<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tr>
<td>Staffing Pressures &amp; Sickness Absence</td>
<td>There are 28 different specialities within the secondary care (consultant based) services. A monthly report is provided by our medical staffing team that collates vacant funded posts in relation to fully funded establishment; this report includes all grades of medical staff including doctors in training, although following implementation of the lead employer model in August 2018, doctors in training in NHS Lanarkshire are employed via NHS Greater Glasgow &amp; Clyde. It is important to report across all grades of medical staff delivering care within each clinical area as this gives a better reflection of any clinical risk that may relate to availability of appropriately trained specialist medical staff. Absolute numbers change over time but the figures used for the Health &amp; Sport Committee meeting were from the February 2019 return which covered 777 WTE medical staff comprising 382 consultants, 95 Specialty and Associate Specialist Doctors (SAS grades) and 300 doctors in training grades. The vacancy levels in the February return were felt to be representative of the position with 110.5 posts vacant with a further 17 posts unfilled due to maternity leaves. This gave an overall total of 16% of posts (excluding sickness absence) that were gaps in the clinical services. Of these gaps 85 posts were filled with locum doctors leaving an overall shortfall of 5% across all services. High pressure areas within the 28 specialties include Emergency Medicine, General Medicine, General Surgery, Trauma &amp; Orthopaedics and Mental Health, with gaps ranging from 17% – 30% mitigated by cover from locum staff and reducing to 3% – 8% as an overall shortfall. Shortfalls at this level can generally managed by existing staff providing some additional cross cover. High locum use is not only expensive, but can result in an amended skill mix of staff and issues with continuity of care. NHS Lanarkshire agency locum spend in February 2019 was £1.15m. There are other specialties that have vacancies and gap rates that are significantly higher than average; these specialties and the associated absolute shortfalls before and after locum cover include ENT (37% reducing to 11%), Urology (28% reducing to 6%), Maxillofacial</td>
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Surgery (20% reducing to 10%), Pathology (21% reducing to 11%) and Radiology (15% reducing to 7%) that reflect a national position. There are some additional pressures in a few smaller specialties where locum cover is harder to secure. These include Dermatology & Vascular Surgery. A full breakdown is attached.

Could you also provide some detail on how you are addressing sickness absence and what work is ongoing to fully understand why it is high?

NHS Lanarkshire’s sickness absence rate is above the Scottish average. Having said that, we have a very robust policy in place, which is effective in managing short term absence. As you will note from ISD figures, NHS Lanarkshire is below the Scottish average for short term absence. This is largely as a result of investment in an early intervention system (EASY – Early Access to Support for You) working in conjunction with Human Resources and Locality Managers.

Our hotspot is long term absence, which is above the Scottish average. A wealth of information is provided on a monthly basis to the service to enable them to identify local hotspots; highlighting where staff members have breached our absence triggers and staff are absent on long term sickness. We have further introduced additional reports which highlight those staff on long term sickness absence, linking to Occupational Health advice, and whether there is likely to be a return to work within a specified time, thus allowing managers to have an overview of individual long term absences within their areas and likely return to work dates.

Over the last two years NHS Lanarkshire has encouraged Managers to consider, and where appropriate to do so, bringing staff members back to work in an alternative role. Phasing staff back into work and maintaining engagement in meaningful work, is of benefit to the organisation and the staff members overall health. Despite this work, our long term absence has not improved. Through ongoing reporting it is recognised that staff on long term sick absence are not always being referred to our Occupational Health Service early enough. Work is planned to improve this, which should in turn reduce long term absence, as the earlier support can be provided, the earlier a return can be achieved. A test of change is being implemented within Human Resources, recruiting staff whose primary purpose will be to support Managers in the management of absence.
It is recognised that staff with a mental health related absence are likely to have a more protracted absence, accounting for a greater number of all days lost to the organisation. We have therefore introduced a mental health case management service through our Occupational Health services, whereby staff are referred at an early stage for focussed, proactive interventions over a period of up to 16 weeks, in order to provide additional support throughout their absence and encourage an earlier return to work. Greater collaboration between our Occupational Health Services and Human Resources is also underway; where staff are absent on long term sick and have not been referred for support, this will be communicated to Human Resources colleagues who will action this timeously with the service.

In addition, a review of operational processes is underway, including benchmarking against other NHS and private employers. NHS Lanarkshire has also recently implemented a new policy, affording staff the ability to retire, and return, enabling the organisation to retain difficult to replace skills and experience.

### How has the board contributed to the National Workforce Planning process which was started by the Scottish Government in 2017?

NHS Lanarkshire continues to contribute to the Scottish Government Workforce Planning process in a number of ways. The Board continues to comply with Scottish Government’s Revised Workforce Planning Guidance, CEL 32 (2011); producing an annual workforce plan and submitting Board projections.

In addition, NHS Lanarkshire has engaged in all National Workforce Planning consultations and supported the development of the TURAS data intelligence platform. The NHSL Board Workforce Planning Manager is also fully engaged with the West of Scotland Workforce Planning Group and will provide support to the reinstated National Workforce Planning Forum once re-established.

### What steps are you taking to reduce agency spending?

**Medical and Dental Staff**

NHS Lanarkshire, together with its neighbouring NHS Boards in the West of Scotland (WoS), recognised that Locum Medical staff expenditure was increasing, and in November 2016 the West of Scotland Regional Planning Group initiated a regional approach to managing Locum Doctor expenditure. In particular, this resulted in the award of a managed services contract. This contract was implemented by the majority of WoS Boards with Retinue Health in
February 2017. The contract was inclusive of a baseline set of hourly payable rates for Locum Doctors within the region.

The reality of current market conditions presented a challenge whereby the achievement of these rates was not possible for various reasons. At the end of the initial year of the contract, an analysis of all rates applied was undertaken in collaboration with the WoS Boards. With the changes to HMRC IR35 regulations taking place in April 2017, this analysis has focused on the pay rates both pre and post IR35. The findings of the analysis was discussed through the Regional Group and Board representatives, following which a new locum rate card has been created for short-term agency locums only to help drive down costs. In practice, this means that “target” and “maximum” pay rates have been set. The implementation of the new rate took effect from early 2018. A pragmatic approach was taken so there would be no risk to the service and the implementation of capped rates is monitored. In addition, there was a concerted effort to reduce the high cost agency locums. These discussions took place at local hospital level where alternative arrangements were put in place such as transferring agency locums to contracts of employment and finding alternative options to deliver services i.e. Consultants undertaking additional programmed activities. Whereas the overall costs for agency locums (covering all job families) increased within NHS Lanarkshire in 2017-18, the overall costs for agency medical and dental staff decreased.

In September 2018, NHS Lanarkshire joined with NHS Greater Glasgow and Clyde and NHS Forth Valley Medical and Dental Staff Banks, which has helped reduce the reliance on agency staff. Since September 2018, 465 junior doctor shifts have been filled through the Bank. All options ran concurrently with traditional and international recruitment campaigns.

**Nursing**

There was an increase in nursing agency costs of £459,000 in 2017/18 compared to 2016/17; this was largely due to increase cover in Theatres for vacancies and sickness absence. Further agency spend was also incurred to provide specialist observation by Registered Mental Health Nurses.

There is on-going weekly monitoring of nurse agency use and there continues to be a strong NHS Lanarkshire Nurse Bank which provides a flexible nursing workforce of 450-520 WTE per month.
### Other Staff Groups

In other staff groups, there has been an increase in agency spend of around £1.2m in this period to cover vacancies and, more significantly, due to increased demand for specialist staff to support with specific projects e.g. IT projects (roll-out of new and replacement IT hardware and installations of new systems), implementation of new Laboratory Management Systems, etc.

### NHS Lanarkshire surcharge payments?

David Stewart highlighted that employers normally pay a surcharge for non-EU staff earning over £30,000. **Can you provide the most recent figures for NHS Lanarkshire surcharge payments?**

NHS Lanarkshire is a licensed sponsor with Borders and Immigration and as such are recognised to apply for certificates of sponsorships for prospective employees who come to work from outside the European Economic Area (EEA) and Switzerland. Employment fees vary depending on what type of visa is required and where the prospective employee resides. In addition, from April 2017 NHS Lanarkshire have to pay a skills charge when they sponsor a Tier 2 worker from outside the UK; inside the UK to switch to the Tier 2 visa from another visa or inside the UK to extend their existing visa. The skills charge is £1,000 per annum. Costs incurred are as follows:

- **2016/2017**: £ 2,587
- **2017/2018**: £ 2,393
- **2018/2019**: £14,393

Please note that certificates of sponsorship for Doctors and Dentists in Training are coordinated through NHS Education for Scotland (NES) and are not included in the above costs.

In addition, the individual themselves are required to pay the healthcare surcharge as part of their application. This means that nationals from outside the European Economic Area, coming to live in the UK for longer than 6 months, will be required to pay a health surcharge in order to gain access to the UK’s National Health Service. Further information is available at [https://www.gov.uk/government/news/uk-introduces-new-health-surcharge-3](https://www.gov.uk/government/news/uk-introduces-new-health-surcharge-3).

### Medical and Dental Recruitment

On a more general note, **could you provide some further narrative on recruitment pressures, and more detail on what you are doing to maximise recruitment in both Medical and Dental Recruitment?**

Recruiting to Medical and Dental jobs remains an ongoing challenge across various specialties. There continues to be a number of hard-to-fill specialties including Psychiatry.
the community and acute services to address delayed discharge in particular?

and sub-specialties, Emergency Medicine, General Medicine and sub-specialties, Radiology, Dermatology, ENT and Pathology. NHS Lanarkshire have been successful in recruiting to key Consultant vacancies there remains a turnover through retirements, etc.

The national microsite [www.medicaljobs.scot.nhs.uk](http://www.medicaljobs.scot.nhs.uk) is used as a gateway to Scotland’s Health on the Web (SHOW) for candidates to apply for jobs. This microsite has been used to provide candidates with as much key information surrounding NHS Lanarkshire as possible including Values, Medical Education and developments within the Board. The use of social media, namely Facebook and Twitter, has been developed to highlight hard-to-fill jobs with a further reliance on followers to forward jobs on to prospective candidates. Word of mouth is also encouraged when jobs are advertised to target individuals to apply for jobs; for example psychiatry staff have been networking at events across the UK, and at an event in Pakistan.

To help aid recruitment, a number of initiatives have been undertaken. International Recruitment has been undertaken through NHS GG&C for Consultants in Radiology when NHS Lanarkshire successfully recruited to one post. NHS Lanarkshire have put forward 3 posts for Psychiatry which are making their way through the recruitment process.

The appointment of Clinical Development Fellows has developed into a recruitment campaign in an attempt to appoint 30 split posts (80/20) for August 2019 across Trauma and Orthopaedics, General Surgery, Urology, ENT, Emergency Medicine, Psychiatry, Obstetrics and Gynaecology. The campaign successfully recruited to 18 vacancies.

Work continues on an annual basis with the Academy of Royal Colleges to appoint doctors through the Medical Training Initiative (MTI), allowing doctors to enter the UK from overseas for a maximum of 24 months so they can benefit from training and development within the NHS. Similarly NHS Lanarkshire work with NES to develop jobs for International Medical Training Fellowships (IMTF’s) who can gain expertise from experienced trainers within the NHS. A recent advert has just closed which yielded 5 applications for Emergency Medicine.

NHS Lanarkshire continues to develop the systems that are in place, and is one of three NHS Boards piloting the national Jobtrain recruitment system. Although this is in the early stages it is believed it will deliver tangible benefits in reducing the time to recruit to jobs.
In order to support the Primary Care Improvement Plan and support the desired outcomes of the GMS Contract 2018, a Primary Care Implementation Workforce Recruitment and Retention Group has been established. The purpose of the Group is not to replace any current discipline specific groups, but seeks to bring together information from all disciplines to allow focus to be placed on synergies and challenges in this area.

