The challenges of scaling up innovative models of integrated care: lessons from the Gnosall primary care-based dementia service

Presentation to the 3rd International Conference on evidence-based policy in long-term care, LSE, London
31 August – 3 September, 2014

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PSSRU
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Context

- Ageing populations – challenges of chronic conditions, multi-morbidity and prevalence of dementia
- Costs of dementia care, and to society and individuals

- Good examples and experiences of care, but concerns raised in England about care services for dementia in general (Gilburt et al 2014; Royal College of Psychiatrists 2011)
- Diagnosis gap – earlier diagnosis
- Model secondary care-based memory service being widely promoted

- A long history of care innovation in mental health generally, e.g. from long-stay institutions to community (Gilburt et al 2014)
- History of endeavours to improve primary care-based mental health care (e.g. Jackson 1993; DH 1999)
- But, primary care has often been seen as a problem rather than part of the solution (Gilburt et al 2014; Banks & Gask 2008)

Gnosall, Staffordshire, England

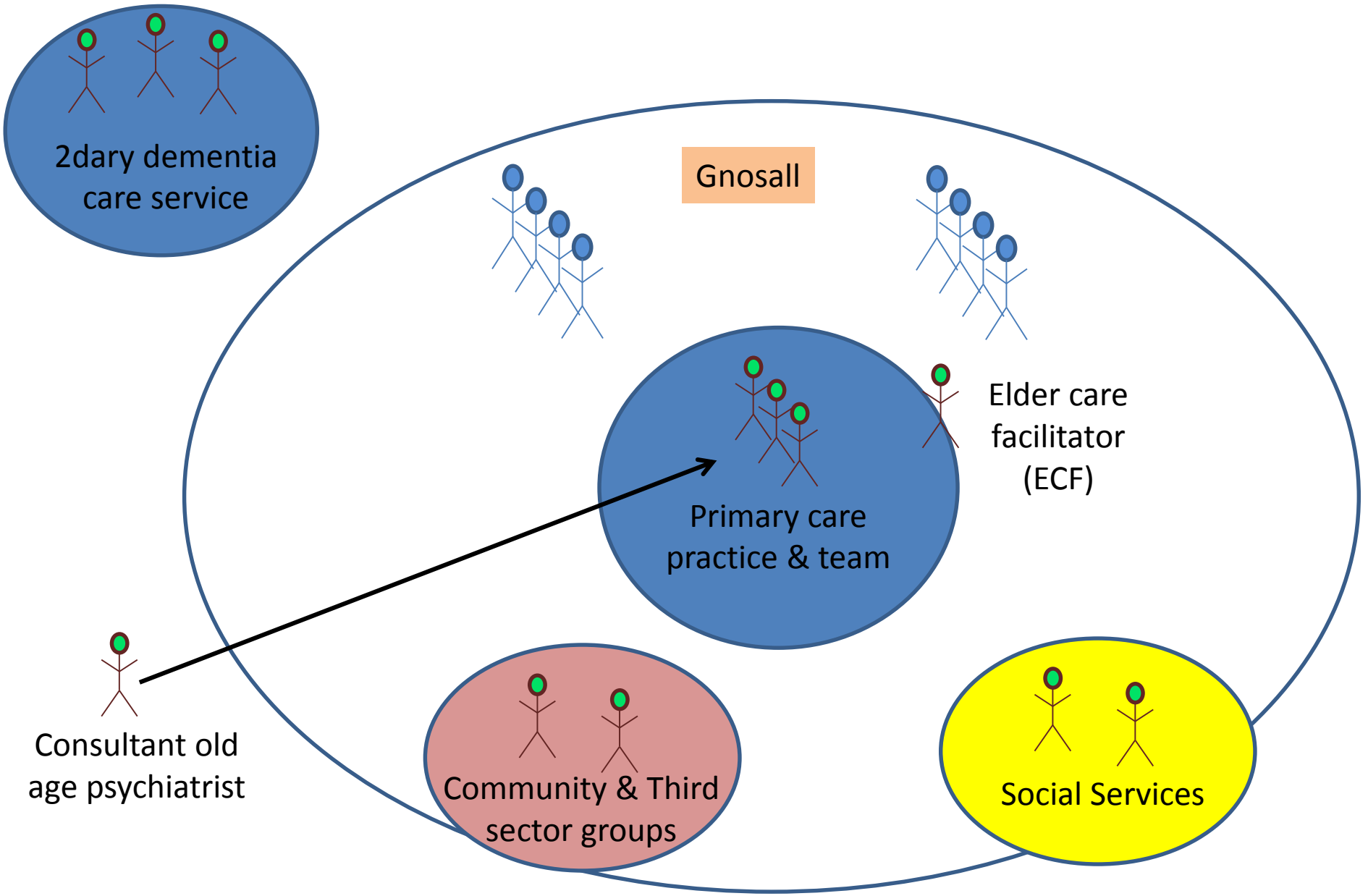
- Village
- Population around 8,500
- Few people from Black and Minority Ethnic backgrounds
- Very rural
- 1 medical centre
- Hospital services in Stafford (c10 miles) and for more complex needs services are in Stoke-on-Trent and Wolverhampton (both c18 miles)

