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National Monitoring and Evaluation Strategy for Primary Care in Scotland

HEALTH AND SOCIAL CARE

social research

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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."[1]

[1] "The Future of Primary Care: a view from the professions" (2017) - https://www.rcn.org.uk/about-us/policy-briefings/sco-pol-future-of-primary-care-1-sept

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

[2] https://www.gov.scot/Resource/0047/00470219.pdf
[3] http://nationalperformance.gov.scot/
[4] http://www.gov.scot/Topics/Health/Services/Primary-Care
[5] http://www.gov.scot/Publications/2016/12/4275
[6] Based on the Institute for Healthcare Improvement's Triple Aim Framework - 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.[7]

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

[7] The Scottish Government (2018) "The National Health and Social Care Workforce Plan Part 3 - improving workforce planning for primary care in Scotland" - http://www.gov.scot/Publications/2018/04/3662
[8] British Medical Association and Scottish Government (2017), "The 2018 GMS Contract in Scotland" - http://www.gov.scot/Resource/0052/00527530.pdf
[9] "Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards" - http://www.gov.scot/Resource/0052/00527517.pdf
[10] The Scottish Government (2017) "Improving Together: A National Framework for Quality and GP Clusters in Scotland" - http://www.gov.scot/Publications/2017/01/7911
[11] Scottish Government (2017) "Transforming Nursing, Midwifery and Health Professionals Roles -The district nursing role in integrated community nursing teams" - http://www.gov.scot/Publications/2017/12/6658
[12] https://www.gov.scot/publications/ministerial-strategic-group-health-community-care-review-progress-integration-health-social-care-final-report/

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
[15] https://www.gov.scot/Publications/2018/04/6385
[16] The Scottish Government (2018) "Scotland's Digital Health & Care Strategy: enabling, connecting and empowering" - https://beta.gov.scot/publications/scotlands-digital-health-care-strategy-enabling-connecting-empowering/documents/00534657.pdf?inline=true
[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

[19] Also on the Primary Care section of the Scottish Government website - 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/
[22] 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 delivery 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 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"[26] (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.

[26] Guthrie, B, et al (2017) "Developing middle-ground research to support primary care transformation", in the "British Journal of General Practice" 67 (664): 498-499.

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:

[27] http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey
[28] Scottish Government (2018) "The National Health and Social Care Workforce Plan Part 3 - improving workforce planning for primary care in Scotland" - http://www.gov.scot/Publications/2018/04/3662
[29] Martin LA, Nelson EC, Lloyd RC, Nolan TW (2007) "Whole System Measures". IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement.

- 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

Who?	Why?
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.[30] 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[31]

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?

[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

[32] Full details of these services are contained in the MOU and the 2018 GMS Contract: "Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards" - http://www.gov.scot/Resource/0052/00527517.pdf; British Medical Association and Scottish Government (2017) "The 2018 GMS Contract in Scotland" - http://www.gov.scot/Resource/0052/00527530.pdf

[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.

