeted input by SWANs to **reactive** management of unscheduled care.
- New system of triaging home visits.
- Development of practice handbook.
- Underpinned by clinical supervision.

Staying Well Programme

- 16 key informants participated in 17 individual interviews
  (one interviewee had a further interview to include additional information about the project).
- Key informants included GPs, SWANs, enhanced role practice based nurses, GP Practice receptionists, a GP practice nurse, a GP practice manager and health board managers.

Key findings

- Total number of homes visits increased but GP home visits decreased; only a minority of patients requested a GP home visit.
- Perception of dual benefits of patient satisfaction about care provision received and releasing GP time through reduction in GP home visits.
- Perception that GP support and time for clinical supervision was critical to ensure safe and confident care delivery.
- Awareness raising and informing patients and public of changing roles within the primary care team was necessary to ensure confidence and acceptance of enhanced nursing roles.

Self-Management Programme for patients with LTC, minor MH problems and physical symptoms

- Self-management group courses in non-clinical setting comprising weekly 2hr sessions over 6 weeks; led by a single GP.

  Week 1 *Introduction to Self-Management,* ***Week 2*** *Stress, Sleep, Racing Mind,*
  Week 3 *Pacing, Expectations,* ***Week 4*** *Thoughts, Feelings, Beliefs,*
  Week 5 *Relationships & Communication,* ***Week 6*** *Adaptation & Moving On.*

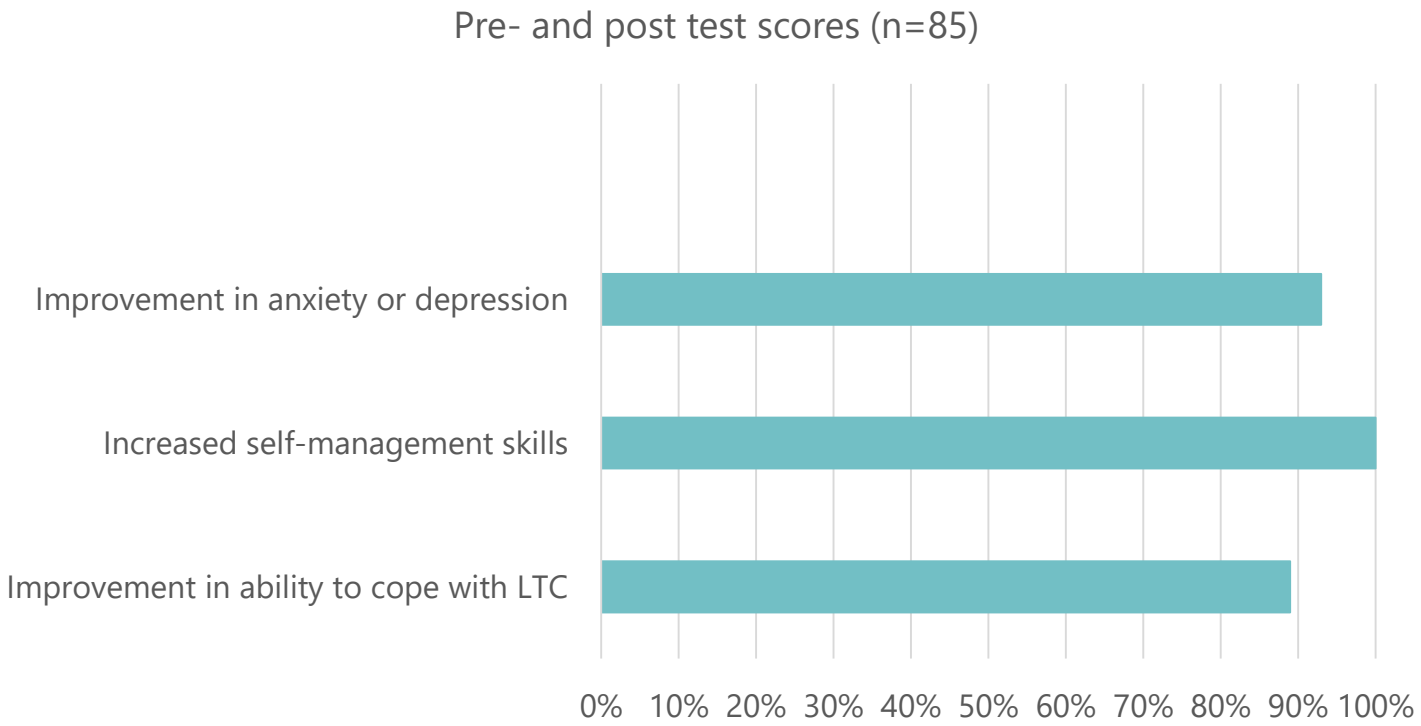
- Courses were based on self-regulation principles of goal setting, planning, self-monitoring, feedback and relapse prevention.
- Techniques included: CBT, Breathing and Relaxation, Mindfulness Based Stress Reduction and Mind Body Interaction, Motivational Practices, Problem Solving, & Behavioural Activation.