<table>
<thead>
<tr>
<th>Waiting Times</th>
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<td>Heather Knox acknowledged that in 2015/2016, NHS Lanarkshire had approximately 10 percent of the overall number of patients in Scotland who were waiting more than 12 weeks. This figure has now fallen to 3.8 per cent of those waits. <strong>Can you elaborate further on how this decrease was achieved and what further steps you are taking to eradicate the ‘amber’ indicator?</strong></td>
<td>NHS Lanarkshire has a robust process in place for managing demand and capacity for every specialty. This allow us to understand the gap that exists for each specialty and also the backlog that exists. Regular meetings take place with the specialty management teams where progress on improvement measures is assessed and actions agreed to bridge the gap/reduce the backlog. This include a range of improvement metrics for example volumes of activity through theatre, implementation of new ways of working – clinical pathways, active clinical vetting, virtual clinics and 2 way texting. These are underpinned by a strong clinical and managerial framework which ensures that patients who are waiting over 12 weeks are regularly reviewed.</td>
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| CAMHS - Mr McGuffie advised that some temporary staff have been moved to permanent contracts. **How has the additional resource been funded and what impact has this had on financial targets and overall budget?** | The CAMHS service in NHS Lanarkshire had a number of fixed term posts due to the fixed term nature of some of the funding streams, such as the National Mental Health Improvement Fund and the NHS Education for Scotland Improving Access Fund. A decision was taken to convert these posts to permanent positions to reduce staff turnover. While this did not result in an additional cost pressure to the Board, it did create a financial risk due to the fact that if the national funding ended, the service would be left in a potential overspend position. |

<p>| In a board paper, the Finance Director expressed concern that if funding wasn’t made available from the £146 million attached to national ‘30 Month Waiting Times Plan’, ‘the board would have to balance a significant deterioration in waiting times with a significant financial gap.’ <strong>Could you update the Committee on any funding that has been received or will be forthcoming to address waiting times in NHS</strong> | A recent Scottish Government press release indicated that waiting times funding for 2019/20 will be announced at the end of May 2019. Like other NHS Boards, the performance delivered by NHS Lanarkshire has, in recent years, relied on in year additional funding, the level of which was unknown at 31st March. In order to maintain patient activity levels NHS Lanarkshire committed (at risk) to the first 6 months programme of additional activity. |</p>
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<tr>
<th>Lanarkshire? How has the board approached the allocation of these resources to ensure sustainable improvement?</th>
<th>The Board received confirmation of the 2019/20 funding to support delivery of waiting times on 16 May 2019. Planning work continues with all specialties on best value sustainable solutions to meet the expected level of demand, including plans to separate trauma and elective work in orthopaedics and regional work on ophthalmology and urology. Although better value than relying on purchasing from the independent sector or internal additional waiting list initiatives, these sustainable solutions would still require investment.</th>
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<tr>
<td>Preventative Health</td>
<td>There appears to have been some confusion regarding the prevalence of smoking in Lanarkshire. I am pleased to confirm that NHS Lanarkshire does not have the highest prevalence of smoking, the correct figure is 20.7%. Smoking cessation is a major priority for NHS Lanarkshire and we are seeking to continue the downward trend that we have achieved. NHS Lanarkshire is delighted to be a participant in the Smoking Cessation in Pregnancy Incentives Trial (CPIT): A phase III randomised controlled trial (RCT). The study is funded by Cancer Research UK, Chief Scientist Office Scottish Government, Health and Social Care Northern Ireland, Chest Heart and Stroke Society Northern Ireland, Lullaby Trust, Scottish Cot Death Trust. The trial is currently in progress and results will be available in 2020. We will be pleased to share these results with the committee once they become available.</td>
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<td>We understand Lanarkshire engaged with the pilot project on paying people to quit smoking. Please can you provide further details on the evaluation of this pilot and detail the results it has achieved?</td>
<td>Dr Findlay explained that the family nurse partnership programme works with people with health inequalities and young mothers on smoking cessation. Please can you provide further information on this programme and detail the impact it has had on the community?</td>
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<td>The NHS Lanarkshire Family Nurse Partnership (FNP) Programme is an evidenced based behaviour change programme designed to support first-time young parents. It is a nurse-delivered, intensive, home-based service, based on a therapeutic relationship between the nurse and the client, aimed at • Improving pregnancy outcomes; • Improving child health and development and future school readiness and achievement; and • Improving parents’ self-sufficiency.</td>
<td>The NHS Lanarkshire Family Nurse Partnership (FNP) Programme is an evidenced based behaviour change programme designed to support first-time young parents. It is a nurse-delivered, intensive, home-based service, based on a therapeutic relationship between the nurse and the client, aimed at • Improving pregnancy outcomes; • Improving child health and development and future school readiness and achievement; and • Improving parents’ self-sufficiency.</td>
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Some of the consistent results have demonstrated improvements in woman’s antenatal health, increases in employment and reduction in welfare dependency. Please find embedded power point presentation that highlights the example of smoking cessation in pregnancy.

| Could you elaborate further on Dr Burns’ thoughts on continuous glucose monitoring and early interventions for the condition? Can you elaborate more generally on plans to invest in new technology and preventative measures in relation to diabetes in particular? | The query from the Committee is in relation to 2 different issues:

Type 1 diabetes, Continuous Glucose Monitoring and new tech; and Type 2 diabetes Prevention.

**Type 1 diabetes, Continuous Glucose Monitoring and new tech:**

All Health Boards, including Lanarkshire, provide quarterly reports to Scottish Government.

The last quarterly return is set out below;

**Insulin pump** adults over 18 now 10.7 % compared to 8.8 % in 2017. Absolute numbers are 330 patients in 2017, up to 432 in the last quarter.

**Continuous Glucose Monitoring** 41 patients on CGM including patients on sensor augmented pump therapy.

**Flash glucose monitoring** 715 patients have been using Freestyle Libre. This includes an education session prior to start.

We have a nationally agreed pathway for Continuous Glucose Monitoring starts based on NICE guidance. We do get national funding for pumps and CGMs in addition to NHSL funding. |
<table>
<thead>
<tr>
<th></th>
<th>People with Type 1 Diabetes</th>
<th>No. with Insulin Pump</th>
<th>% on an insulin pump</th>
<th>No. eligible for a pump, but do not have one</th>
<th>No. of people currently with CGM (provided by your Board)</th>
<th>No. of people eligible for a CGM (based on NICE guidelines), but do not have one</th>
</tr>
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<tr>
<td><strong>Under 18s</strong></td>
<td>458</td>
<td>152</td>
<td>33%</td>
<td>&lt; 5</td>
<td>14</td>
<td>&lt; 5</td>
</tr>
<tr>
<td><strong>Over 18s</strong></td>
<td>4054</td>
<td>432</td>
<td>10.7%</td>
<td>Approx 10 - NHSL</td>
<td>41</td>
<td>&lt; 5 – NHSL 7 ref by NHS GG&amp;C</td>
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</table>

**In relation to Type 2 diabetes prevention:**

In relation to investment in new services that will be funded by the Diabetes Framework funds.


The plans for preventative interventions for T2DM which will be piloted this year are as follows.

**T2DM Prevention**

- Let’s Prevent, an intervention aimed at those with Pre-diabetes. It’s a way for patients to find out more about pre-diabetes, help them to manage pre-diabetes & meet and share experiences with others.
- We provide secondary prevention to diabetes patients through individual support programmes. We offer 1:1 support with a dietician and personal training to encourage weight loss.
| **Could you also outline the strategic approach of the board in relation to preventative healthcare, in the context of ‘shifting the balance’ and health and social care integration priorities?** | **T2DM Treatment**
- Counterweight Plus a total dietary replacement programme with intensive specialist support for those diagnosed with T2DM in the last 6 years that aims for large (15Kg+) weight loss to achieve diabetes remission
- Development of a group-based multi-disciplinary diabetes & weight management intervention for those with established diabetes
- Delivery of STEP 2 DM, a structured education intervention for those diagnosed with T2DM

**Adult Weight Management with a T2DM prevention focus**
- Delivery of a weight management intervention for people with additional support needs and their carers
- Enhanced delivery of Healthy Lifestyle in Pregnancy and postnatal weight management
- Enhancement of standard Weigh to Go and the Weigh to Go Specialist Individual Support intensive weight management service The classes offer 45 nutrition input combined with 45 minutes of physical activity. The aim is achieve a healthy weight, contributing to the avoidance of conditions such as diabetes.

**NHS Lanarkshire and North and South Lanarkshire Health and Social Care Partnerships are working collaboratively to shift the balance of care with a particular focus on prevention. Although this is challenging in the current financial climate, and pressures on clinical services, we are working collaboratively with specific focus on reducing inequalities.**

The prevention and inequalities agenda features highly on the board’s agenda and is driven by our high level inequalities action plan. Similarly they are also a key component of both strategic commissioning plans. Currently through our Population Health, Community and Primary Care Committee we are reviewing a number of strategic plans focusing on prevention and inequalities with a view to streamlining these wherever possible.

There are a range of highly innovative programmes of work. The work on smoking cessation is an example of where we have targeted the resources to our most deprived populations. We are particularly proud of our work with the homeless population. We have responded to the findings from our needs assessment and are focusing services that support our homeless population.
The Lanarkshire Green Health Partnership is also an excellent example of how we are promoting participation in physical activity and using the outdoors to promote health and wellbeing particularly in relation to social isolation and mental wellbeing.

Lanarkshire fully embraced the concept of the Early Years Collaborative when it was introduced by the then Chief Medical Officer, Professor Sir Harry Burns. This work has continued and there are numerous examples of innovative programmes that address the needs in early years.

We have engaged the University of Strathclyde, through Professor Sir Harry Burns, to engage in a highly innovative programme to address inequalities. This is at the very early stages.

### Delayed Discharge

**Can you further elaborate on the steps taken to achieve improvements in Lanarkshire?**

In Lanarkshire, a whole-system Delayed Discharge and Unscheduled Care Improvement Board has been created to coordinate activity around the management of delayed discharge.

Across both partnerships, there have been a range of actions as follows:

- **New models of home support** - both partnerships have undertaken reviews of Home Support, with the aim of creating a greater focus on reablement, rapid response (for both discharge and admission avoidance) and specialist support (e.g. end of life care)

- **Reviews of intermediate care** - as part of a whole-system Bed Modelling Steering Group, both partnerships have undertaken reviews of intermediate care. These work programmes have included a review of off-site bed numbers, changes in SW intermediate care, increasing rehabilitation input to the off-site beds and tackling PJ Paralysis. This will create greater step-down capacity from acute sites and improve transitions to community services (around 50% of delayed discharge bed days are currently in off-site facilities)

- **Discharge to Assess** - The development of discharge to assess models is a current area of focus. This will enable more complex cases to be discharged home with a wrap-around support to allow assessments to take place in the patient’s own home. This maximises the opportunity to maintain independent living, while also reducing
the chance of over-provision of services or supports. In North Lanarkshire, over 50 patients have now been supported home via discharge to assess
- **Redesigning the AWI Pathway** - the pathways for patients undergoing the guardianship process have been reviewed in line with the national best practice statement, significantly reducing the number of over 100 bed day delays (the national best practice guide aims for completion of the process within 91 bed days)
- **Hospital Interface** - a system is in place that supports conference calls across the system to coordinate complex cases and times of challenging performance.

**Estimated Date of Discharge/Dynamic Board Rounds** – a programme has been in place to roll out across all three acute sites in Lanarkshire, with an added focus of increasing pre-noon discharges.

| Reviewing the figures from January 2018 to January 2019, please can you explain why there appears to be little improvement on delayed discharge year on year compared to other health boards? | While January 2019 proved to be a challenging month in Lanarkshire due to increased demand, overall there have been marked improvements in delayed discharge performance in the 2018/19 financial year. If taking performance from April 2018 to January 2019 cumulatively across the Board area, overall delayed discharge bed days have reduced by 12%.

<table>
<thead>
<tr>
<th>April - Jan</th>
<th>NHSL</th>
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<tbody>
<tr>
<td>2018/19</td>
<td>54845</td>
</tr>
<tr>
<td>2017/18</td>
<td>62435</td>
</tr>
<tr>
<td>Improvement</td>
<td>-7590</td>
</tr>
<tr>
<td>% Improvement</td>
<td>-12%</td>
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| What steps are being taken to resolve this important issue in Lanarkshire? | See commentary above. |

| Please can you also provide further information on the work of the delayed discharge integrated teams in Lanarkshire and how patients are supported when they leave hospital? | The question posed by the Committee was in relation to the response made by Ross McGuffie about the arrangements in North Lanarkshire, therefore this information relates to North Lanarkshire only.

The Integrated Rehabilitation teams commenced across all six Localities in North Lanarkshire in November 2018. The work of the teams was recently shared with all Chief Officers in |
Scotland for a session with the Cabinet Secretary and Secretary General, with the summary attached below:

Since March, over 50 individuals have been supported home from hospital via discharge to assess, with wrap-around Home Support packages and immediate input from the Integrated Rehabilitation teams.

