Sheffield CCG

Overview of site and work

NHS Sheffield CCG comprises of 87 GP practices and has responsibility for commissioning services for approximately 580,000 people.

The PAM has been used in four project areas:

1) A pilot project with Sheffield Health and Social Care (SHSC) NHS Foundation Trust working with 14 patients with serious long-term mental health problems in the community.
2) A six week, peer-facilitated course focused on activation was run for patients with long term conditions. The PAM was administered at the start and end of the course.
3) As part of diabetes self-management annual reviews in a large primary care practice. The project has been running for around a year and follow-up PAMs are beginning to be completed.
4) Citywide care planning, using the PAM as part of a locally commissioned service for long-term condition management. Citywide care planning is now in the third year of a five year programme.

Project 1: Mental Health Pilot

As part of a pilot project commissioned April 2013 – March 2015, people with serious mental health problems and physical co-morbidities in three GP practices were provided with extra support to improve health outcomes with the long-term goal of reducing health inequalities. The project worked across primary and secondary care providers to develop an annual health check taking a holistic view of mental and physical health. A community development worker also worked with this patient group to introduce small interventions with the aim of reducing isolation. Between September 2014 and March 2015, the community development worker integrated the PAM into her work with 14 patients to measure activation levels. Activations levels were used to tailor these small interventions and to capture further information about the patient cohort and their needs compared with the general population. The EQ5D (a standardised instrument for use as a measure of health outcomes) was also administered for this purpose.

Though the initial mental health pilot work has finished, there are currently plans to use the PAM in a further SHSC NHS Foundation Trust project, measuring the improvement in self-management confidence following a six week course for people with long-term conditions developed with Sheffield Increasing Access to Psychological Therapies (IAPT).

Project 2: Peer Facilitated Course

The peer-facilitated course was a six week training course for people with long term conditions; it was funded by the CCG. Of 17 patients who began, 12 people finished it. Participants had been signposted to the course by GPs and health trainers, and had self-referred into it. A paper version of the PAM was handed out to individuals who completed this on their own.

The course provided a forum where patients could talk through problems with their peers and jointly explore solutions. The course was facilitated by two people with a long term condition, one of whom was an expert patient. When the PAM was re-administered, at the end of the course, it was found that all patients' scores had increased, and it was felt that the PAM could be a useful measure for similar assets-based interventions. The course has been internally reviewed and, at present, there are no plans to run it again.

Project 3: Diabetes Self-Management

The type 2 diabetes self-management project is based in the Sloan Medical Centre practice. The practice has ~12,000 patients and 10 regular GPs. The PAM has been used for some time, and one GP and the practice nurses initially piloted its use for diabetes self-management, which was rolled out across the practice in early 2015. The practice had already bought PAM licences before joining the learning set. Activation levels are fed back to patients as part of an intervention to improve self-management and tailor services at an individual level. As part of the Diabetes Year of Care pilot, all clinical and administrative staff (GPs, nurses, reception staff, admin and IT support team, HCAs) at the practice received training about the PAM in late 2014. All diabetes patients have pre-testing (BMI, blood pressure, blood and urine testing and foot check) with a HCA prior to their annual review appointment. The PAM is completed at this pre-testing appointment, and patients receive their results, including the PAM, from the administrator, both over the phone and via a letter, prior to their review appointment. At their 20-to-30 minute review appointment with a practice nurse, patients have the opportunity to discuss the results of their tests and to be coached in a manner appropriate to their level of activation. Follow-up appointments are focused around person-centred care planning, as appropriate. Measures including changes in the PAM score, emergency admissions, prescriptions and contacts with the GP will also be recorded as outcomes data as part of an evaluation being undertaken by the city council.

The practice staff are broadly positive about this new way of working, including the PAM, which they say provides a more robust system for ensuring diabetes reviews are conducted. It is felt that getting the system right, including where and when the PAM was completed by the patient, was critical to ensuring its success. Since the initial phase of work, one of the practice nurses who led the diabetes work has left to work at another practice. This has led to some small scale changes in how the appointments are organised, with a GP seeing the more complex/ uncontrolled diabetes patients and another practice nurse seeing the patients who have more stable HbA1c levels.

By 2016, the project has been running for around a year, and the practice continues to collect PAMs on all patients with type 2 diabetes; the practice reports that few

patients have declined to participate, and a broad range of activation scores have been found within the type 2 population.

Since some slowing of the project following staff changes, two nurses have been trained in care planning and the GP leading the project has become the practice lead for diabetes; the project is regaining momentum and follow-up PAMs are starting to be done.

Some feedback from those administering the PAM has indicated that sometimes the patient's score does not reflect the clinician's view of that patient's level of activation and, consequently, the PAM is increasingly viewed as an indicator or guidance tool, rather than as a hard outcome measure. The PAM is also thought to have value as a means by which the concept of activation can be introduced to patients and practitioners.

Although there are no plans to significantly change the diabetes programme, it is felt that care planning (with PAM as a component) could be useful for all patients as a general marker of health because of concerns that focussing on a specific disease could mean that other problems were missed. There is some uncertainty as to how it might be feasible to administer the PAM to a general population (by post or at routine consultations). When reflecting on how the PAM could be used in a general population, an interviewee commented that ideally scores would rise, but considered it equally important that they did not fall; 'a score staying constant need not necessarily be a bad thing as it would signal that there was no deterioration'.