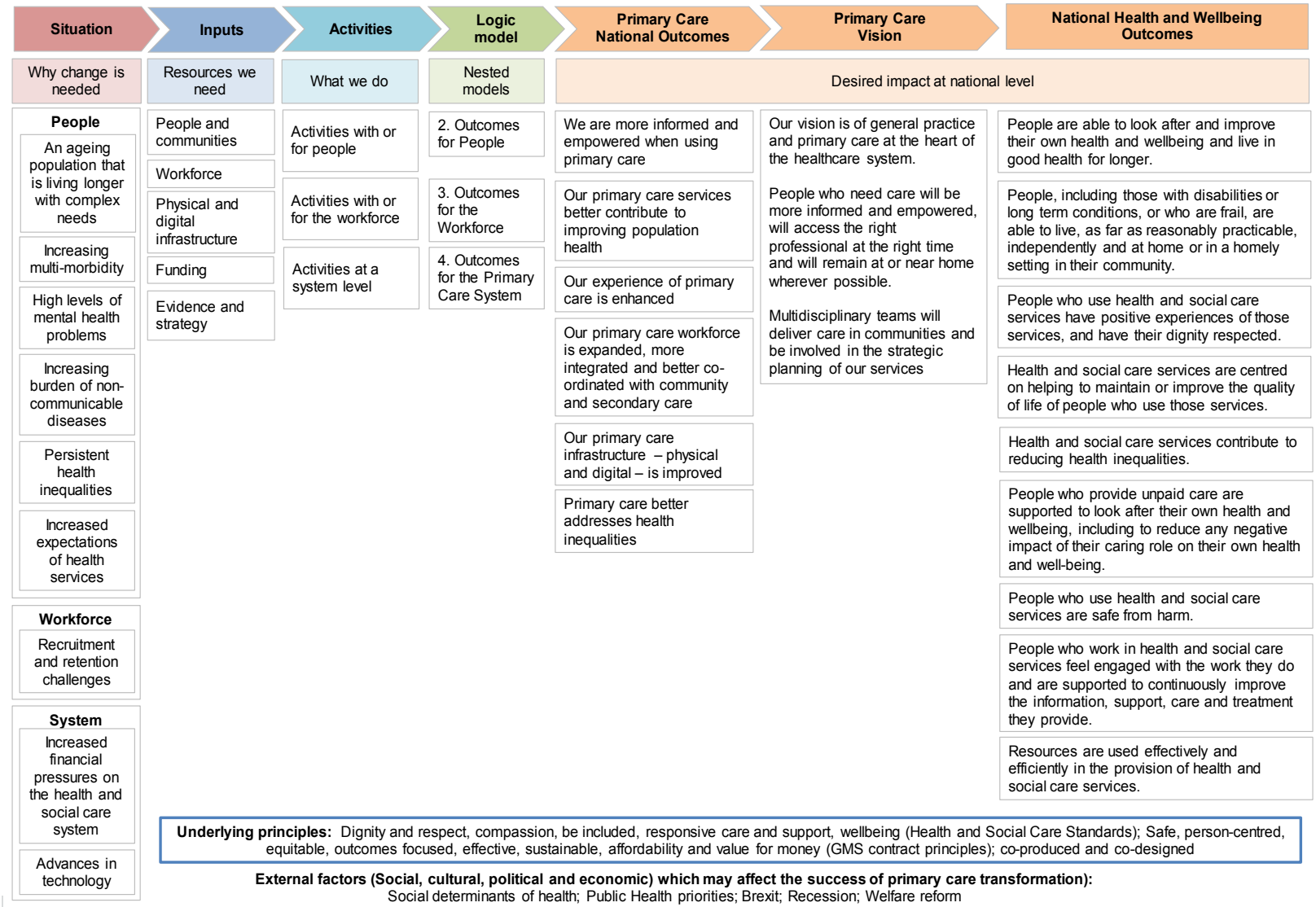
Clearly, we will not have sufficient resources to monitor and evaluate all changes with the same intensity. The Scottish Government will, in close consultation with the Primary Care Monitoring and Evaluation Steering Group and our national partners, prioritise activity, taking account of developments 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

