

Islington CCG

Overview of site and work

At the start of the project, NHS Islington CCG comprised 36 GP practices and had responsibility for commissioning services for around a quarter of a million people living in an area under six square miles. Islington is one of NHS England's 14 pioneer sites, developing a more integrated approach to care within the borough.

The aim was to use PAM with patients with long-term conditions across the primary care setting and build on previous outcome measure work conducted in the area. In October 2013, the CCG sent out the LTC6 questionnaire, which asked ~40,000 people with a long-term condition about their healthcare over the previous 12 months, and a 25% response rate (~10,000 people) was achieved. The object was to provide evidence of the efficacy of new services being commissioned. It was felt that use of PAM fitted with the broader direction of travel and work around embedding self-care and self-management support into clinical practice in Islington. Islington decided to use PAM as a means of measuring the effectiveness of a specific intervention. There were two main ways in which the PAM was being used:

- 1) Alongside care and support planning consultations in general practice, with ~28,000 patients
- 2) Embedding the PAM into the contracts for self-management support in three services - Expert Patient Programme, Diabetes Self-Management Programme (DSMP) and the Bariatric service weight regain intervention programme.

The CS-PAM was also scoped by the site as a training tool to measure clinician activation as part of the Advanced Development Programme (a coaching-style training programme for clinicians). Islington CCG requested a total of 38,000 PAM licences and mainly distributed the questionnaires by post.

Project 1: Care and support planning in general practice

Islington CCG commissions GP practices to offer collaborative care and support planning consultations with their patients with a list of long-term conditions, historically agreed in collaboration with Islington Public Health department. These conditions included: chronic obstructive pulmonary disease (COPD); diabetes; heart failure; atrial fibrillation; a cancer diagnosis; ischaemic heart disease; chronic kidney disease; dementia; hypertension; mental health problems (including depression); liver disease.

GPs were initially commissioned (February 2013 to November 2014) to offer enhanced collaborative Year of Care support plans only to people with diabetes, and this was implemented via a locally commissioned service (LCS). From December

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2014, this LCS was merged into an LCS which offered the enhanced care planning approach to all patients with a long-term condition.

As part of the 2014/15 GP contract, NHS England also commissioned GPs to develop a care plan with patients identified as being in the practice's top 2% of people who are deemed to be at risk of being admitted to hospital. The care planning commissioned by NHS England was not a collaborative enhanced care plan in the style of Year of Care, but the patients in this cohort often also included people with multiple long-term conditions who were receiving a Year of Care approach.

Commitment to engagement with the PAM project was embedded into the long-term condition LCS, which was initiated in October 2013. In order to ensure consistency across each GP practice, a search to identify patients who should complete the PAM was developed and uploaded onto each practice's clinical system. The team developed a template, enabling practices to code the patient activation score and free text space to record the level. The method of survey distribution (postal or face-to-face) could also be recorded. A pack detailing how to deliver the PAM tool was developed and sent out to each practice. The pack included:

- A letter to practices explaining patient activation, how this would be measured with the PAM tool, and what was expected of the practice;
- A step-by-step guide for how the CCG wanted practices to collect the PAM data;
- A letter to be sent to patients explaining why the tool was being sent to them and a copy of the questions;
- A letter including the PAM tool, to be sent to patients who had not responded to the initial mail out, with their invitation for their collaborative care and support planning appointment; and
- A copy of a spreadsheet that would enable practices to calculate the PAM score and level.

Practices were paid £2.50 to calculate and register PAM scores to patient records. GP practices were also sent details of a retrospective review that they were expected to complete a year later, after a second PAM has been sent out to patients.

Although practices recorded the PAM score, Islington was keen to embrace the principles underpinning patient activation as a concept and not just focus on the number/score the tool produced. The score was not formally used by clinicians within the care and support planning process (as a tailoring tool), however it is visible in patients' electronic records. The team believed that there was a danger in focusing on the numbers in a superficial manner and limiting the depth of the ongoing relationship that clinicians were trying to develop: e.g. if a patient has a low activation score, the GP may decide it is not worth discussing the full range of support services available and thereby limit choice.