Project 4: Citywide Care Planning

Training for the citywide locally commissioned scheme for person-centred care planning in primary care started in the last quarter of 2014/15. The PAM has been used since April 2015 to help to deliver person-centred care planning. It is administered by practice staff (particularly healthcare assistants, administrative staff and nurses), and also by community support workers employed by Sheffield City Council who are working closely with practices, and by community nurses for housebound patients. NHS Sheffield CCG is split into four localities (Central, North, West and Hallam and South Localities (HASL)). Training for person-centred care planning and using the PAM was delivered in a group setting by a mix of internal and external experts, and supported by online training resources available from Insignia. Each GP practice was required to send at least one clinician and manager to one of 11 repeated standard training afternoons. Follow-up support was then available via multidisciplinary locality support teams (LSTs), who act as champions and trouble-shooters. GP practices were incentivised between £2,500 and £10,000 per year depending on practice size to carry out the requirements of the locally commissioned service.

Use of the PAM builds on a previous year-long pilot of care planning, in which a lack of effective training was identified as a potential barrier to successful person-centred care planning. The PAM is seen as a tool to help clinicians to alter their approach to self-management and person-centred care, changing the manner of clinical consultation to ensure that the patient's goals are captured and inform their healthcare. The overall aims are for staff to develop skills in person-centred care, to

increase work with the local authority and the third sector, and to build on the national Unplanned Admissions Enhanced Service to include patient views, goals and self-support, with the goal of ensuring that patients feel empowered to self-manage. Of the 87 practices across Sheffield, 80 have signed up to participate in the care planning work. Following feedback from the training sessions, the CCG allowed individual practices to make a case for using the care planning approach and the PAM with a different cohort of patients with long term conditions, if they felt it would be more effective. Fourteen practices had taken this up for the purpose of the pilot work. The CCG started to receive completed PAM questionnaires in July 2015, at the end of the first quarter of the year's piloting implementation.

The total number of patients in the pilot projects was 7,550 and, by the end of the last quarter in April 2016, 4,915 PAMs had been returned, and 4,715 care plans (using the template) have been completed. It was hoped that, ideally, 2% of the population would have care plans, but a hard and fast quantity was not demanded and, in practice, a lower limit of around 1% of a practice's patients was set, but it was felt that if a practice was making progress then money would not be withheld if they failed to meet the target. It was considered more important that practices became engaged with the underlying ethos of care planning.

Informed by learning from the second pilot phase, the next phase of the citywide care planning is underway. The CCG has successfully applied for 100,000 PAM licences. Practices have been invited to develop their own plans for 2016/2017 and to submit them by end of May. As of June 2016, 60 out of 69 plans have been returned and the review process is underway. Support will be offered by the LST if plans need to be refined. Practices are being encouraged to identify their own cohort of patients and give a rationale for why they have been chosen. No fixed number has been defined as a target and, again, it is hoped that this will enable practices to prioritise 'quality' over 'quantity' and use the process to embed person centred care. The plans will be used as a benchmark or a 'soft contract' against which to evaluate a practice's performance over the year; in this way, practices are able to participate in defining the measure of success to which they can be held accountable. As part of the accountability process, practices will be required to produce 'case studies' that document their work.

In response to feedback from the pilot, which indicated the PAM was too American and too lengthy, an English language, 10 question version has been introduced. Practices have been assured that the score from the 10 question version aligns to the 13 question version, and so practices can move to the 10 question version and use it to re-test patients.

Locality Support Team (LST)

In the last two years the LST has grown, as has the range of support that they are able to offer practices. The LST is made up of a range of health professionals including GPs, practice nurses and practice managers. The team is funded until autumn 2016 and each member's time (generally 1-2 days a month) is bought out. The team have regular meetings. The practical remit of the team is to offer training, support and disseminate learning around care planning, as well as to evaluate activity. At a strategic level, the team are advocates for person centred care and seek to drive engagement with new ways of working.

Amongst the LST, care planning and PAM is seen as an opportunity for services and staff to engage with the changes to practice envisioned in NHS Five Year Forward; particularly, person centred care and ‘get ahead of the curve’. The aim is to ensure that staff are skilled at allocating resources (clinical and social) to ensure that patients have the right support at the right time and to gain an understanding of how ready/receptive patients are to become more active participants in their care. When visiting practices, the team tries to include personnel who are doing the same jobs as those they are visiting; it is felt that this ‘matched perspective’ gives the advice of the LST greater legitimacy. The team intend to visit all 69 practices and will use the information generated from the 2016 practice plans to prioritise which practices might need the most help. The team have developed a system for documenting and tailoring their visits to practices, and recording and feeding back the issues that practices bring to them.

The LST have some limited resources available and have organised two events centred on person centred care planning, one in November 2015 and one in April 2016 and they offer practical training (for example, on motivational interviewing). Although the LST programme has been funded for another year in a difficult financial climate, it is not clear that the type of support offered by the LST will be available in the longer term and the LST are keen that practice plans show sustainable ways of working. Some LST members have reflected that achieving the desired cultural shift will be a long game, but they feel that getting a critical mass of practices on board will herald a ‘tipping point’, after which person centred care will become normalised into routine practice.