Gnosall Medical Centre

- New building opened in 2006
- Primary Care Practice
- Integrated pharmacy, optician and dentist, and other services
- History of innovation

- Initiated a primary care-based memory service in June 2006

The Gnosall Memory Service Model



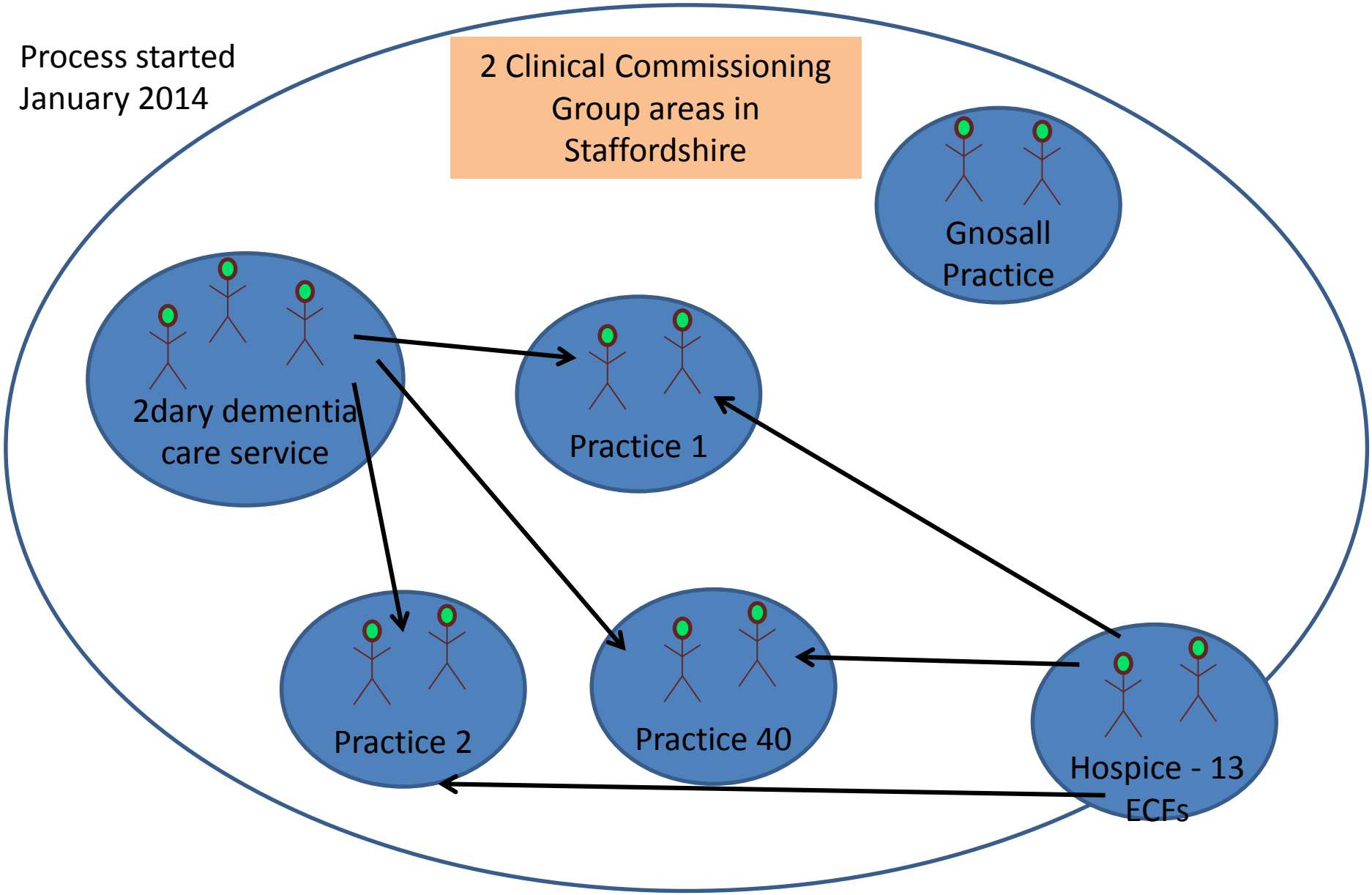
The Gnosall Memory Service Model

Successes of the services:

1. In the first 12 months the service had a referral rate 3 times that of the model secondary care memory service (Croydon);
2. Number of people registered as having dementia has remained at or above the predicted prevalence;