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<tr>
<th>Question</th>
<th>Answer</th>
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<tr>
<td>When will the Cabinet Secretary’s target to eradicate delayed discharge be met in Lanarkshire?</td>
<td>The Cabinet Secretary has indicated that the Board’s focus should be on taking all possible action to reduce over 72 hour delays, due to the deterioration this causes. Delayed discharge is an area of significant focus across both partnerships, aiming for continuous improvement across all areas. Both partnerships have participated in the recent national benchmarking exercise on delayed discharge and will maximise the learning opportunity this brings. Whole-system actions plans are in place and progress is reviewed frequently within both the Corporate Management Team the Board’s Population Health and Primary and Community Services Committee.</td>
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<tr>
<td>Heather Knox mentioned that ‘Lanarkshire is unique in that it has an emergency referral centre”. Please can you further elaborate on this point and provide statistical information? Can you also advise the extent to which this programme is cost effective?</td>
<td>The Elective Referral Centre (ERC) was established in June 2008. The annual call rate volume at that point was 17,521, this compares to the annual call volume in 2018 of 26,880 (56% increase). The centre is staffed by nurse call advisors. Formal feedback has previously been very positive and a recent meeting with East Kilbride GP cluster the functionality and routes of referral were well received, and GP’s offered positive feedback on the service, and suggestions for increased referral routes such as alternatives to acute/secondary care. We are about to initiate a review of the service to establish if even more functionality can be achieved.</td>
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<td>How does the board balance the urgent requirements to reduce delayed discharges with the strategic need to</td>
<td>Within Lanarkshire, the strategic developments across delayed discharge and unscheduled care are coordinated via a whole-system Improvement Board, co-chaired by the two Chief Officers and the Director of Acute Services.</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
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<tr>
<td>ensure that reductions in unscheduled treatment and care are sustainable?</td>
<td>The Measuring Performance Under Integration dataset has been a helpful development in this area, widening the focus to cover both elements. Tackling unscheduled care is absolutely vital in reducing demand on hospital and doing so will also impact on delayed discharge. Wider programmes such as the Primary Care Improvement Plan and Mental Health Strategy will provide community based alternatives that will be fundamental to creating a sustainable change.</td>
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**Primary Care**

Given the shortage of physiotherapists in Lanarkshire, please can you elaborate on this model (physiotherapists working on a rotational basis, moving from hospital to a GP environment) and provide further information on the financial impact of this initiative?

As discussed at the Committee, this is a proposed model and has been postulated as a potential method of improving recruitment and retention whilst also ensuring that recruitment to one part of the system does not impact negatively on another. It looks at a model which offers rotational posts as a way of maximising resource whilst offering interesting careers. It also allows for a greater skill mix of staff. The model is currently being worked up for further discussion with relevant groups.

What representation have you made to the Scottish Government about this lack of access (to the primary care indicators) and how does the lack of access restrict your ability to monitor and if necessary, drive improvements in the services they deliver on your behalf?

Since the removal of QoF (Quality and Outcomes Framework) in 2016 in preparation for the new GP contract which saw a move to GP Clusters driving quality, it has been more difficult for NHS Boards to monitor General Practice, although there is data on ISD, which is helpful.

At the Committee meeting Dr Findlay specifically detailed the lack of access to SPIRE (Scottish Primary Care Information Resource) https://spire.scot/ for Boards. Since the Committee meeting, the National Monitoring and Evaluation Strategy for Primary Care has now been published and sets the strategic context for monitoring and evaluation of Primary Care until 2028.

The new contract sets quality improvement firmly within GP Practices and Clusters and the revised national guidance around cluster working is expected in the near future.

How does or will the board work, through locality planning, with GP clusters in the context of a growing focus on multi-disciplinary teams.

There are regular Locality Forums in each Locality which allow engagement with GPs and also the fostering of collaborative working between GPs and locality management colleagues, including the integrated locality manager, locality lead GP, senior nurse,
fieldwork manager and service manager. In the context of these forums discussions around locality infrastructure e.g. integrated health and social care teams are taken forward.

In the context of the PCIP the negotiating group for GPs is the GP Sub Committee. We also work with GPs through the locality structure to agree the allocation of PCIP workforce e.g. GPs were consulted on in relation to the new Phlebotomy Services and via locality structures GPs have agreed the allocation the first tranche of pharmacotherapy resource.

The model for the Primary Care Multi-Disciplinary Teams (MDT) is being developed in collaboration with the GP Sub Committee and will be similarly discussed and developed with GPs at a locality level taking cognisance of the resources which are already in the locality to ensure synergy of resource rather than duplication.

| Are there examples of good practice of cluster/MDT working? What are the elements of success and how have these been evaluated and reported? | In the context of the PCIP, MDT working is currently at a test of change level. We have not yet undertaken the implementation of a full cluster model but do have positive examples of MSK Physiotherapists working across a number of practices. In addition and currently ongoing is an Advance Nurse Practitioner Test of Change. This sees 3 practices working with the ANP team, with the ANPs attending patients requesting urgent care visits. This test of change is due to end in the next 2 weeks and has been successful in the rural setting, showing that a number of practices are able to triage urgent house visits to a single resource. A further test is planned in an urban setting immediately thereafter. |
| What steps are you proposing to increase patient use of primary care instead of secondary? What role does the Primary Care Improvement Plan have in addressing such challenges in Localities? | 90% of health care contacts occur in primary care settings. There is a local group chaired by the Director of Acute Services which looks at reducing reliance on the emergency department, which is only one aspect of shifting the balance of care.

The PCIP will see more staff working in Primary Care which will have 2 main benefits - firstly it will improve access to primary care services by increasing the range of professionals available to patients. Secondly the PCIP implementation supports GPs in their role as expert medical generalists, meaning they will have more time to focus on patients with complex multi morbidity, much of which can be appropriately managed in the community by GPs, again meaning more people can be seen and managed in primary care in a more proactive and planned way, thus reducing the need for emergency care in Secondary Care Settings. Both of these benefits will reduce the numbers of people attending the ED for management |
of health issues which could and should be managed in Primary Care settings and additionally will support shifting the balance of care.

The PCIP cannot sit in isolation in the above aims and we are already seeing our localities test initiatives which move people from crisis to more planned care, (thinking in particular of our COPD work) we are also pushing the boundaries of what can be managed in the community with tests of change around IV therapies in the community and step up care. There are also gains to be had by looking across whole system pathways and ensuring Modernising Outpatients considers both sides of the Primary/Secondary Care interface.

Monklands Hospital

You mentioned that of the overall £42 million backlog maintenance, more than £31 million relates specifically to Monklands hospital. There is a physical-fabric problem at Monklands which has had an impact on the recruitment and retention of domestic and nursing staff to the hospital and delivery of a high quality service. What steps are you taking to resolve or manage this issue and restore staff morale at the hospital?

We are working very hard to recruit to additional staff at University Hospital Monklands (UHM). We recruit a batch of the new out turn of registered nurses once per year, picking up the opportunity for winter bed planning at that stage as well, to reduce the need to recruit again. In particular UHM have been recruiting all year round both new and experienced staff to try to reach optimum levels of staffing. There are some areas within UHM where the teams use a small proportion of vacancy funds to manage fluctuations in demand, this is supported by a strong infrastructure of additional staffing solutions to meet demand.

UHM hold at least daily huddles to manage workforce governance and work across directorates and the whole site, with the support of flexible staffing solutions (excess hours, overtime and bank) to meet the demands on the service. There is also a weekly workforce governance meeting which looks retrospectively at the past week and also looks at the week coming to ensure any known issues are dealt with using the most efficient staffing solution.

The practices of each of the acute hospital sites is monitored through a workforce, staff and financial governance perspective, to ensure all aspects are reviewed to understand pressures, meet demand and safely replace staff at the most financially efficient level.

The site continues to recruit on an ongoing basis to support getting staff into posts and are developing a range of strategies to attract staff to UHM.

There is recognition that there has been significant investment at Monklands to ensure that the facility can continue to provide clinical services. This maintenance work can, however,
be disruptive and a current challenge is the current level of Domestic vacancies, currently at 8%. We employ staff over a range of shift patterns covering the full 7 day period, and staff can request to change their working patterns to maintain work life balance e.g. carer/child care responsibilities - this does result in an additional level of staff movement, which compounds the vacancy factor.

Domestic staff do, however, continue to work closely with nursing and estates colleagues to deliver a safe environment for patients, visitors and staff against this backdrop.

<table>
<thead>
<tr>
<th>Are there any differences in cleaning and infection control regimes between the PFI and non-PFI facilities? Could you elaborate on how each is managed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. All NHS facilities within Lanarkshire, PFI and non-PFI, adhere to the NHS Scotland National Cleaning Specification, which sets out clearly the cleaning regime requirement. NHS Lanarkshire undertakes a rigorous continuous monitoring regime across all facilities using the NHS Scotland Facilities Monitoring Tool (FMT). The results of these audits are reported to Health Facilities Scotland (HFS), and are published quarterly, in the public domain.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Given the recent issues at the Queen Elizabeth University Hospital (QEUH) regarding water hygiene, external cladding, the ventilation system and glazing failures which have raised concerns regarding patient safety, what steps are you taking to ensure a similar situation does not arise at Monklands?</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is an NHSL governance arrangement (Statutory Compliance Group) which oversees the application of rigorous healthcare facilities technical guidance in relation to achieving statutory compliance, mainly through updates on regular planned preventative maintenance programmes. Any emerging issues from the QEUH Report are shared at Scottish Facilities Group, chaired by Health Facilities Scotland (HFS). HFS coordinate responses from NHS Boards and where required this includes the undertaking of specific surveys, such as in the case of the Pigeon associated infection lessons learned from the QEUH report. Where known national industry design or construction standard shortcomings have been identified (e.g. Edinburgh schools wall ties, Grenfell Fire cladding issue) a systematic check of NHS Lanarkshire properties has been undertaken to identify any probability of similar issues being identified in the NHS Lanarkshire estate. These checks have not resulted in the identification of any material issues presenting significant risk to NHS Lanarkshire building users.</td>
</tr>
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<tr>
<th>To what extent are the challenges of recruiting domestic staff exacerbating the issue of health hazards in the healthcare environment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The application of continuous monitoring of the cleanliness standards using the NHS Facilities Monitoring Tool (FMT) is key to ensuring that resources are allocated to the areas of highest priority, and this approach ensures that the level of domestic vacancies does not</td>
</tr>
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</table>
In light of the (MRRP) controversy, **how would or does the board approach public involvement differently when considering the need for change in service delivery or reprovision?**

**NHS Lanarkshire’s approach to stakeholder engagement is in line with the Scottish Government’s guidance CEL 4 (2010) “Informing, Engaging and Consulting People in Developing Health and Community Care Services” which includes the principle of involving public and service users in service changes at the earliest opportunity.**

NHS Lanarkshire works closely with the Scottish Health Council (SHC) to ensure compliance with CEL 4 (2010) particularly in relation to the SHC’s assurance role for major service change consultations. NHS Lanarkshire undertook a major service change consultation on the replacement or refurbishment of University Hospital Monklands in 2018/19. The consultation, which ran from 16 July until 15 October 2018, gave the public, patients, carers, NHS Lanarkshire staff and many other stakeholders across Lanarkshire and the wider West of Scotland the chance to share their views at public meetings and through other channels. Cabinet Secretary for Health and Sport Jeane Freeman established an Independent Review Team (IRT) in December 2018 to review the Monklands public consultation and options appraisal undertaken by NHS Lanarkshire.

NHS Lanarkshire will fully take into account any recommendations and implications from the IRT’s report to inform future service change engagement activity. The IRT is due to present its report to the Cabinet Secretary on 31 May 2019.

**How does the Scottish Government support the board in disinvesting in locally-valued assets and services?**

**Scottish Government has been very supportive of the Board’s programme for the disposal of property and assets declared as surplus, in providing flexibility in relation to the receipt of funds and their reinvestment into local patient care, and in supporting the Board to disinvest in local services where this has been identified as prudent and necessary, and the local engagement undertaken in line with current guidance.**

23 May 2019
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Smoking Cessation in Pregnancy

Tracy Henderson, Health Improvement Practitioner
Susan Kayes, Family Nurse Supervisor Team A
NHS Lanarkshire
Local and national policies and strategic drivers

➢ Improving Scotland's Health – Raising Scotland's Tobacco-Free Generation

➢ Smoke-free Lanarkshire – For you, for children, forever: Lanarkshire Tobacco Control Strategy 2018 – 2023

➢ Smoke-free Generation – 5% prevalence by 2034

➢ Local Delivery Plan 2018/2019 Target is 1,287 twelve week quits from SIMD 1 & 2
Impact of smoking in pregnancy

- Causes harm to the baby in the uterus from day 1
- Every day a baby dies in the UK related to their mother smoking in pregnancy
- Smoking while pregnant is the main modifiable risk factor for stillbirth
- Smoking while pregnant is the number one risk factor for babies to die unexpectedly after birth
- Smoking in pregnancy has up to twice the impact on birth weight as illegal drug use. Stopping smoking in pregnancy is at least as important to improving pregnancy outcomes as abstaining from illegal drugs such as heroin or cocaine during pregnancy
Impact of smoking in pregnancy

- The highest levels of smoking before or during pregnancy were among those aged under 20 (57%).

