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**Person-Centred Care**

**Local CQUIN Templates 2016/17**



**Person-Centred Care: Local CQUIN Templates 2016/17**

Version number: 1.0

First published: March 2016

Prepared by: The Incentives Team, Commissioning Strategy

Classification: OFFICIAL

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# 19. Motivational Interviewing

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| --- |
| **Indicator name** | Increased training of staff in core skills of motivational interviewing for improved care planning |
| **Indicator weighting (% of CQUIN scheme available)** | To be agreed locally |
| **Description of indicator** | There are three parts to the indicator:1. Percentage of identified staff that complete training.
2. Percentage of patients in the agreed cohorts who have had a Care Plan developed utilising Motivational Interviewing techniques.

Percentage improvement in staff reporting confidence in completion of care plans which use motivational interviewing techniques |
| **Numerator** | Part 1 – staff trainingNumber of identified staff that complete trainingPart 2 – Application of trainingNumber of patients in the agreed cohort who have had a care plan developed utilising motivational interviewingPart 3 – Staff confidenceTo be determined based on how staff confidence is decided to be measured using a self-reported tool. |
|  **Denominator** | Part 1 – staff trainingNumber of identified staff to be trainedPart 2 – Application of trainingNumber of patients in the agreed cohortPart 3 – Staff confidenceTo be determined based on how staff confidence is measured, using an agreed self-reported tool. |
| **Rationale for inclusion** | The rationale is to develop the skills of appropriate staff in the techniques of motivational interviewing/health coaching, so that effective care plans can be developed which support patients to self-manage their long-term condition and actively participate in the decision-making related to their care.Motivational interviewing is a tool that care professionals can use to help develop, in partnership with the patient, care plans which encourage self-management and choice; and which empower and support the patient to improve control of their own condition. A key component of this is that health (and other/social) care professionals work with a patient to identify their own care plan, and address potential barriers to behaviour change. |
| **Data source** | Providers |
| **Frequency of data collection** | Quarterly |
| **Organisation responsible for data collection** | Providers |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | To be agreed locally |
| **Baseline value** | To be agreed locally |
| **Final indicator period/date (on which payment is based)** | Q4 2016/17 |
| **Final indicator value (payment threshold)** | Payment based on achievement of quarterly milestones |
| **Final indicator reporting date** | To be agreed locally |
| **Are there rules for any agreed in-year milestones that result in payment?** | See section on milestones |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | See section on milestones (note that some elements of the milestones are geared to a multi-year scheme so these will need to be amended as appropriate). |
| **EXIT Route** | To be agreed locally |

##

## Milestones

| **Date/period milestone relates to** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| **Quarter 1** | Providers must identify the relevant staff members required to undergo training, and identify the training provider and course to be undertaken. Providers must also confirm course dates. |  | 5% |
| Providers are to source a self-assessment tool for staff, to establish staff confidence pre training (as a baseline) |  | 10% |
| **Quarter 2** | At least 95% of identified staff must complete the jointly agreed motivational interviewing training, which will be verified by training schedules and attendance records by the end of Quarter 2 2016/17. |  | 25% |
| **Quarter 3** | At least an agreed percentage of the relevant patients have had a motivational interviewing care plan developed. The care plan must be:Developed with the patient and focus on self-management, with patients setting their own goals in partnership with the healthcare professional. * Support health and wellbeing by addressing lifestyle improvement.
* Integrated across agencies and systems
* Shared with the patients’ GP
* Monitored for progress against goals at review appointments

Signpost to relevant support agencies, such as the voluntary sector as appropriate |  | 15% |
| Providers to submit a year 2 draft action plan which will have been developed using feedback from staff, and must identify potential patient cohorts for inclusion in year 2, and provide rationale as to their inclusion. |  | 10% |
| **Quarter 4** | At least an agreed percentage of the relevant patients have had a motivational interviewing care plan developed. |  | 15% |
| Audit in Q4 of the care plans of patients discharged from acute care being followed up by the community team in Q3 &4:* To see if the patients have achieved their goals (Fully, partially or not achieved)
* To see whether there has been an increase in staff confidence after training by use of the self-assessment tool developed in Q1.