3. Patient and family/carer satisfaction very high;
4. In the first 6 years, only 3 referrals made for secondary mental health support, and 1 for tertiary;
5. Analysis by the (then) Strategic Health Authority – actual use in 12 months of secondary mental health care was £6k p.a. against a predicted £122k p.a., and £450k less than expected use of all secondary care facilities;
6. Nationally recognised service, won several awards.

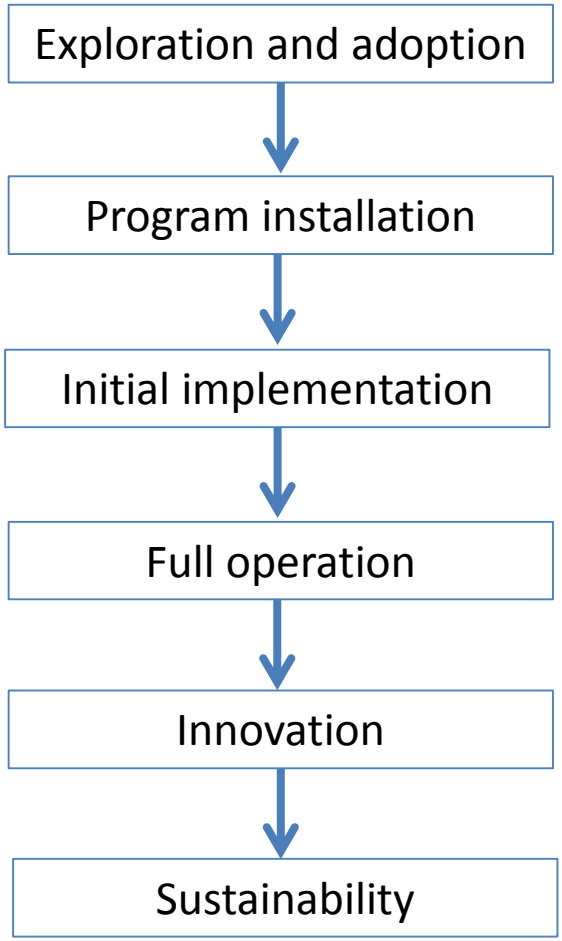
Clark et al (2013), Greaves et al (2013)