- Mothers aged under 20 were also the least likely to have given up smoking at some point before or during pregnancy (38%).

- There is evidence that self-reported smoking is under-reported and that the true smoking figures for pregnant women may be underestimated by up to 25%
Percentage of current smokers at booking appointment, by maternal age

Year


Percentage

<20 20-24 25-29 30-34 35-39 40+
Percentage of current smokers at booking appointment by deprivation category
Target group

Pregnant women enrolled on the Family Nurse Partnership Programme who smoked during early pregnancy.
Aim

- To support women to stop smoking during pregnancy.
- To support women who lapse in their quit attempt in pregnancy to stop again.
What we did

Training initially for 3 Family Nurses:

- Increase knowledge of health implications for baby and mother
- Awareness of local and national smoking cessation provisions
- Supplied with and trained in the use of carbon monoxide (CO) monitors
- Use of scripted conversation to support a brief, evidence-informed conversation with pregnant women who blow a high CO reading.
What we did

- Improved referral pathway to local Quit Your Way Services
- Awareness of ‘Quit my way‘ resources.
- Joint visits
- Provision of additional materials to complement existing FNP facilitators.
- Smoking raised at each pregnancy visit when reviewing their antenatal health list.
- Use of electronic cigarettes and nicotine replacement therapies in pregnancy
3 Family Nurses initially tested the CO monitors with 21 clients who smoked in early pregnancy.
Stopped smoking: 57%
Reduced smoking: 23%
Continued to smoke: 20%

Outcome of test
Outcome of test

- CO monitoring at FNP visits was acceptable to clients.

- Family Nurses felt confident to support a brief, evidence-informed conversation with pregnant women who showed a high CO reading.
Following test all Family Nurses in team participated in training and were provided with CO monitors.
Family Nurses identified 88 women who smoked in early pregnancy.
Smoking Statistics at Intake

- Smokers: 88
- Not smoked in previous 48 hours: 47
- Smoked in previous 48 hours: 40
- Not captured: 1
Smoking Statistics at 36 Weeks

- Smokers: 88
- Not smoked in previous 48 hours: 54
- Smoked in previous 48 hours: 28
- Not captured: 6
Challenges

- Some initial confusion with correct use of CO monitors
- 1 member of our team off on long term sick
- Specialist Smoking Cessation Nurse left post
- Clients willingness to engage with Smoking Cessation Services
- Reviewing the data
What are we considering next

- Tested home monitoring in infancy
- PurpleAir sensors
Chief Officers Group Health and Social Care Scotland  
Sharing Practice Session 12th April 2019

<table>
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<tr>
<th>Chief Officer: Ross McGuffie</th>
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<td>Title of Presentation</td>
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**Situation:** Brief summary of the issue faced – keep this brief as focus of discussion is to be on the solutions.

Following an intense period of engagement with service users, HSC staff, GP’s and acute clinicians it was identified that there were many sources and destinations for referral for community rehabilitation in North Lanarkshire causing possible inefficiencies and duplication.

North Lanarkshire Health and Social Care Partnership are committed to the continued evolution of a locality model of health and care. The commissioning intentions direct us to develop multidisciplinary teams that include a range of professionals which include physiotherapists and occupational therapists, within the six localities. The Rehabilitation plan is to provide early supported discharge, to include the provision of intensive rehabilitation which may have previously been provided in acute hospitals and to respond in crises to prevent admission where possible.

**What action did the IJB take:** We are looking for examples of service redesign; new models or change processes where you can evidence have delivered improved outcomes for less/the same resource. How did your leadership influence the process?

Health and Social Care North Lanarkshire (HSCNL) commissioning intentions have recommended a central, locality based point of access for rehabilitation/therapy service. It has been acknowledged that to reduce overlap and duplication, therapists from the acute sector, community and local authority should be co-located in an integrated community team by using a unique joint system of triage and prioritisation. From 18th September 2017 in the Motherwell Locality, the demonstration site ensured service users received timely access to the appropriate service and practitioner. This placed rehabilitation and reablement principles at the heart of social service and care delivery in the Motherwell Locality.

The Motherwell demonstrator project has realised the potential to achieve these ambitions, beginning with one small integrated therapy team that has now evolved over a 13 month period to Integrated Rehabilitation Teams in all 6 HSCNL localities. The overarching aim is to develop and strengthen rehabilitation services within HSCNL by
shifting 25% of capacity. This redirection of resource will allow service users to be seen by the right person, at the right time in the right place and will allow for greater focus on early intervention and prevention strategies. Achievement of this aim should help balance the increasing demands required with an ageing, frailer and more expectant population.

The roll out across all 6 Localities was accomplished due to a tremendous team effort from multi-disciplinary colleagues: Human Resources, Finance, IT, Trade Unions, Admin Team and Senior Management. The first few months has identified some issues (IT, office equipment, administrative support, referral sources, the challenges supporting staff in new teams and new ways of working) however each week we move closer to resolving those.

The integrated rehabilitation model was rolled out across all six North Localities on 29th October 2018, following the successful completion of the Motherwell Demonstration Project. The work in Motherwell has shown significant service benefits, particularly around shorter waiting times and increased coordination of activity, in line with our aspirations for creating a single service from the point of view of the service user which we anticipate over the next few months and years the other localities service users and staff will also benefit from this way of working.

**Impact:** *What difference has your approach made?*

A number of achievements to date have been noted below:

- ✓ Co-location
- ✓ Shared IT
- ✓ Increases Ease of Access with reduced waits
- ✓ Development by front line staff and implementation of the Prioritisation Tool with triage process
- ✓ Increased use of Fast track clinics (outpatient clinics for assessment and provision of equipment)
- ✓ Development and introduction of a rehabilitation focused community care assessment Level 2
- ✓ Reduction in waiting times for physiotherapy and Social Work occupational therapy
- ✓ Reduced Home Support requirements
- ✓ Increase in number of service users being assessed and receiving Reablement services
- ✓ Positive staff feedback
Other:

- Project Board and Operational group established
- Staff and partnership communication at all levels and HR process at project board level.
- Staff development and refection sessions for team members and those immediately affected (e.g. CARS leads). These sessions included staff in the early stages of operational planning and feedback from staff was hugely positive, despite some understandable anxieties. (Appendix 3)
- Staff shadowing, sharing roles and experience
- Wider social work team support, involvement
- Team meetings established
- Databases being established to ensure clear demand, capacity and queue data to inform future service levels
- Standing Operational Procedure devised based on the Motherwell experience which will be shared with the other localities
- Communication Plan
- What has also been evident is the streaming of communication has been instrumental in preventing duplication.
- Information leaflet for service users, families, carers and other agency staff.

**Motherwell Data**
Core components of your example which should be applicable across Scotland:
Potential for replication. We want to be able to demonstrate that we are going beyond sharing learning to implementing learning across Scotland as applicable to the different contexts.

The guidance from the leaders that have supported this process indicated that there are **FIVE** essential components required to ensure effective Rehabilitation Teams which are:

1. Universal Use of Prioritisation Tool
2. Leadership Structures, including professional governance
3. Staff Engagement sessions to clarify roles and responsibilities
4. Administrative Support
5. Shared processes including IT

It is also crucial to note that the rehabilitation roll work is not in isolation and links with the following HSCNL **Interconnecting workstreams**
- Reablement
- First Point of Contact
- Making Life Easier
- Intermediate Care Model
- Discharge to Assess

<table>
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<th>How you intend to deliver your 5 min input?</th>
<th>E.g. short video clip, slides</th>
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<tbody>
<tr>
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<td>Slides, including service user feedback</td>
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National Monitoring and Evaluation Strategy for Primary Care in Scotland
National Monitoring and Evaluation Strategy for Primary Care in Scotland
Introduction

Primary care is an individual’s most frequent point of contact with the NHS. Its influence on population outcomes and the function of the wider health and social care system cannot be overstated. This National Monitoring and Evaluation Strategy for Primary Care sets out the Scottish Government’s approach to ‘telling the story’, through research and analysis, of the changes we are seeking to deliver through the reform of primary care in Scotland over the next 10 years. It will help to ensure that we understand what works, where, for whom and why, and at scale, and have the evidence needed to shape sustainable policy and service developments. We also need to better understand how primary care contributes, across the wider health and social care system, to equality of outcome and access in Scottish society, to ensuring our communities thrive, and to delivering public value.

The research, data collection and analysis activity which will deliver the intentions of this long-term strategy will focus on primary care service redesign and reform policies. This activity will acknowledge the interdependencies between primary and secondary care, social care, community resources and services, and public health, while maintaining an emphasis on work designed to reshape primary and community care.

The definition below, from professional bodies representing clinical staff, offers a useful perspective on what primary care means. Clearly, however, delivering high quality services to meet outcomes for individuals, communities and organisations requires the combined inputs of many non-clinical workers. This includes management and administrative staff, social workers and social care workers, others who connect patients with public resources and assets (e.g. Community Links Workers), and those who provide unpaid care to family and friends. This understanding of the wider community of organisations and individuals who have a role and a stake in primary care will shape the research and analysis we undertake and commission to deliver this strategy.

Primary Care in Scotland: a definition from clinical professionals

“Most of the time, people use their own personal and community assets to manage their health and wellbeing and achieve the outcomes that matter to them. Primary care professionals enhance this by providing accessible health care and support to individuals and families in the community, when it is needed, at whatever stage of life “Primary care is provided by generalist health professionals, working together in multidisciplinary and multiagency networks across sectors, with access to the expertise of specialist colleagues. All primary care professionals work flexibly using local knowledge, clinical expertise and a continuously supportive and enabling relationship with the person to make shared decisions about their care and help them to manage their own health and wellbeing. Primary care is delivered 24 hours a day, 7 days a week. When people need urgent care out of core service hours, generalist primary care professionals provide support and advice which connects people to the services they need, in a crisis, in a timely way.”

Background: Primary Care Policy in Scotland

There is clear international evidence that strong primary care systems are positively associated with better health and better health equity. Figure 1 illustrates how the Scottish Government’s six Primary Care Outcomes align to the National Health and Wellbeing Outcomes\(^2\) and the National Performance Framework.\(^3\) Tackling inequalities runs as a thread through the Primary Care Outcomes and associated actions to deliver them.

Figure 1: Scottish Government Primary Care Outcomes\(^4\)

As set out in “The Health and Social Care Delivery Plan”,\(^5\) the Scottish Government’s vision for the future of primary care is for enhanced and expanded multi-disciplinary teams, made up of a variety of roles across health, social and community services, each contributing their unique skills to improving outcomes for individuals and local communities. This will help deliver our aspiration of care being provided at home or in a homely setting, and help ensure rewarding, well-supported careers for our healthcare workforce. Getting primary and community care right is an essential component in ensuring the health and social care system is sustainable, helping achieve the Delivery Plan’s “triple aim” of better care, better health and better value.\(^6\)

With our local and national partners, we have embarked on an ambitious programme to support and develop primary and community care. The First Minister announced in October 2016 an increase in funding for primary care of £500 million by the end of the current


\(^3\) [http://nationalperformance.gov.scot/](http://nationalperformance.gov.scot/)

\(^4\) [http://www.gov.scot/Topics/Health/Services/Primary-Care](http://www.gov.scot/Topics/Health/Services/Primary-Care)


\(^6\) Based on the Institute for Healthcare Improvement’s Triple Aim Framework - [http://www.ihi.org/engage/initiatives/TripleAim/Pages/default.aspx](http://www.ihi.org/engage/initiatives/TripleAim/Pages/default.aspx)
Parliament. This investment will see at least half of frontline NHS spending going to community health services and will enable us to expand the primary care workforce to deliver improved patient care. Our commitments to significantly develop and expand the primary care multidisciplinary team (MDT) are set out in our national primary care workforce plan.  

The next three years will see significant reform in primary care that will provide the bedrock for what we do in the years beyond 2021. The General Medical Services Contract for GPs\(^8\) establishes a refocused role for all GPs as Expert Medical Generalists (EMGs) and as the senior clinical decision maker in the community. The Memorandum of Understanding (MoU)\(^9\) between Integration Authorities, the British Medical Association, NHS Boards and the Scottish Government supports the delivery of the EMG role through service redesign and the expansion of the multidisciplinary workforce. The MoU sets out agreed principles of service reconfiguration (including patient safety and person-centred care), ring-fenced resources to enable the changes to happen, new national and local oversight arrangements, and agreed priorities over the 3-year period 2018-2021. Locally agreed Primary Care Improvement Plans (PCIPs), produced for the first time in summer 2018, outline how Integration Authorities, working with their partners, will deliver the aims of the MoU.