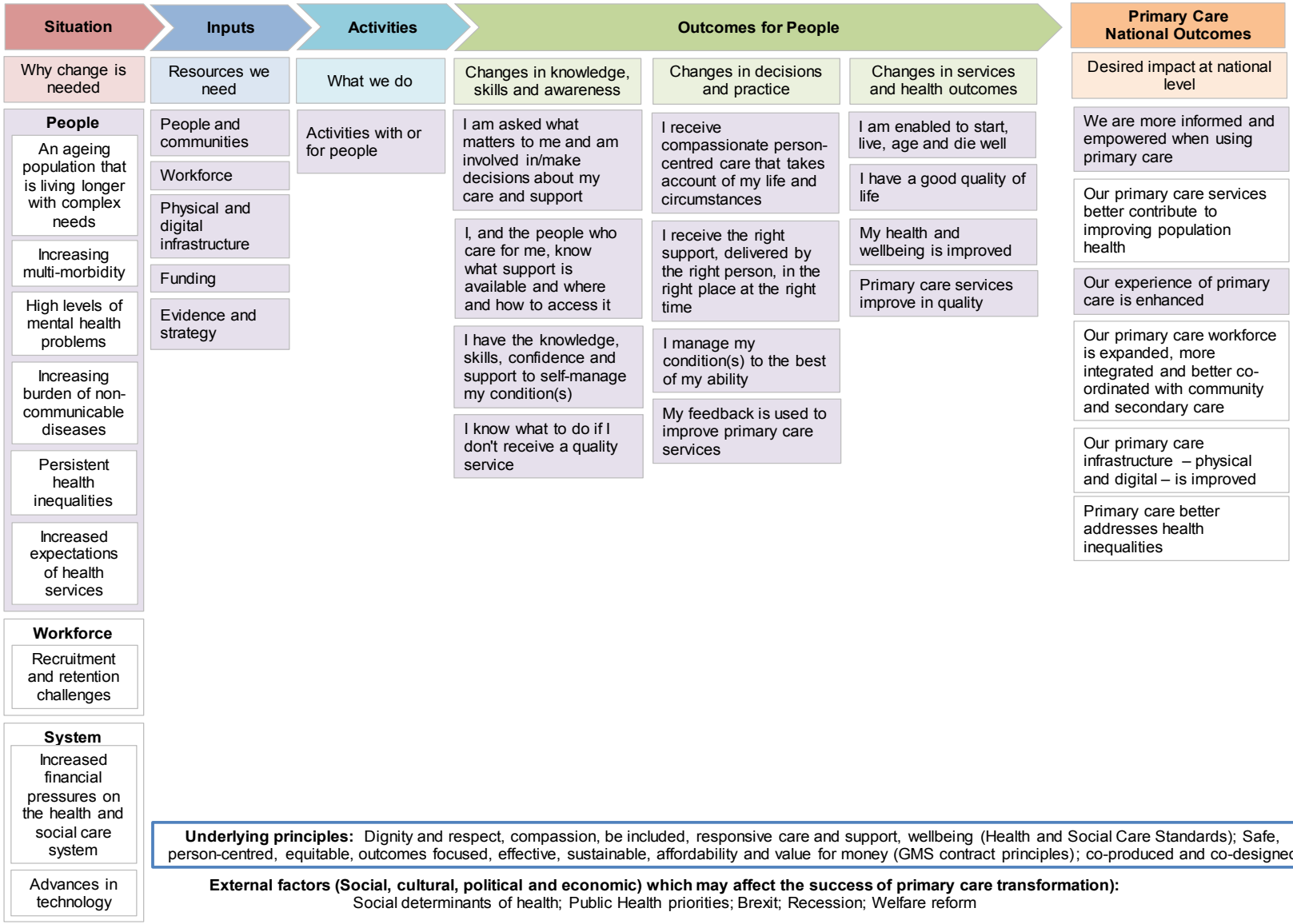
Our anticipation is that the approach, principles, priorities, and the roles and responsibilities laid out in this Strategy provide direction for telling the story of how we reform primary care over the next decade – for patients and communities, for a diverse multi-disciplinary workforce, and for the 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