Wider implementation - the roll out



Understanding implementation

Stages of implementation



Understand features and interactions of:

- The innovation
- The adoptees
- The system
- Diffusion processes
- Wider context

Fixsen et al (2005); Greenhalgh et al (2004)

Normalization Process Model (NPM)

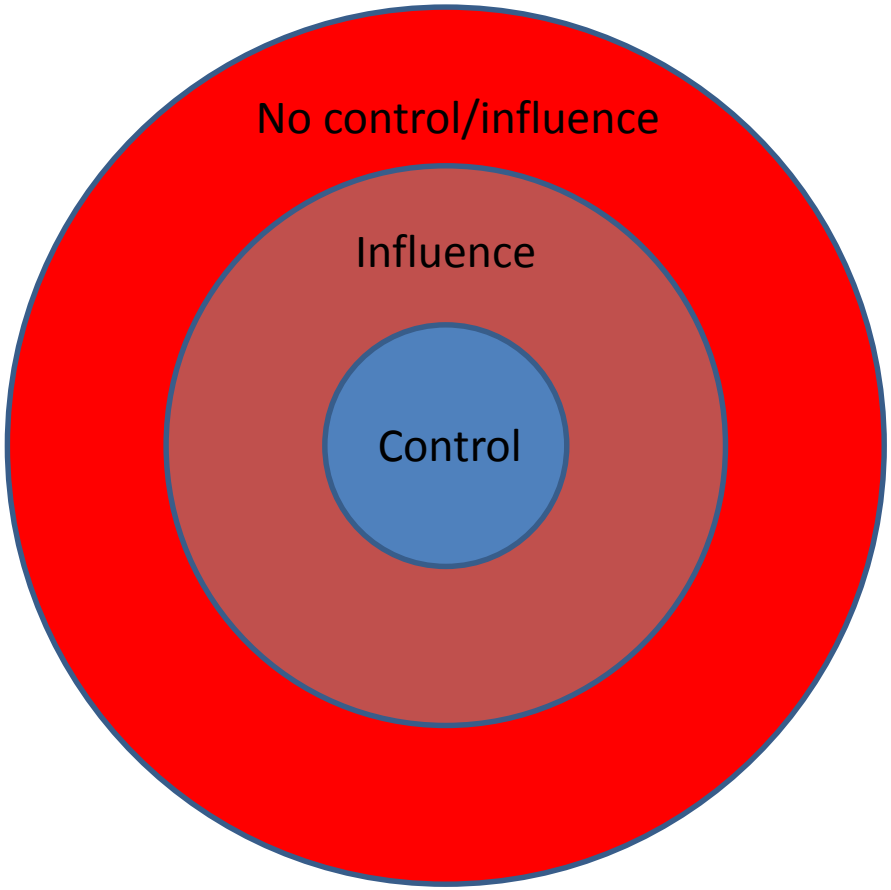
Analytical framework to understand *how and why practices become normalised in a setting*.

4 broad components:

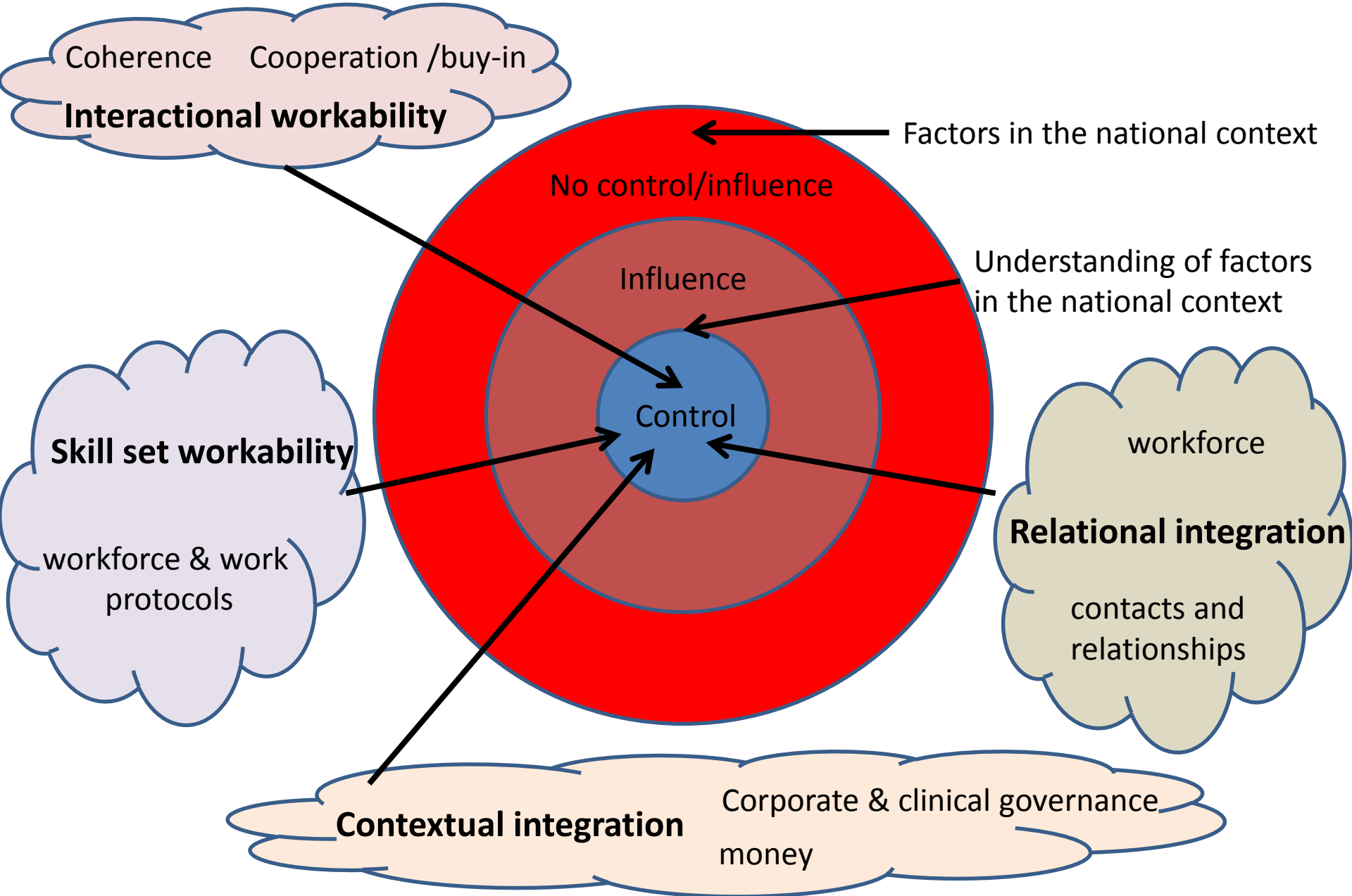
1. *Interactional workability* – is the new practice consistent with participants assumptions about the work – legitimacy, goals, meaning, outcomes, and conduct and cooperation of participants;
2. *Relational integration* – do the new practices embody what participants regard as valid knowledge and appropriate sources of expertise;
3. *Skill-set workability* – is the new practice compatible with the existing division of labour – resources, methods of monitoring work, quality of work;
4. *Contextual integration* – can the host organisation understand and agree the allocation of control and infrastructure resources to implement the practice and negotiate its integration into existing patterns of activity

Gask (2008), May (2006), May et al (2007)