A report must be submitted to commissioners to include an over-arching milestones plan, and detailed action plan with timelines for implementation in year 2. This must include (but is not limited to) the above audit results, staff feedback and a thorough evaluation of the use of this technique. This will be considered by commissioners and agreement will be reached as to the final implementation plans for year 2 as appropriate. |  | 20% |

**Rules for Partial Achievement at Final Indicator P**e**riod/ Date**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
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## Supporting Guidance and References

Further guidance on the scheme:

1. Training of staff in core skills of motivational interviewing/health coaching

Specialist Nurses working in the Acute or the Community Trust that are involved in direct patient care and contribute to care plan development with patients who have long term conditions e.g. COPD and diabetes.

There are a number of recognised training methods which could be employed and providers have the flexibility of developing their training package, but it must be jointly agreed between providers and:

* Be multidisciplinary
* Be multiagency
* Align with best evidence based practice in behaviour change.
1. Embedding of approach within key staff groups with staff able to demonstrate confident delivery of motivational/coaching interviewing with patients to develop an agreed care plan

Using motivational interviewing/health coaching to develop a patient centred care plan with the patient/client that focuses on behaviour change

The care plan must be:

* Developed with the patient and focus on self-management, with patients setting their own goals in partnership with the healthcare professional.
* Support health and wellbeing by addressing lifestyle improvement.
* Integrated across agencies and systems
* Shared with the patients’ GP
* Monitored for progress against goals at review appointments
* Signpost to relevant support agencies, such as the voluntary sector as appropriate

# 20. Patient Activation Measures

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| --- |
| **Indicator name** | Introducing an Activation System for patients with Long Term Conditions (LTCs) |
| **Indicator weighting (% of CQUIN scheme available)** | To be agreed locally – indicative costs of implementation provided in the ‘further information’ section of the template.  |
| **Description of indicator** | Development of a system to measure skills, knowledge and confidence needed to self-manage long term conditions to support (understanding of how to take medication) adherence to medication and treatment and to improve patient outcomes and experience. |
| **Numerator** | Not applicable as the scheme is based on achievement of milestones |
| **Denominator** | Not applicable as the scheme is based on achievement of milestones |
| **Rationale for inclusion** | The implementation of a system focussed on self-care or support for self-management is designed to realise significant benefits to the healthcare system from improved patient outcomes and experience of care and from a reduction in the use of non-elective services.Adherence to treatment has been linked to improved health outcomes and has been shown to increase patient satisfaction by supporting independence which can also be linked to higher quality interactions with healthcare professionals.The CQUIN aims to encourage use of the "patient activation measurement" (PAM) survey instrument, in the first instance to assess levels of patients skills, knowledge, confidence and competence in self-management. Subsequent action will be to support Activation Interventions to tailor service provision according to self-management capability and to raise activation levels.  |
| **Data source** | To be agreed locally. If a software solution is adopted for administration of the PAM, then extracts from the implemented software will be usable to confirm active users and active records.Reporting of action plans should be sufficiently detailed for stakeholders to be able to identify obstacles to optimum patient flows and the actions that are required to improve flow.There is a risk of data contamination – completion of the PAM being influenced by expectations of staff administering it. Ultimately, however, the CQUIN will be judged by intermediate and final outcomes, so the incentive to encourage positive self-assessment should be limited.NOTES:For consistency, and given its validation and the relationship and contract that is in place with NHS England it is proposed that all schemes involve use of the Patient Activation Measure PAM available from Insignia:<http://www.insigniahealth.com/products/pam-survey>Please contact Patricia Muramatsu in NHS England for details on how to obtain a licence. p.muramatsu@nhs.net  |
| **Frequency of data collection** | Quarterly |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | Not applicable as the scheme is based on achievement of milestones |
| **Baseline value** | Not applicable as the scheme is based on achievement of milestones |
| **Final indicator period/date (on which payment is based)** | See milestones section |
| **Final indicator value (payment threshold)** | See milestones section |
| **Final indicator reporting date** | See milestones section |
| **Are there rules for any agreed in-year milestones that result in payment?** | See milestones section |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | See milestones section |
| **EXIT Route** | To be agreed locally |