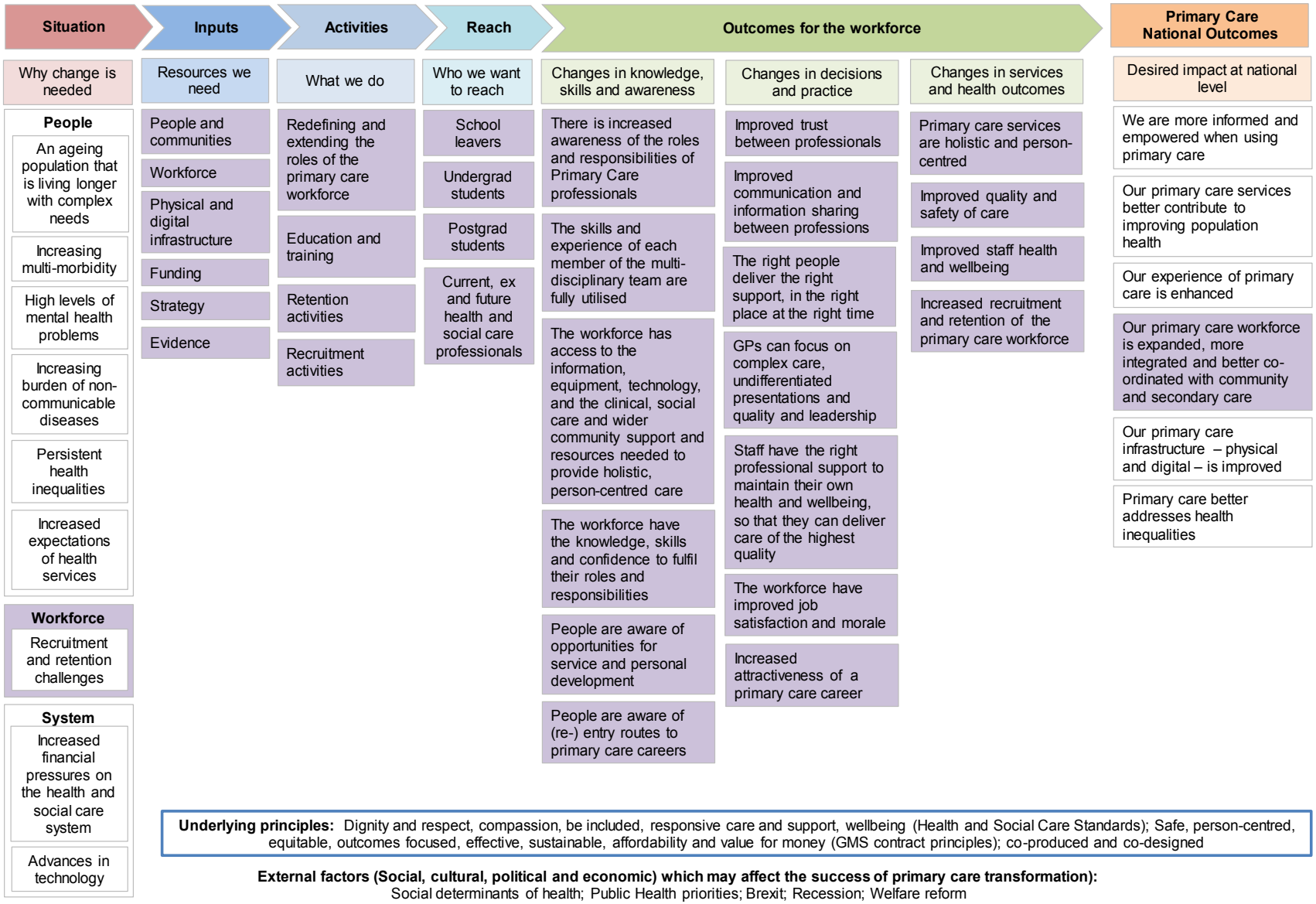
1. Strategic Level Outcomes Framework



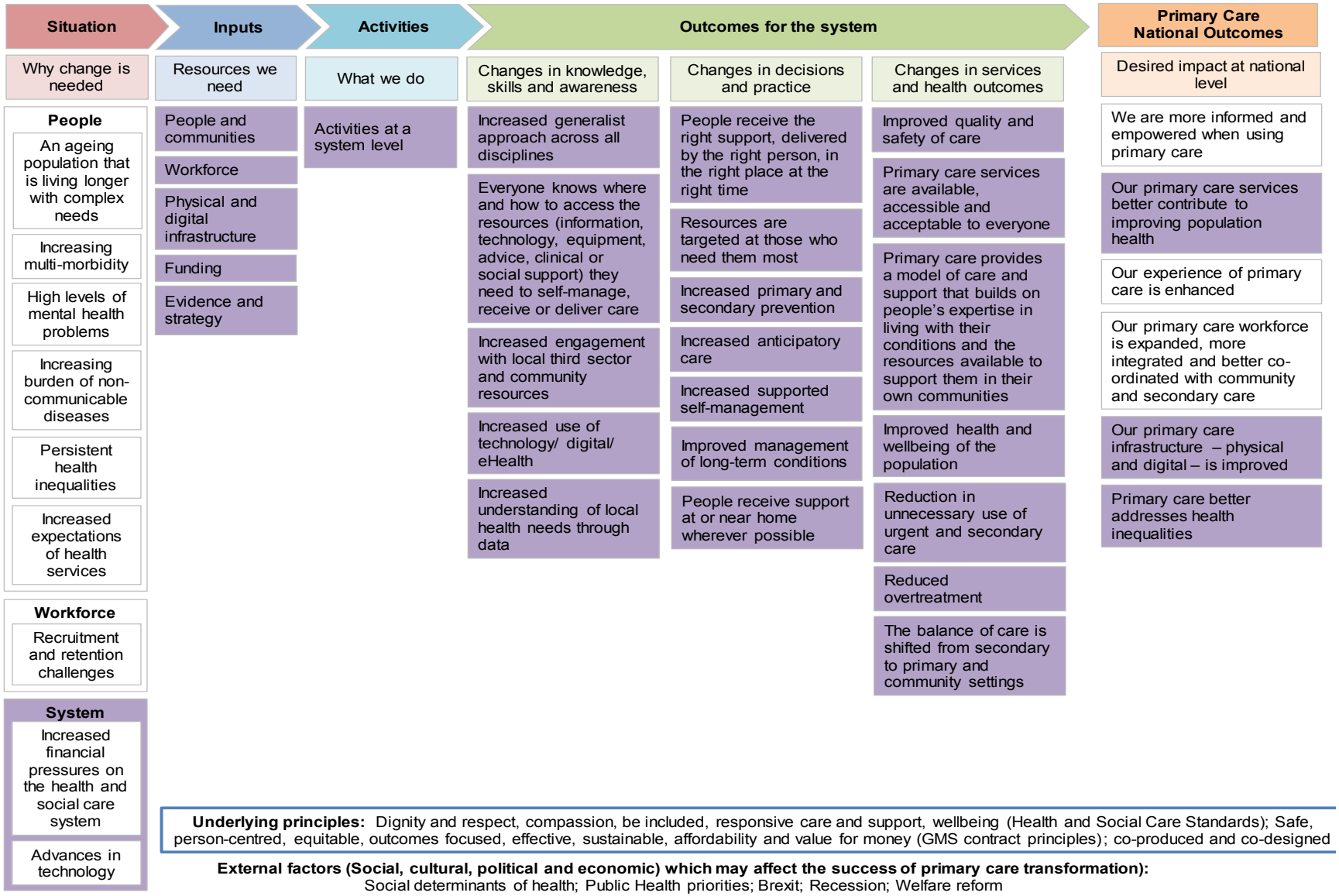
2. Primary Care Outcomes for People



3. Primary Care Outcomes for the Workforce



4. Primary Care Outcomes for the System



Annex 2: National Indicators for Primary Care: Overview

Primary Care Outcome	Sub-outcome	Measure	Source
1. We are more informed and empowered when using primary care	1a. People are more informed	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)	HACE - established
	1b. People are more empowered	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)	
2. Our primary care services better contribute to improving population health	2a. Primary care services better contribute to improving population health (Process)	Increase in the % of people responding to the HACE survey who felt they were able to look after their own health "well" or "very well" *	HACE - established. Possibly replace with public health indicator once established?
3. Our experience as patients in primary care is enhanced	3a. Patient experience is enhanced (in-hours)	Increase in the % of people completing HACE with positive experience of care (rated excellent or good) at their GP practice *	HACE - established
	3b. Patient experience is enhanced (out of hours)	Increase in the % of people completing HACE with a positive experience of Out of Hours care (rated as excellent or good)	
4. Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care	4a. Our primary care workforce is expanded	**Increase in the number (headcount/FTE) of GP employed staff**	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
		Increase in the number (headcount/FTE) of NHS employed staff working in primary and community care settings	
4. Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care	4b. Our primary care workforce is more integrated and better co-ordinated with community and secondary care (in-hours)	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	HACE - established