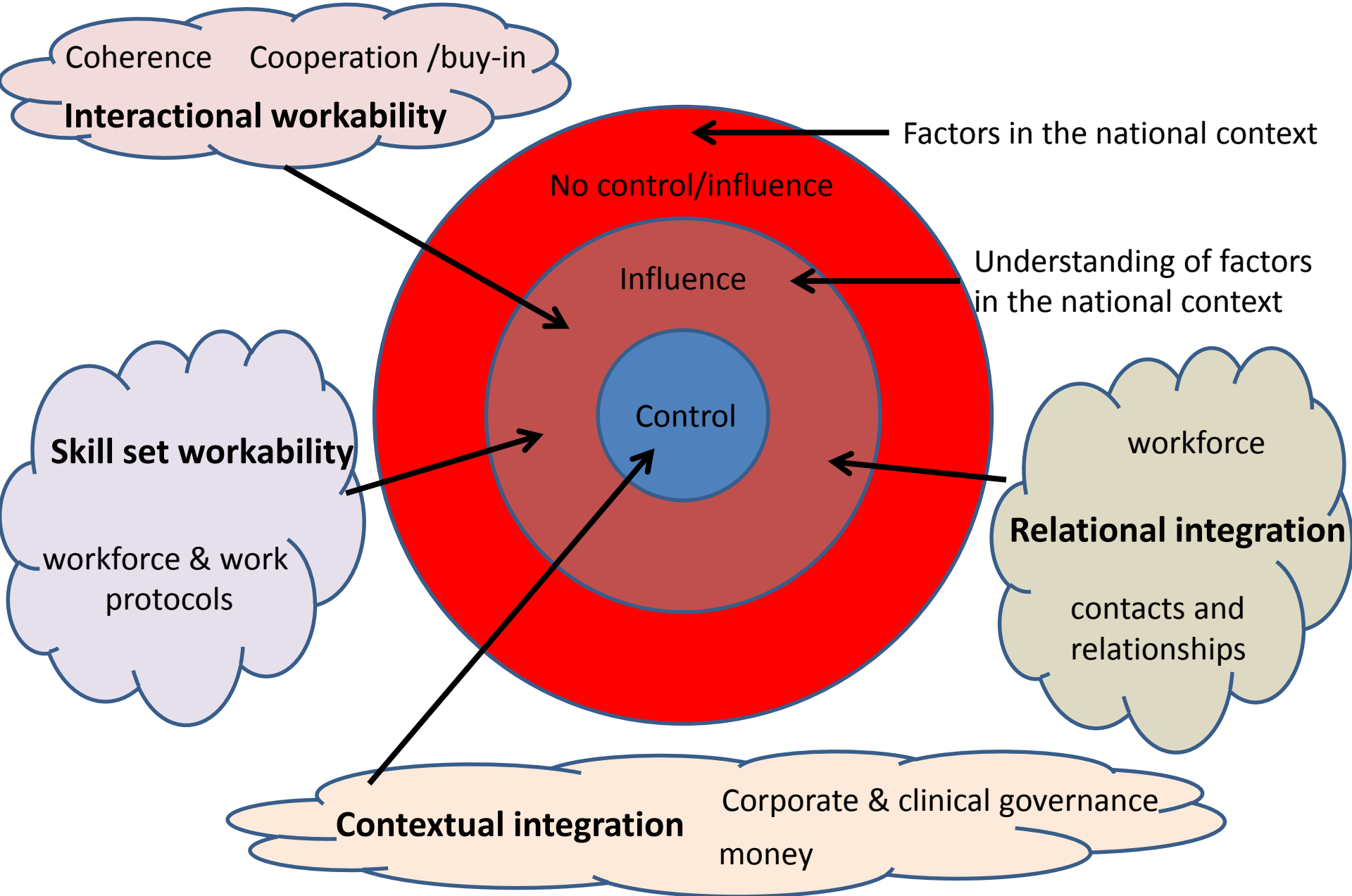
Control, Influence



NPM & Initial development and implementation in Gnosall



NPM & Roll-out


Coherence
Cooperation /buy-in
Interactional workability
Factors in the national context
No control/influence
Influence
Understanding of factors in the national context
Control
Skill set workability
workforce & work protocols
workforce
Relational integration
contacts and relationships
Contextual integration
Corporate & clinical governance
money

Thank you

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