Self-Management Programme for patients with LTC, minor MH problems and physical symptoms

- 20 key informants participated in 2 focus groups and 15 participated in individual interviews.
- Key informants included GPs, ANPs, administrative staff, NHS and GP managers, hospital consultants, and members of third sector organisations for people with Long Term Conditions.

Key findings

180 pts referred; 117 pts attended; 79 pts completed the course.



Mean anxiety scores reduced from 10.3 to 5.75 (GAD 7).

Mean depression scores reduced from 13.0 to 8.7 (PHQ 9).

"…this self-management course has literally been a life line for me, I really feel I wouldn't be here today otherwise …"

Key findings

- Perception by healthcare professional key informants that the course had contributed to fewer GP appointments because people were better self-managing their LTC.
- Perception that the course success was due to the particular characteristics of the GP delivering it, which raises challenges for i) sustaining the programme and ii) rolling it out to other areas.
- Uncertainty as to whether observed benefits are maintained in the longer term and/or if there might be need for refresher sessions; this could challenge the feasibility of sustaining the programme.

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In summary

So what….?

Now what…?

Context matters

- Transformation is challenging in remote and rural areas due to location, scale, geographical distances and cultural perceptions.
- Transportation and travel times are fundamental issues to accessing services and the patent experience.
- Online health care programmes have the potential to improve early access to health care support and consequently impact on health inequalities in remote and rural communities.

Rural proofing ought to be considered when planning new initiatives so that projects are appropriate for remote and rural settings.

Stakeholder engagement matters

- Implementation of projects was facilitated when stakeholders were supported to identify problems or gaps in service delivery and were involved in the design of local solutions.
- Consultation with stakeholders during the planning and implementation phase might have been helpful to reach consensus and if necessary revise new models of care.
- Models of primary care that use existing evidence or build on earlier projects were more acceptable to stakeholders.

Co-production including PPI in project design ought to be promoted.

Sustainability, spread and scale

- Sustainability ought to be a key consideration in project design
  e.g. person-dependent projects pose a risk to sustainability.
- Adopting a whole systems approach might have highlighted how change in one part of the system impacts on another, including unintended impacts.
- Self-evaluation of the deep-dives was of a variable quality.

Measurement of actual impacts, sustainability and spread of new models of care will require additional support for data collection and analysis. Evaluations must be adaptive and be flexibly designed to measure unintended impacts.

Thank you

- Questions?

QUALITY IMPROVEMENT

Spreading and scaling up innovation and improvement

OPEN ACCESS

Disseminating innovation across the healthcare system is challenging but potentially achievable through different logics: mechanistic, ecological, and social, say **Trisha Greenhalgh** and **Chrysanthi Papoutsi**

Trisha Greenhalgh *professor*, Chrysanthi Papoutsi *postdoctoral researcher*

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