	4c. Our primary care workforce is more integrated and better co-ordinated with community and secondary care (out of hours)	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	
5. Our primary care infrastructure – physical and digital – is improved	5a. Improved physical infrastructure	% of General Medical Services premises surveyed as being in "good" or "excellent" condition	GMS premises survey
	5b. Improved digital infrastructure	% of GP practices which have an updated clinical IT system	First data expected 2020. Possible link to Quality data in contract?
6. Primary care better addresses health inequalities	6a. Primary care better addresses health inequalities (Process)	Increase in the % of GP practices with access to a community links worker and/ or money/welfare advice services	Primary Care Workforce Survey / Primary Care Improvement Plans?
*** These measures are also existing integration indicators**			

Annex 3: Who will contribute evidence and analysis for monitoring and evaluating primary care reform?

Support agency	Role
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-specific/clinical 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

Methods and sources	For example…
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
Patient Opinion/Care Opinion and other forms of service user feedback	• Qualitative, unsolicited opinion and accounts of experiences

Evaluability Assessment	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.[34] 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.

[34] How to undertake an EA is described in a 2015 paper by What Works Scotland: "Evaluability Assessment: a systematic approach to deciding whether and how to evaluate programmes and policies" - http://whatworksscotland.ac.uk/publications/evaluability-assessment-a-systematic-approach-to-deciding-whether-and-how-to-evaluate-programmes-and-policies /

Annex 5: Evaluation: introductory references

- Health Research Authority (2017) Decision tool - 'Is my study research?
- Health Research Authority (2017) Defining research table