Initial data collection for 2014/15 finished in March 2015, with a response rate of 25%, providing baseline PAM scores for around 9,000 patients. This data was then

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shared (following appropriate NHS Information Governance procedures) with the Health Foundation Data Analytics team, who undertook a detailed analysis of this data.

The PAM was used for the second time from October 2015, and the deadline for completion was February 2016. These data were also been passed to the Health Foundation Data Analytics team and analysis is ongoing. Of a population of 40,528, 7,000 scores were collected representing a completion rate of 17%.

It is intended that there will be a retrospective audit (July 2016) on 10% of patients with long-term conditions who have had two PAM scores; this will explore how their activation levels may have changed and it is hoped that this work may enable the development of more targeted approaches to improving activation within practices. Relevant patients will be identified using EMIS, and a template has been designed that will enable other data to be recorded; for example, if a new long-term condition has been diagnosed since the last PAM, number of care planning appointments carried out and information on how the PAM survey was completed and returned.

More broadly, in their integrated care work stream, the CCG has started to test new models of multi-disciplinary team working, introducing a new team to work with patients seen as at higher risk. As an informal part of this work, the team has compared their referrals list with patient PAM scores where available. The aim of this very small-scale work is to start to look at whether the patients referred into the service also have low levels of activation.

An independent evaluation of the Year of Care diabetes care planning work was conducted in 2015, to ascertain if there are links between diabetic patients with care plans and improved clinical outcomes. The evaluation also assessed how engaged GP practices had been with this process. In summary the evaluation found:

- High performing practices (in terms of number of care plans completed) were achieving better patient outcomes.
- Practice staff were interviewed and it showed that there was good buy-in to the ethos of the new approaches, but that there were sometimes skills gaps in practices, in terms of delivery.
- The need for training in coaching and motivational interviewing has been recognised.

Work is currently underway to devise training, tailored to practice needs. The training will also serve to develop a greater understanding of the concept of activation and how patient activation scores/levels can be utilised in the delivery of collaborative care and support planning (CC&SP). It is expected that this approach will result in directly tailoring interventions to patients based on their levels of activation. The practices who have demonstrated the most commitment and enthusiasm for delivering CC&SP will be asked to trial this way of working and their learning will inform a wider roll out across the whole of Islington's primary care landscape later in the year.

Project 2: Self-management commissioning contracts

This project involved embedding the PAM into the contracts for self-management support in three services, all commissioned from Whittington Health NHS Trust:

- Expert Patient Programme
- Diabetes Self-Management Programme (DSMP)
- Bariatric service weight regain intervention programme

Those administering the service were asked to record PAM scores at the start and end of each programme. The focus was on using the PAM as a measure of intervention effectiveness, rather than as a measure to shape how the support programme would be delivered. Work using the PAM started later than originally planned, which was due to a number of issues including staffing changes which meant that early enthusiasm for using the PAM stalled.

After a slow start, the projects are now starting to generate data.

- Expert Patient Programme: For those who completed both pre- and end-course questionnaires the average Patient Activation score prior to participation in EPP was 50 and the average end-of-course score was 59, an average increase of 9 points (based on 17 completed pre- and end-course questionnaires).
- Diabetes Self-Management Programme: For those who completed both pre- and end-course questionnaires the average Patient Activation score prior to DSMP was 58 and the average end-of-course score was 70, an average increase of 12 points (based on 36 completed pre- and end-course questionnaires).
- Bariatric service weight regain intervention programme: Fifteen patients took part in the study which looked at post bariatric-surgery activation levels (measured at attendance in dietetic clinics). Although the study was small, there was some suggestion that low PAM levels might be associated with poor outcomes and it is hoped that this work can be pursued further.