These changes are part of wider ongoing reforms to primary care in Scotland. This includes the removal of the Quality and Outcome Framework (QOF) and the establishment of Improving Together,\(^10\) a national quality improvement framework to support the work of GP Clusters. The Transforming Roles Programme\(^11\) is ensuring nationally consistent, sustainable and progressive roles, education and career pathways for nurses, supported by investment in additional training and continuous professional development. There has been considerable investment in testing new models of care and improvement in every territorial Health Board in Scotland, with the Scottish School of Primary Care (SSPC) tasked with capturing key learning from tests funded by the Scottish Government. Innovative models are also being tested in our national boards (particularly the Scottish Ambulance Service and NHS24) to improve patient outcomes. Developing the analytical, digital and physical infrastructure in primary care to help facilitate wider reforms continues to be a key long-term strategic priority.

Recently, “The Review of Progress with Integration of Health and Social Care”,\(^12\) conducted under the auspices of the Ministerial Strategic Group for Health and Community Care, was

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published on 4 February 2019. It includes a commitment to develop a framework for community-based health and social care integrated services, including primary care services. The framework will be key in identifying and promoting best practice in local systems to clearly illustrate what “good” looks like in community settings, with a firm focus on improving outcomes for people. The Scottish Government and COSLA will lead this work, involving Chief Officers and other partnership staff to inform the framework.

All these developments sit within a dynamic context of: Health and Social Care Integration and the 2020 Vision to shift the balance of care from secondary to primary and community care settings;13 “The National Clinical Strategy”14 and Realistic Medicine;15 Scotland’s “Digital Health and Care Strategy”;16 continued public sector financial challenges; increased demand arising from demographic change and more complex clinical cases; workforce pressures; and evolving clinical practice. It is also essential to see the reform of primary care within the context of “the Scottish Approach” to designing and delivering public policy and services.

Our Strategic Approach to Monitoring and Evaluation

This Strategy sets out the overarching national approach and principles for how we will evidence and understand the reform of primary care between now and 2028, through varied and ongoing evaluation research and data analysis.17 The Scottish Government and its partners will use the approach outlined in this document to prioritise research and analytical activity and to allocate resources. Over the 10 years of the strategy, we will build the evaluation evidence base through, for example: bespoke research projects commissioned by the Scottish Government, using methods appropriate to the specific research questions; synthesis of data and findings from others’ research and evaluation within Scotland and internationally; and expansion and improvement in primary care statistics. Fundamental questions for national evaluation of primary care will generally demand the triangulation of different sources of qualitative and quantitative evidence.

Much of the considerable work needed over the next decade to ensure that we are capturing and understanding changes in primary care will not be undertaken by the Scottish Government or the national health boards.18 It will happen in diverse places, generating evidence for and about primary care. There is merit, therefore, in having a shared vision and principles for evaluation, a shared outcomes framework and agreed national indicators which

13 https://www.gov.scot/Topics/Health/Policy/2020-Vision
14 https://www.gov.scot/Publications/2016/02/8699
17 Our approach was informed by close collaboration between the Evaluation Team at Health Scotland and the Scottish Government, and by dialogue with the Primary Care Evidence Collaborative (see Annex 3).
18 References to NHS Health Scotland and ISD should be taken as accommodating their inclusion in the new body Public Health Scotland which will be established in 2019.
offer the basis of an approach that delivery partners and researchers could apply and adapt. This would support the comparability of evidence across the country and over time.

The strategy incorporates the **Primary Care Outcomes Framework**, which maps out activities and policies with their relationships to intended outcomes (Annex 1\(^{19}\)), and introduces a set of key **National Indicators for Primary Care Reform** for system-level measures. An annual **Primary Care Monitoring and Evaluation Workplan** will set out the priority research projects and data activities for that year. We will use the outputs from this work to populate the Outcomes Framework as evidence and learning emerge.

**Scope of the Strategy**

For national government, there are two main drivers for evaluation: learning and accountability.\(^{20}\) National policy evaluation must be objective, dispassionate, proportionate and rigorous. Evidence needs should be carefully identified and prioritised as early as possible, with sound methods for data-capture built into projects and policies (that have clear articulated and plausible outcomes), to maximise the potential for meaningful evaluation and learning. It is important that monitoring and evaluation are not viewed as being done to those who are responsible for delivering primary care or as a post hoc activity. Rather, we want to foster an evidence-based culture within primary care, where evaluation, monitoring and other intelligence needs are considered from the early phases of conceptualising and shaping a new way of working or a new policy. This includes an appreciation of the complexities of policy development and implementation within systems as well as the relevance of different forms of evidence, at every step.

The focus of this strategy is: informing strategic policy decisions; understanding the impacts of policy at a national level; and being able to give a good, evidence-based account of what difference primary care reform has made for individuals and communities, the workforce and the system, especially at scale. Its outputs and the processes involved in its delivery will contribute to the ongoing evolution of our thinking about the purpose and potential of primary and community care

We recognise that, below the national level, learning needs to be captured and fed back in ways and over timescales that are better achieved through **improvement activity and local self-evaluation**. These generate evidence which can contribute to national evidence of what works and why. The role of Healthcare Improvement Scotland (HIS) is core here (especially through the improvement and evaluation support they provide to Health and Social Care Partnerships and GP Clusters, their ihub\(^{21}\) and the Scottish Health Council\(^{22}\)) to support effective public and service user engagement in the design and delivery of primary care services. Delivery of the evidence for this strategy will partly depend upon the wider knowledge generation and research capacity-building of the Primary Care Evidence Collaborative and its member organisations, and the activities of other generators and

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\(^{19}\) Also on the Primary Care section of the Scottish Government website - [http://www.gov.scot/Topics/Health/Services/Primary-Care/PrimaryCare-Outcomes-Framework](http://www.gov.scot/Topics/Health/Services/Primary-Care/PrimaryCare-Outcomes-Framework)

\(^{20}\) “The Magenta Book” and “The Green Book” provide guidance for Government and are a useful resource for a wider audience (Annex 5 for references).

\(^{21}\) [https://ihub.scot/](https://ihub.scot/)

\(^{22}\) [http://www.scottishhealthcouncil.org/home.aspx](http://www.scottishhealthcouncil.org/home.aspx)
funders of evidence, including national research councils, the Scottish Government’s Chief Scientist’s Office, and academic units not represented on the Collaborative.

Our approach acknowledges that local data collection, small-scale policy and service evaluations, self-evaluations, improvement activity and learning, economic analysis, modelling, and research (including clinical studies) contribute to a broad evidence base and may relate to, or be part of, wider programmes of monitoring and evaluation. \(^{23}\) We will use a phased approach across the ten years, with an evolving portfolio of studies and data collections mapped against actions, activities and intended outcomes in the Outcomes Framework to capture learning and analyse the contribution of different actions and inputs. In some cases, process data and process evaluation will be more appropriate and helpful than analysis of outcomes which will take longer to emerge. We expect that the principles and approaches of Realist Evaluation, Contribution Analysis and Implementation Science will shape our approach over the decade.

**What will we monitor and evaluate?**

We are guided by the principles that:

- evaluation should only happen when there is a reasonable assumption that genuinely new and useful learning can be generated;

- research and evaluation must be proportionate, well timed, and have clarity of purpose.

Work undertaken to deliver this strategy will focus on policies and changes intended to generate impacts that will be discernible at the national (‘macro’) and regional, pathway or sectoral (‘meso’) levels within the primary care system. Our approach is concerned with changes with the potential to be scalable from a local to wider geography; or which involve significant investment, systemic change or risk. Clearly, not all tests of change or new ways of working across Scotland in the coming decade will be subject to evaluation or research - nor should they be. It is also not for central government to decide how evidence is used to inform local or cluster-level decision-making, and service delivery or clinical practice (the ‘micro’ level), or how learning is captured from those and then acted on. This strategy, however, offers transferrable principles, methods and core research questions, and we have a responsibility to encourage the development of a more intelligence-informed primary care system, to support an improved data infrastructure, and to work with national partners to promote evidence and appropriate methods.

Our early monitoring and evaluation priorities are set out in more detail below. Much of our focus in the early years will necessarily be on how we integrate evidence from across diverse programmes and projects which are testing new models of care. Criteria for prioritising evidence gaps and the deployment of national evaluation resources are likely to include:

\(^{23}\) For example, the evaluation of Primary Care Transformation Fund projects by the Scottish School of Primary Care consists of a number of case studies of tests of change, learning from which will be synthesised in a final evaluation report in 2019.
- Level of investment (not just financial)
- Public commitment to report on progress or impact
- Risk – real or perceived
- Public profile of the project or policy
- What matters to people using services in relation to the topic or policy
- The evaluability of the project or policy
- How evidence-based or innovative is the policy or the model being piloted. Ideally, policies being introduced and models being piloted should be founded on a sound evidence base. However, there may be occasions where it is justified to make changes and run innovative tests for which there is little current evidence, as there is a reasonable underlying logic that activities will lead to positive outcomes. Some models will have been developed in quite different contexts to the test environment, in which case issues of fidelity, adaptability and generalisability will be important.

The Primary Care Outcomes Framework

The Primary Care Outcomes Framework was developed through an extensive process of engagement and mapping of related activity, firstly across Scottish Government health and social care policy areas (recognising that primary care is part of a wider, increasingly integrated health and care system) and then with a wider set of stakeholders through meetings and events.\(^{24}\) The Framework (Annex 1)\(^{25}\) provides a shared structure (in the form of a logic model) to articulate how we expect to realise the Primary Care Vision and is an important conceptual and practical evaluation tool.

The Framework can be adapted for different levels or scales within the system and will evolve over time. It consists of an overarching, strategic level logic model with three nested logic models which set out how outcomes will be achieved and what continuous improvement should look like for: people, the workforce, and the wider health and social care system. The Framework is, therefore, an important evaluation tool.

The Framework provides a flexible organisational mechanism for planning and undertaking analysis and review (including self-evaluation), for planning, for articulating theories of change, for understanding contributions to outcomes and attribution, and for communicating evidence. It can be used to:

\(^{24}\) This activity was led by Health Scotland and the Scottish School of Primary Care.
\(^{25}\) Also available on the Primary Care section of the Scottish Government website - [http://www.gov.scot/Topics/Health/Services/Primary-Care/PrimaryCare-Outcomes-Framework](http://www.gov.scot/Topics/Health/Services/Primary-Care/PrimaryCare-Outcomes-Framework) The Framework was co-produced by the Primary Care Evidence Collaborative with input from the Scottish Government's Primary Care Division, Healthcare Improvement Scotland, the Health and Social Care Alliance Scotland (the ALLIANCE), and the Person-Centred Stakeholder Group.
- Map and analyse whether and how actions are contributing to intended changes

- Identify and address primary care evidence gaps and appropriate ways to address these

- Improve the availability, quality and comparability of primary care data and evidence by identifying and recommending appropriate methods, data sources and indicators to capture local and national learning

- Identify and prioritise common research and evaluation questions

- Inform decisions about what to evaluate and how

- Represent and refine theories of change underpinning the Outcomes, policies and services

- Coordinate and share learning from local changes and pilots to inform scale-up and roll-out of the most effective interventions in particular contexts.

Research and evaluation undertaken or commissioned on behalf of the Scottish Government (at the macro or meso levels) will complement and, at times, include other fields of activity concerned with evidence, understanding and learning. This may comprise, for example, improvement methods, organisational change management, “middle ground research” (in a space between policy, practice and science), and traditional clinical research. The Framework therefore offers bodies, with responsibilities for planning, delivering and reporting on primary care, a tool for planning evaluation and research activity, locating evidence and analysis within a wider evidence framework, and encouraging reflection on activity and assumptions.

Monitoring Improvements with Statistics

It is vital that we underpin the story of primary care reform with high quality, comprehensive quantitative data, collected, analysed and disseminated in an efficient and robust way. Such data will provide up to date information on the progress of primary care reform, and will identify areas where more detailed additional statistical data, follow-up analysis, improvement activity, policy intervention or other actions may be required.

The data needed for monitoring and evaluation at the national macro level will often be different in nature to that which is needed at a local level. For example, ready access to up-to-date, detailed and accurate information from SPIRE and other local systems is essential at a practice and cluster level to drive quality improvement. Some of this information will also be required to monitor progress nationally, but this will be needed on a less frequent basis and generally in a more summative form. All of these data needs are important, however this strategy focuses on national level statistics.