- Scottish Government (2015) Social Research Ethics Guidance and Sensitivity Checklist

- HM Treasury, "The Magenta Book: HM Treasury guidance on what to consider when designing an evaluation" plus supplementary guidance.
  https://www.gov.uk/government/publications/the-magenta-book
  (Version at 27 April 2011 (under review).

- HM Treasury, "The Green Book: appraisal and evaluation in central government. HM Treasury guidance on how to appraise and evaluate policies, projects and programmes."
  https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-govervent

- What Works Scotland (2015) "Evaluability Assessment: a systematic approach to deciding whether and how to evaluate programmes and policies":
  http://whatworksscotland.ac.uk/publications/evaluability-assessment-a-systematic-approach-to-deciding-whether-and-how-to-evaluate-programmes-and-policies/

- Scottish Government (2016) "The 5-Step Approach to Evaluation. Designing and Evaluating Behaviour Change Interventions. Guidance for service providers, planning partnerships, funders and commissioners." https://beta.gov.scot/publications/5-step-approach-evaluation-designing-evaluating-behaviour-change-interventions/

- Project Oracle Resource Library: https://project-oracle.com/resource-library/ and https://project-oracle.com/resource-library/evaluation-planning

- National Audit Office "Framework to review models." https://www.nao.org.uk/report/framework-to-review-models/

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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This document is also available from our website at www.gov.scot.
ISBN: 978-1-78781-363-2

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

Produced for
the Scottish Government
by APS Group Scotland
PPDAS495126 (03/19)
Published by
the Scottish Government,
March 2019

GSR
GOVERNMENT SOCIAL RESEARCH
Social Science in Government

Social Research series
ISSN 2045-6964
ISBN 978-1-78781-363-2

Web and Print Publication
www.gov.scot/socialresearch

PPDAS495126 (03/19)