##

## Milestones

| **Date/period milestone relates to** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| **Quarter 1** | Provider to:* agree vision for use of PAM measure with cohorts of patients in context of increasing support for self care
* agree the baseline metrics e.g. proportion of patients in each condition recruited into the programme for application of the PAM;
* establish a working group;
* submit an implementation plan to the commissioner;
* agree training plan, including engagement activities to help the workforce understand the importance of patient activation;
* secure licence from insignia
 |  | 30% |
| **Quarter 2** | Demonstrate local engagement, regular working party outputs, performance against implementation plan |  | 10% |
| **Quarter 3** | Implementation of the programme locally with pilot testing and evaluation |  | 10% |
| **Quarter 4** | Implementation of the programme: baseline measure of PAM administered to first cohort of patients.Report to commissioners on progress against implementation plan including results from pilot and shared learningDevelopment of plan to roll this programme into next year and expand patient cohort or develop additional parameters for inclusion. Suggested steps for subsequent years outlined in the ‘further information’ section.  |  | 50% |

## Rules for Partial Achievement at Final Indicator Period/ Date

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
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## Supporting Guidance and References

**What is Patient Activation?**

The definition below is taken from a King’s Fund appraisal of ‘patient activation’[[1]](#footnote-1)

*“Patient activation is a behavioural concept. It captures a number of core components of patient involvement, each of which is important for active engagement and participation. It is defined as ‘an individual’s knowledge, skill, and confidence for managing their health and health care”.*

**Identifying appropriate patient groups**

Patient groups who stand to benefit include those with persistent conditions for which

* + there is a Care regime of known effectiveness
	+ Adherence to care regime is complex
	+ Symptomatic abreaction to poor adherence is distal
	+ Symptomatic consequences of poor adherence may – if poor adherence is not recognised – lead to misdiagnosis and mistaken prescription
	+ The severity of the condition does not itself preclude self-care (e.g. through occluding insight (an understanding of the nature of the condition and the factors that make it better/worse) or capacity (in terms of being able to make informed decisions regarding management of the disorder)

Suggested conditions include: Chronic kidney disease; maternity; Chronic Heart Failure, COPD, Coronary Artery Disease, Diabetes, Asthma, severe depression, that have a high rate of unwarranted/preventable A&E visits and hospital admissions.  These are conditions where self-management is quite important and requires patient involvement in many areas — self-monitoring, medications, nutrition, physical activity, managing stress

**Steps for extension of the programme into subsequent years**

The aim of the CQUIN scheme described above is to implement a system for the measurement of patient activation. Realisation of the benefits of PAM depends upon improvement in patient activation and so this should be the focus of subsequent efforts.

Expected outcomes from the continuation of a patient activation programme are:

* Improvement in PAM Score, and/or introduction of other interventions to sensitise service delivery to PAM level
* Aggregate improvement of patient reported health outcomes, improvement in adherence and a reduction in access to non-elective attendances.

There are two broad categories of Activation interventions:

* + stratification of the patient groups to help diagnose problems and determine appropriate care plan;
	+ work with patients to raise motivation, skills and self-management, etc

Regarding activation of patients, there are a large number of behavioural change models available. It is recommended that the COM-B model is used as a default understanding of behaviour change: Capability+Opportunity+Motivation=> Behaviour change.

However, this should not restrict the range of interventions that may be useful in different contexts for different groups, including:

* Commitment support via:
	+ 1. peer group (as proposed for example for HIV patients)
		2. joint appointments (e.g. as default)
		3. carer involvement, etc.
	+ health coaching with Clinical Nurse Specialist or other professional input

**Indicative costs of implementation**

The main cost drivers and their indicative values are as follows:

* number of patients in each condition recruited into the programme for application of the PAM (subject to appropriate exclusions). £45 per patient
* team building and training of staff to administer the PAM. £50,000 per team

Total payment is scaled by the proportion of patients within the designated patient group(s) receiving a PAM score.

1. <http://www.kingsfund.org.uk/publications/supporting-people-manage-their-health> [↑](#footnote-ref-1)