At present, data relating to primary care is limited. Existing (but incomplete) data for national monitoring relates to:

- the primary care workforce
- GP practice level information (such as list sizes)
- some activity data (e.g. Out of Hours, previous QOF data collection)

In addition, some patient reported outcome measures are available from the Scottish Government’s Health and Care Experience Survey.\(^{27}\)

The lack of data and an inadequate data infrastructure are substantial challenges to developing the effective policies required to address increasing demand across the health and social care system. This includes, for instance, questions about the efficiency and economy of primary care spending and difficulties in attributing the role of policy to improved outcomes. It is also important to develop better data for understanding the impact of primary care reform on inequalities and better approaches to address these.

The Scottish Government’s workforce plan notes (chapter 7) key developments already underway to improve the primary care data landscape.\(^{28}\) This includes the roll-out of SPIRE, improved general practice workforce data under the terms of the GMS Contract, and a platform NHS National Education for Scotland (NES) are developing to bring together and align relevant workforce data to inform workforce planning.

Historically, the availability of data from primary care to support research has been limited and has often involved bespoke data collections. In time, the roll-out of SPIRE to all practices in Scotland should provide an unprecedented source of accessible primary care information to support research and evaluation.

Currently, primary care data is available to different groups of stakeholders in a number of different locations and formats. To facilitate synthesis of these data, and to identify continued data gaps, we will work with the national boards to create an online resource which draws together data sources, analyses and other relevant evidence.

**National Level Indicators for Primary Care Reform**

There is a recognised need for a small number of national measures that track system-level progress. To address this we have developed a set of high level (predominantly national level) indicators across the six primary care outcomes. This is included at Annex 2 and will be further discussed with stakeholders over the coming months. The development of this indicator set follows the model in the Institute for Healthcare Improvement whole system measures white paper,\(^{29}\) which describes the importance of having a balanced set of system level measures which provide:


- A conceptual framework for organising measures of care quality
- A specific set of quality metrics (that can contribute to the Scottish Government’s broader set of strategic performance measures)
- A relatively small number of “big dot” measures which track system level change within primary care at a high level
- A balance among structures, processes, and outcomes measures.

The current proposed set of national indicators are not intended to cover all of these aspects of primary care, at least initially, and process measures will initially predominate for some topics. It remains a longer-term ambition to broaden the scope of the indicators as the data availability and quality improve and we gradually incorporate and aggregate data from sub-national sources. We will also take account of the framework that the Scottish Government and COSLA are committed to develop for community-based integrated services.

**Who will use the indicators and why?**

The table below describes the main groups who will have an interest and stake in the national indicators and why. Not all of these groups will require the same levels of detail, or be interested in all of the proposed indicators.

**Table 1: Users and purpose of primary care indicator data**

<table>
<thead>
<tr>
<th>Who?</th>
<th>Why?</th>
</tr>
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| Ministers and Scottish Government policy | - to understand the contribution that primary care makes to the overall quality of the health and care system  
- to consider future priorities for policy and spending  
- to understand whether the quality of primary care is improving  
- to inform strategic quality improvement planning and resource allocation  
- to understand the impact of primary care redesign, including in relation to inequalities and informing approaches to address these |
| Integration Authorities, Health Boards, Cluster leads, the primary care MDT | - to understand the quality of care provision in the context of the agreed primary care outcomes  
- to inform where future improvement activity might be needed  
- to consider changing workforce requirements and alignment  
- to allow benchmarking with other similar organisations and over time  
- to help support Cluster and other local-level improvement activity |
| Researchers, academics, evaluators and other analysts | - to understand the quality of primary care, with reference to the agreed primary care outcomes  
- to inform the evaluation of primary care redesign activity |
The public/service users
- to widen and improve understanding of services and policies through greater data accessibility and transparency about service activities and quality
- to support public accountability and engagement

Methods and Core Evaluation Questions

Quantitative data and statistics-based indicators can tell us some of what is happening, where it is happening, and by whom and to whom. They usually cannot tell us about: why and how changes and outcomes occur; explain variations and the unexpected or unintended consequences of policies; reveal what people think and feel; or explain resource implications and trade-offs. On its own, quantitative data seldom allows for reflection on policies or the identification of options. For that, the triangulation of evidence and mixed methods primary research are generally required.

To provide decision makers with the best available and most appropriate local, national and international evidence, our approach encourages the use and triangulation of varied methods and evidence sources to answer evaluation questions. These could include evidence reviews (including international studies and policies), evaluations of policy initiatives, routine data, qualitative research, “middle ground research”, primary and secondary research, economic studies, and public engagement methods. As noted above, there will be an annual workplan to deliver this Strategy through specific projects and initiatives. This will be underpinned by detailed consideration of the best and most cost-effective methods and sources for addressing evaluation priorities.

Questions for primary care at the national level

We have suggested some core questions to shape national research and evaluation on primary care policy for both accountability and learning. We hope that others will also use these questions and the Outcomes Framework as useful tools to shape and guide (and facilitate greater comparability across) research and evaluation activity.

- How are major national commitments being implemented? Are they achieving their objectives, and how?
- To what extent are we making progress towards achieving each of the six primary care outcomes, and how?
- What impacts have national programmes and investment had on sustainability and productivity in primary care, including delivering the “triple aim” of better health, better care, better value?
- What impacts have national programmes and investment had on people who use services and what matters to them?

30 Annex 4 includes examples of methods and associated evidence sources and there are many good and comprehensive guides to evaluation methods (a small selection are listed in Annex 5).
- To what extent have new models of primary care contributed to the 2020 Vision of supporting people to remain at or near home where possible?

- What impacts have national programmes and investment had on supporting the development of extended MDTs, and why?

- What factors have supported or hindered the effectiveness of new models of care (including local contextual variation, external factors, unforeseen events)?

- Over time, do primary care policies and structures remain fit for purpose, to meet local and national needs? Are they supported by the best available evidence?

- What impacts has primary care reform had on other parts of the wider health and social care system? And wider system reform on primary care?

Questions for programmes and projects

It may also be useful to consider a set of core questions to use alongside any research questions which are specific to a project or programme, at different levels or scales. For example:

- What was the need and intended outcomes for the change?

- How was the activity to be tested chosen or new approach developed?

- How were the projects and policies implemented (including resources required); and was this as planned? Where relevant, was there fidelity to the model being tested?

- What external factors supported or hindered implementation?

- What are the outcomes for both people who use services and for the workforce (e.g. quality of experience, wellbeing, perception)?

- What are the outcomes for the system (e.g. on access, demand, sustainability, efficiency and productivity, (cost-)effectiveness, safety and quality)?

- To what extent are short and medium-term outcomes achieved and attributable to the new policy or way of working?

- Were there any unintended consequences (positive or negative)?

- What are the ‘active ingredients’ of the project or programme? Which aspects, if replicated elsewhere, can be expected to give similar results and what contextual factors are needed for success?

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31 These have been developed from an initial set devised by the Primary Care Evidence Collaborative.
- What impacts has the programme or project had on other parts of the wider health and social care system?

**Governance, Reporting and Resources**

**Decision-making**

Ownership of this 10-year National Monitoring and Evaluation Strategy lies with the Scottish Government. The following governance and reporting arrangements will apply:

- responsibility for delivering and reporting on the Strategy lies with the Scottish Government Health and Social Care Analysis Division (SG HSCA), supported by Health Scotland/Public Health Scotland
- the Senior Responsible Owner (SRO) for the Strategy will be the Head of Primary Care Division in the Scottish Government
- a Primary Care Monitoring and Evaluation Steering Group will provide analytical and operational oversight and direction for the Workplan
- SG HSCA will produce a 12-month Workplan which will be developed in collaboration with the Steering Group, and through appropriate consultation with the Scottish Government’s Primary Care Programme Board, other SG policy areas, the Primary Care Evidence Collaborative and other stakeholders
- the SRO will sign off the Workplan and resourcing decisions for monitoring and evaluation activity
- SG HSCA will provide updates to the Primary Care Programme Board and to the Steering Group
- lead responsibility for promoting and populating the Outcomes Framework with evidence and for revising it when required, at the national level, lies with Health Scotland and SG HSCA

The Scottish Government will develop full terms of reference for the Primary Care Monitoring and Evaluation Steering Group. The Group’s core functions are likely to be to:

- act on directions from the SRO and the Primary Care Programme Board
- agree and propose to the SRO and Primary Care Programme Board an annual Workplan, defining required operational resourcing decisions
- be responsible for the ethical and analytical governance of the Strategy
- delegate activities to members of the Group and their organisations
- co-ordinate the best use of resources for Strategy delivery across represented organisations

- foster and maintain links with other policy areas and relevant programmes of monitoring and evaluation across government and the public sector

- quality assure outputs from research and data it commissions (in-house and externally)

- work closely with the Primary Care Evidence Collaborative

The Group is likely to include, as a minimum: SG HSCA Division; SG Primary Care Policy (including clinical advisers); the SG Person Centred and Quality Unit; Health Scotland, HIS, ISD and NHS Education for Scotland; representation from Integration Authorities; the SG Chief Scientist’s Office; the ALLIANCE; and the SG’s Chief Medical Officer Directorate. It will consult more widely, where appropriate, with stakeholders, including Integration Authorities, NHS Boards and Health and Social Care Partnerships, the third sector, members of the Collaborative, the Scottish Health Council (part of HIS) and other routes for engaging with lived experience, the wider academic and policy analysis community, and clinical interests.

**Principles for Government Research and Statistics**

Any data-collection or evidence analysis activities initiated under the Strategy will be subject to established research and data governance and legislation, and best practice in healthcare and public policy research. Depending on the nature of the data and analysis, the Scottish Government’s Protocol for the Publication of Research, National Statistics Codes or other publication requirements may apply. External studies will be procured through fair and open competition, in line with public sector procurement law and best practice and to ensure best use of public resources, unless there is sound justification for an alternative commissioning approach.

Evaluation, whether undertaken internally or externally, on behalf of the Scottish Government, will reflect the Government Social Research (GSR) principles:

- Principle 1: Sound application and conduct of social research methods and appropriate dissemination and utilisation of the findings

- Principle 2: Participation based on valid informed consent

- Principle 3: Enabling participation

- Principle 4: Avoidance of personal harm

- Principle 5: Non-disclosure of identity and personal information

All reports and other outputs should conform to the four principles for GSR products: rigorous and impartial; relevant; accessible; and legal and ethical.
Roles and reporting

The Scottish Government Health and Social Care Analysis Division has been tasked with delivering the Strategy and will monitor progress and report to the Steering Group. It will jointly produce and own, with Health Scotland, a short annual overview report, which maps progress against each section of the Outcomes Framework and details the work planned for the following year. It is likely to cover:

- a summary of research activity and findings;
- an update on quantitative indicator trends;
- evidence from other research sources (including specific evaluation projects, qualitative case studies) which demonstrate a contribution to whether and how primary care reform is being realised;
- a narrative overarching assessment of progress to date;
- relevant research and policy internationally which could inform ongoing primary care reform in Scotland.

More comprehensive reports, in 2021, 2024 and 2028, will synthesise the progress and learning, describe trends in key indicators, take-stock of the evidence-base, and identify gaps we need to address. Health Scotland will have a key role in synthesising evidence as it emerges. SG HSCA will be responsible for reporting on indicator framework data and changes over time.

Resources

It will be challenging to deliver a comprehensive programme of monitoring and evaluation over the next decade in a context of competing priorities for public sector resources and a complex and evolving policy and delivery landscape. The need to be realistic and proportionate, only undertaking research that has genuine value, is keener than ever. At the same time sufficient investment of resources in research, evaluation and data is fundamental to ensuring good quality, cost-effective, evidence-informed policies and initiatives. The Scottish Government will use evaluation resources and research budgets strategically and effectively on the basis of annual workplan priorities and in consultation, particularly, with its national partners in evidence and analysis - ISD, HIS and Health Scotland.

As already noted in this document, evidence for monitoring and evaluating primary care will not just come from activities undertaken or funded by the Scottish Government or the national boards. Sources for evaluation and research activity could come from the following:

- Organisations (e.g. SG, national health boards) undertaking research or analysis in-house
- Organisations commissioning others to undertake research (e.g. as Scottish Government Social Research projects)
- Funding for research and evaluation, including self-evaluation, being built into project grants by the funder

- Integration Authorities or Boards undertaking or commissioning local evaluation and self-evaluation which generate findings relevant to the national level

- Other funders - e.g. the SG Chief Scientists Office, National Institute for Health Research, Medical Research Council, Economic and Social Research Council, Health Foundation, and Wellcome Trust

- Building in-house capacity for (self-)evaluation and data analysis in organisations delivering change

- Collaborations or partnerships with national funders and think tanks.

Stakeholders, including public agencies and academic institutions, are encouraged to be strategic in their approaches to maximising the use of existing evidence; to exploiting existing funding sources; and to encouraging investment by significant national research funders to further the evidence base for primary care.

**Anticipated challenges and risks to effective evaluation**

It is our intention to be strategic in planning primary care evaluation, data collection and research over the next 10 years. We recognise that there are considerable challenges and risks for the success of this undertaking:

- Many outcomes will only be fully achieved over the longer term and system changes will take time.

- The availability, sufficiency and quality of primary care data are currently limited, and the supporting data infrastructure requires development.

- Complexity – primary care is part of a wider system undergoing significant change and establishing a “baseline” from which to document change is challenging. It will be challenging to attribute changes in a complex system to specific policies or set of policies. Established Contribution Analysis methods help with this.

- There is always the danger that we focus on what we can count or measure so that scarce evaluation resources are not available for telling the story, that we focus on the wrong things, or miss other valuable but “difficult to measure” things.

- The results of evaluation need to be shared in a timely and effective fashion with those who are responsible for reforming primary care or their usefulness risks being diminished.

- Local learning and success may not be generalisable or scalable and short-term pilots may not lead to sustainable, cost-effective changes. Many service redesign
projects and tests of change are locally chosen and their potential might not be well understood when planning monitoring and evaluation, although lessons from the process of how they were introduced may be helpful.

- Availability of funding for the delivery of new models of care and for research and evaluation.
- The limited evaluation capacity and expertise of local and national organisations.

**Early Priorities for the Strategy**

A three-year period of significant transition for transformative service redesign, described in the 2018 GMS Contract, will shape national priorities for monitoring and evaluating in the early years of this Strategy. These priorities are likely to concern:

- Synthesising and sharing learning from good quality evaluations by others of new models of care, service redesign, tests of change and other innovations in the community and primary care setting where these show promise for scaling-up, sustainability and a notable contribution to achieving the primary care outcomes.

- Policy initiatives and investment intended to reshape and increase the effectiveness of primary care (including specific national commitments and investments; IT changes), including implementation of the 2018 GMS Contract for GPs and the responsibility of transferring the six priority areas set out in the Memorandum of Understanding.\(^{32}\)\(^{33}\) This will include iterative modelling to progressively improve the evidence base and methodology for local and national workforce planning required to deliver the MoU and longer-term reform.

- Developing and using the national-level primary care indicator set, establishing indicator reporting arrangements and developing an online data resource. There will be ongoing discussion about the purpose of different sets and levels of data and collaboration with ISD Scotland and NES to ensure indicator activity complements their broader data development activity and the data for local areas.

- Public and workforce understanding and acceptability of the changes, especially as reshaping primary care will require public trust and some behaviour change by those who deliver and those who use services.

Alongside these priorities, long-term work is required to improve and modernise data and intelligence infrastructure and governance for primary care to ensure the highest standards

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\(^{33}\) Some of this work may be evaluated by others (e.g. at a Health and Social Care Partnership level).
in data entry, capture, management, processing, and sharing. This will enable practitioners, decision makers, policymakers, researchers and other analysts to have the intelligence that they need. Relevant here are SPIRE, work on patient pathways, the Scottish Atlas of Variation, the Scottish Burden of Disease Study, and other data mapping activities.

Clearly, we will not have sufficient resources to monitor and evaluate all changes with the same intensity. The Scottish Government will, in close consultation with the Primary Care Monitoring and Evaluation Steering Group and our national partners, prioritise activity, taking account of developments across the health and social care system (e.g., the new framework for community based integrated services initiated this year), and will take the long view beyond 2021.
Conclusion

Our anticipation is that the approach, principles, priorities, and the roles and responsibilities laid out in this Strategy provide direction for telling the story of how we reform primary care over the next decade – for patients and communities, for a diverse multi-disciplinary workforce, and for the health and social care system. While the Scottish Government will lead on national evaluation of primary care, at the heart of our approach lie partnership and collaboration across public sector organisations and the wider research community represented on the Primary Care Evidence Collaborative. We hope that others will find the evaluation approach described in this publication, the national indicator set and the Outcomes Framework useful for planning and prioritising their own data collection, analysis and research, and for better understanding the contribution their policies, practice and service redesign are making to the changes we need to see in primary care across Scotland.
Annex 1: Primary Care Outcomes Framework

1. Strategic Level Outcomes Framework

<table>
<thead>
<tr>
<th>Situation</th>
<th>Inputs</th>
<th>Activities</th>
<th>Logic model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why change is needed</td>
<td>Resources we need</td>
<td>What we do</td>
<td>Nested models</td>
</tr>
<tr>
<td>People</td>
<td>People and communities</td>
<td>Activities with or for people</td>
<td>2. Outcomes for People</td>
</tr>
<tr>
<td>An ageing population that is living longer with complex needs</td>
<td>Workforce</td>
<td>Activities with or for the workforce</td>
<td>Our vision is of general practice and primary care at the heart of the healthcare system.</td>
</tr>
<tr>
<td>Increasing multi-morbidity</td>
<td>Physical and digital infrastructure</td>
<td>Activities at a system level</td>
<td>People who need care will be more informed and empowered, will access the right professional at the right time and will remain at or near home wherever possible.</td>
</tr>
<tr>
<td>High levels of mental health problems</td>
<td>Funding</td>
<td></td>
<td>Multidisciplinary teams will deliver care in communities and be involved in the strategic planning of our services.</td>
</tr>
<tr>
<td>Increasing burden of non-communicable diseases</td>
<td>Evidence and strategy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent health inequalities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased expectations of health services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruitment and retention challenges</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>System</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased financial pressures on the health and social care system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advances in technology</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resources we need</th>
<th>What we do</th>
<th>Desired impact at national level</th>
</tr>
</thead>
<tbody>
<tr>
<td>People and communities</td>
<td>Activities with or for people</td>
<td>We are more informed and empowered when using primary care</td>
</tr>
<tr>
<td>Workforce</td>
<td>Activities with or for the workforce</td>
<td>Our primary care workforce contributes to improving population health</td>
</tr>
<tr>
<td>Physical and digital infrastructure</td>
<td>Activities at a system level</td>
<td>Our experience of primary care is enhanced</td>
</tr>
<tr>
<td>Funding</td>
<td></td>
<td>Our primary care workforce is expanded, more integrated and better coordinated with community and secondary care</td>
</tr>
<tr>
<td>Evidence and strategy</td>
<td></td>
<td>Our primary care infrastructure – physical and digital – is improved</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Desired impact at national level</th>
</tr>
</thead>
<tbody>
<tr>
<td>People are able to look after and improve their own health and wellbeing and live in good health for longer.</td>
</tr>
<tr>
<td>People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.</td>
</tr>
<tr>
<td>People who use health and social care services have positive experiences of those services, and have their dignity respected.</td>
</tr>
<tr>
<td>People who use health and social care services are safe from harm.</td>
</tr>
<tr>
<td>People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.</td>
</tr>
<tr>
<td>People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.</td>
</tr>
<tr>
<td>Resources are used effectively and efficiently in the provision of health and social care services.</td>
</tr>
</tbody>
</table>

Underlying principles: Dignity and respect, compassion, be included, responsive care and support, wellbeing (Health and Social Care Standards); Safe, person-centred, equitable, outcomes focused, effective, sustainable, affordability and value for money (GMS contract principles); co-produced and co-designed

External factors (Social, cultural, political and economic) which may affect the success of primary care transformation:
- Social determinants of health
- Public Health priorities
- Brexit
- Recession
- Welfare reform

System
2. Primary Care Outcomes for People

Primary Care
National Outcomes

Our primary care workforce is expanded, more integrated and better coordinated with community and secondary care.

Our primary care infrastructure – physical and digital – is improved.

We are more informed and empowered when using primary care.

Our primary care services better contribute to improving population health.

Our experience of primary care is enhanced.

Our primary care workforce is expanded, more integrated and better coordinated with community and secondary care.

Primary care better addresses health inequalities.

Underlying principles: Dignity and respect, compassion, be included, responsive care and support, wellbeing (Health and Social Care Standards); Safe, person-centred, equitable, outcomes focused, effective, sustainable, affordability and value for money (GMS contract principles); co-produced and co-designed.

External factors (Social, cultural, political and economic) which may affect the success of primary care transformation:
Social determinants of health; Public Health priorities; Brexit; Recession; Welfare reform.
### 3. Primary Care Outcomes for the Workforce

**Primary Care National Outcomes**

Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care. Our primary care infrastructure – physical and digital – is improved. We are more informed and empowered when using primary care. Our primary care services better contribute to improving population health. Our experience of primary care is enhanced. Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care. Our primary care infrastructure – physical and digital – is improved. Primary care better addresses health inequalities.

#### Situation

<table>
<thead>
<tr>
<th>Why change is needed</th>
<th>Resources we need</th>
<th>What we do</th>
<th>Who we want to reach</th>
<th>Changes in knowledge, skills and awareness</th>
<th>Changes in decisions and practice</th>
<th>Changes in services and health outcomes</th>
<th>Desired impact at national level</th>
</tr>
</thead>
<tbody>
<tr>
<td>People</td>
<td>An ageing population that is living longer with complex needs</td>
<td>People and communities</td>
<td>Redefining and extending the roles of the primary care workforce</td>
<td>There is increased awareness of the roles and responsibilities of Primary Care professionals</td>
<td>Improved trust between professionals</td>
<td>Primary care services are holistic and person-centred</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increasing multi-morbidity</td>
<td>Workforce</td>
<td>School leavers</td>
<td>Improved communication and information sharing between professions</td>
<td>Improved quality and safety of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High levels of mental health problems</td>
<td>Physical and digital infrastructure</td>
<td>Undergrad students</td>
<td>The skills and experience of each member of the multi-disciplinary team are fully utilised</td>
<td>Improved staff health and wellbeing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increasing burden of non-communicable diseases</td>
<td>Funding</td>
<td>Postgrad students</td>
<td>The right people deliver the right support, in the right place at the right time</td>
<td>Increased recruitment and retention of the primary care workforce</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent health inequalities</td>
<td>Strategy</td>
<td>Current, ex and future health and social care professionals</td>
<td>The workforce has access to the information, equipment, technology, and the clinical, social care and wider community support and resources needed to provide holistic, person-centred care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased expectations of health services</td>
<td>Evidence</td>
<td>Recruitment activities</td>
<td>GPs can focus on complex care, undifferentiated presentations and quality and leadership</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Underlying principles:** Dignity and respect, compassion, be included, responsive care and support, wellbeing (Health and Social Care Standards); Safe, person-centred, equitable, outcomes focused, effective, sustainable, affordability and value for money (GMS contract principles); co-produced and co-designed

**External factors (Social, cultural, political and economic) which may affect the success of primary care transformation:**

- Social determinants of health
- Public Health priorities
- Brexit
- Recession
- Welfare reform

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4. Primary Care Outcomes for the System

<table>
<thead>
<tr>
<th>Situation</th>
<th>Inputs</th>
<th>Activities</th>
<th>Outcomes for the system</th>
<th>Primary Care National Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why change is needed</td>
<td>Resources we need</td>
<td>What we do</td>
<td>Changes in knowledge, skills and awareness</td>
<td>Desired impact at national level</td>
</tr>
<tr>
<td>People</td>
<td>People and communities</td>
<td>Activities at a system level</td>
<td>People receive the right support, delivered by the right person, in the right place at the right time</td>
<td>We are more informed and empowered when using primary care</td>
</tr>
<tr>
<td>Workforce</td>
<td>Physical and digital infrastructure</td>
<td>Increased generalist approach across all disciplines</td>
<td>Resources are targeted at those who need them most</td>
<td>Primary care services are available, accessible and acceptable to everyone</td>
</tr>
<tr>
<td>Funding</td>
<td>Evidence and strategy</td>
<td>Increased engagement with local third sector and community resources</td>
<td>Increased primary and secondary prevention</td>
<td>Primary care provides a model of care and support that builds on people’s expertise in living with their conditions and the resources available to support them in their own communities</td>
</tr>
<tr>
<td>People</td>
<td>People and communities</td>
<td>Activities at a system level</td>
<td>Increased anticipatory care</td>
<td>Our experience of primary care is enhanced</td>
</tr>
<tr>
<td>Workforce</td>
<td>Physical and digital infrastructure</td>
<td>Increased use of technology/ digital/eHealth</td>
<td>Increased supported self-management</td>
<td>Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care</td>
</tr>
<tr>
<td>Funding</td>
<td>Evidence and strategy</td>
<td>Increased understanding of local health needs through data</td>
<td>Improved management of long-term conditions</td>
<td>Our primary care infrastructure – physical and digital – is improved</td>
</tr>
<tr>
<td>People</td>
<td>People and communities</td>
<td>Activities at a system level</td>
<td>People receive support at or near home wherever possible</td>
<td>Primary care better addresses health inequalities</td>
</tr>
</tbody>
</table>

**Underlying principles:** Dignity and respect, compassion, be included, responsive care and support, wellbeing (Health and Social Care Standards); Safe, person-centred, equitable, outcomes focused, effective, sustainable, affordability and value for money (GMS contract principles); co-produced and co-designed

**External factors (Social, cultural, political and economic) which may affect the success of primary care transformation):**
Social determinants of health; Public Health priorities; Brexit; Recession; Welfare reform
### Annex 2: National Indicators for Primary Care: Overview

<table>
<thead>
<tr>
<th>Primary Care Outcome</th>
<th>Sub-outcome</th>
<th>Measure</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. We are more informed and empowered when using primary care</strong></td>
<td>1a. People are more informed</td>
<td>Increase in the % of people responding to the Health and Care Experience (HACE) survey who agreed or strongly agreed with the statement: “I understood the information I was given” (at their GP practice)</td>
<td>HACE - established</td>
</tr>
<tr>
<td></td>
<td>1b. People are more empowered</td>
<td>Increase in the % of people responding to the HACE survey who agreed or strongly agreed with the statement: “I was in control of my treatment/care” (at their GP practice)</td>
<td></td>
</tr>
<tr>
<td><strong>2. Our primary care services better contribute to improving population health</strong></td>
<td>2a. Primary care services better contribute to improving population health (Process)</td>
<td>Increase in the % of people responding to the HACE survey who felt they were able to look after their own health &quot;well&quot; or &quot;very well&quot;</td>
<td>HACE - established. Possibly replace with public health indicator once established?</td>
</tr>
<tr>
<td><strong>3. Our experience as patients in primary care is enhanced</strong></td>
<td>3a. Patient experience is enhanced (in-hours)</td>
<td>Increase in the % of people completing HACE with positive experience of care (rated excellent or good) at their GP practice *</td>
<td>HACE - established</td>
</tr>
<tr>
<td></td>
<td>3b. Patient experience is enhanced (out of hours)</td>
<td>Increase in the % of people completing HACE with a positive experience of Out of Hours care (rated as excellent or good)</td>
<td></td>
</tr>
<tr>
<td><strong>4. Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care</strong></td>
<td>4a. Our primary care workforce is expanded</td>
<td>Increase in the number (headcount/FTE) of GP employed staff</td>
<td>Needs to align with data requirements in the contract. May be additional data collection required to capture numbers of staff employed via NHS Boards/ Health and Social Care Partnerships</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase in the number (headcount/FTE) of NHS employed staff working in primary and community care settings</td>
<td></td>
</tr>
<tr>
<td><strong>4. Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care</strong></td>
<td>4b. Our primary care workforce is more integrated and better co-ordinated with community and secondary care (in-hours)</td>
<td>Increase in the % of people responding to the HACE survey who rated the coordination of the treatment/care they received at the service they were referred to as excellent or good</td>
<td>HACE - established</td>
</tr>
<tr>
<td></td>
<td>4c. Our primary care workforce is more integrated and better co-ordinated with community and secondary care (out of hours)</td>
<td>Increase in the % of people responding to the HACE survey who agree or strongly agree that their treatment/care was well coordinated out of hours</td>
<td></td>
</tr>
<tr>
<td><strong>5. Our primary care infrastructure – physical and digital – is improved</strong></td>
<td>5a. Improved physical infrastructure</td>
<td>% of General Medical Services premises surveyed as being in “good” or “excellent” condition</td>
<td>GMS premises survey</td>
</tr>
<tr>
<td></td>
<td>5b. Improved digital infrastructure</td>
<td>% of GP practices which have an updated clinical IT system</td>
<td>First data expected 2020. Possible link to Quality data in contract?</td>
</tr>
<tr>
<td><strong>6. Primary care better addresses health inequalities</strong></td>
<td>6a. Primary care better addresses health inequalities (Process)</td>
<td>Increase in the % of GP practices with access to a community links worker and/or money/welfare advice services</td>
<td>Primary Care Workforce Survey / Primary Care Improvement Plans?</td>
</tr>
</tbody>
</table>

* These measures are also existing integration indicators
### Annex 3: Who will contribute evidence and analysis for monitoring and evaluating primary care reform?

<table>
<thead>
<tr>
<th>Support agency</th>
<th>Role</th>
</tr>
</thead>
</table>
| **Scottish Government Health and Social Care Analysis Division (SG HSCA)**    | • Report to, and be core member of, the PC Monitoring and Evaluation Steering Group.  
• Report to the SG Primary Care Programme Board on the Strategy.  
• Develop and manage an annual monitoring and evaluation Workplan, with evaluation support from Health Scotland, data and data analysis support from ISD and improvement and evaluation input/intelligence from HIS.  
• Produce short annual update reports in collaboration with Health Scotland.  
• Design, commission and manage research and evaluation for SG.  
• Manage and deliver the national care experience surveys.  
• Quality assure and critically appraise evidence.  
• Identify and advise on the implications of research and evaluation for national policy-making and delivery.  
• Identify gaps in the evidence and how to fill those.  
• Manage and prioritise SG analytical resources. |
| **Health Scotland/ New Public Health Body**                                  | • Coordinate the Collaborative.  
• Be a core member of, the PC Monitoring and Evaluation Steering Group.  
• Produce short annual update reports in collaboration with SG HSCA.  
• Collate and synthesise results from research and data analysis relevant to primary care.  
• Populate and test the Outcomes Framework.  
• Support decision-making by Integration Authorities, Health and Social Care Partnerships and SG by providing them with the best available evidence about what does and does not work in different primary care contexts  
• Identify gaps in the evidence and how to fill those.  
• Support, commission and undertake evaluation. |
| **Information Services Division/New Public Health Body**                      | • Be a core member of, the PC Monitoring and Evaluation Steering Group.  
• Lead on NHS primary care data collation and reporting  
• Help to populate and develop the Outcomes Framework with data  
• Produce short annual update reports  
• Support decision-making by Health and Social Care Partnerships, Integration Authorities and SG by providing them with the best available evidence about what does and does not work in different primary care contexts  
• Identify gaps in the evidence and how to fill those. |
| **Local Intelligence Support Team (LIST) analysts (ISD)**                    | • Provide analytical support to GP Clusters and Health and Social Care Partnerships to help them source, link and interpret data.  
• Support local areas to understand and assess population needs.  
• Champion the use of data and intelligence in local decision-making, resource allocation and service delivery. |
| Healthcare Improvement Scotland, including Improvement Advisors | • Be a core member of the PC Monitoring and Evaluation Steering Group.  
• Support organisations’ evidence, quality assurance and improvement functions at the local level.  
• Sharing and translating lessons from the local to the national level.  
• Provide improvement support to GP Clusters and Tests of Change sites.  
• Help build analytical/evaluation capacity in Clusters and Health and Social Care Partnerships  
• Communication and liaison strategy for sharing evidence with Health and Social Care Partnerships, across the Collaborative member organisations, and more widely.  
• Support patient and public participation through the Our Voice framework  
| Primary Care Evidence Collaborative (see below) | • A champion for evidence-based practice and service delivery across the primary care sector  
• Communication, liaison and co-ordination across generators and users of primary care evidence  
• Support decision-making by Integration Authorities, Health and Social Care Partnerships and SG by providing them with the best available evidence about what does and does not work in different primary care contexts  
• Identify gaps in the evidence and how to fill those  
• Deliver or facilitate delivery of evaluation activities  
• Help to populate, test and develop the Outcomes Framework  
• Leverage for capacity and resources for evaluation, research and other evidence-generation  
• Build capacity for primary care research and analysis in Scotland  
| SG Professional Advisers | • Provide profession-specificclinical guidance and advice to Scottish Government  
• Lead/support for national and local interventions specific to their profession  
• Communication and liaison with policy, national boards and members of their professions  

**The Primary Care Evidence Collaborative**

An important element of the national approach to co-ordination of research and the generation of evidence relevant to Primary Care has been the formation of the Primary Care Evidence Collaborative, instigated and co-ordinated by Health Scotland. The Collaborative is a network of organisations and institutions in Scotland who have a responsibility and a shared commitment to improve the quality, relevance, timeliness, and use of evidence relevant to primary care policy and practice.

It is the intention that subgroups of the Collaborative will focus on particular challenges or questions for evidencing primary care, which will include work that supports the delivery of this strategy. For example, a data subgroup of the Collaborative has been looking at how to use routine data, surveys and bespoke data collection to monitor the outcomes articulated in the Primary Care Outcomes Framework alongside the development of the Primary Care Indicators.
The Collaborative’s emphasis is on outward-facing and bottom-up co-operation and support, looking towards working with and for Integration Authorities and Health and Social Care Partnerships, with LIST analysts and improvement advisers, and with research peers and colleagues in Scotland and beyond. It currently includes NHS Health Scotland (NHS HS), the Scottish School of Primary Care (SSPC), Health and Social Care Alliance Scotland (the ALLIANCE), the International Centre for Integrated Care, the Scottish Government Health and Social Care Analysis Division, Healthcare Improvement Scotland, and NSS Information Services Division.
Annex 4: Examples of methods and associated sources for monitoring and evaluation

<table>
<thead>
<tr>
<th>Methods and sources</th>
<th>For example...</th>
</tr>
</thead>
</table>
| **Administrative and national survey data:** to monitor progress against intended outcomes and describe trends over time | • SG Health and Care Experience Survey  
• Primary Care Workforce Survey and improved practice data on staffing as result of the GMS contract  
• Financial and management data  
• Public opinion surveys  
• Professional body data and registrations  
• Routine and administrative data from Integrated Authorities and other bodies  
• ISD Primary Care Information Dashboard (NHS access only) |
| **Secondary analysis and synthesis of data:** including monitoring and reporting data | • Future ad hoc projects focussed on specific policy or services  
• HIS monitoring of the Health and Social Care Partnerships’ tests of change (Primary Care (in hours, Mental Health, Out of Hours/ Urgent Care) |
| **Data linkage:** will enable better understanding of population needs and patterns of service use and of impacts across the system | • Scottish Longitudinal Study  
• Increasing numbers of linked datasets, some dealing with specific populations conditions  
• The Burden of Disease study  
• Scottish Primary Care Information Resource (SPIRE)  
• SOURCE  
• ISD Primary Care Information Dashboard (NHS access only) |
| **Primary research:** qualitative and quantitative, including evaluation activity and, where feasible, analysis of economic impacts | • Future ad hoc projects focussed on specific policy or services  
• Our Voice Citizen Panel  
• Research and evaluation of related programmes and projects (e.g. Pharmacists based in General Practice, House of Care, Links Workers)  
• SSPC evaluation of the Primary Care Transformation Fund |
| **Evidence reviews:** draw on existing literature, including systematic reviews and meta-analyses, as well as less formal evidence summaries | • International research literature on primary care  
• SSPC evidence briefings for GP Clusters  
• Think tank analyses (e.g. Nuffield Trust – Shifting the Balance of Care report)  
• Grey literature |
| **Documentary analysis and policy reviews** | • Integration Authorities’ Primary Care Improvement Plans  
• Policy and strategy documents |
<p>| <strong>Patient Opinion/Care Opinion and other forms of service user feedback</strong> | • Qualitative, unsolicited opinion and accounts of experiences |</p>
<table>
<thead>
<tr>
<th><strong>Evaluability Assessment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>For larger programmes of work or far-reaching policies, it may be appropriate to undertake an Evaluability Assessment before deciding on whether and how to evaluate.(^3^4) An Evaluability Assessment is an objective process for decision-making about evaluation. It typically entails: structured engagement by researchers with stakeholders to clarify policy, project or programme outcomes and how they expect them to be achieved; the development and testing of a logic model or theory of change; the generation of research questions; and advice or recommendations on whether or not an evaluation can or should be conducted practically and at reasonable cost, and what methods should be used, often including an appraisal of different methods.</td>
</tr>
</tbody>
</table>

Annex 5: Evaluation: introductory references

- Health Research Authority (2017) Decision tool - ‘Is my study research?’
- Health Research Authority (2017) Defining research table
**How to access background or source data**

The data collected for this *<statistical bulletin / social research publication>*:

- ☐ are available in more detail through Scottish Neighbourhood Statistics
- ☐ are available via an alternative route *<specify or delete this text>*
- ☐ may be made available on request, subject to consideration of legal and ethical factors. Please contact *<email address>* for further information.
- ☐ cannot be made available by Scottish Government for further analysis as Scottish Government is not the data controller.
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