NHS Somerset CCG

Overview of site and work

NHS Somerset CCG comprises 400 GPs (310 whole time equivalents) based in 72 practices and has responsibility for commissioning services for a dispersed rural population of around 560,000 people. The design of the organisation is based on a locality model, with nine Commissioning Localities. In 2014, Somerset CCG introduced a local pilot of a GP quality scheme, known as the Somerset Practice Quality Scheme (SPQS) which replaces elements of the QOF for practices who sign up to it.

Building on this work, Somerset CCG is working with providers to develop a capitated budget, outcomes-based commissioning framework for all services for people living with long-term conditions in Somerset. In July 2015, the CCG published a comprehensive document which outlined the way in which outcomes-based commissioning would be implemented The 'pay for performance' criteria to be used are currently under negotiation, but patient activation will be a core outcome measure.

The CCG's strategy was to encourage and support providers to consider using the PAM in their evolving work programmes (encouraging 'provider pull' rather than relying on 'commissioner push'), so that using the concept of activation becomes normalised.

Initially, Somerset CCG requested 11,000 licences for the PAM. The PAM has mainly been used across primary care amongst patients with long-term conditions, but it has been trialled in a secondary care setting.

The following work programmes have been using the PAM:

1) Using the PAM as part of the SPQS outcome framework, with around 25 GP practices who have undergone the House of Care training focused on patients with long-term conditions. Additionally, there are a number of smaller pilot projects, including:
   - Health Connections Mendip
   - Village Agents working with practices in North Sedgmoor
   - West Somerset Living Better project for people with long term conditions
   - Musgrove Park Hospital Patient Voices programme focused on care planning for hospital discharge
   - MCBT (mindfulness-based cognitive behavioural therapy) group for long-term conditions, with 100 patients completing the PAM as an outcome measure.

2) South Somerset, Taunton and Mendip Symphony schemes, as part of long-term condition management in primary and secondary care with people with long-term conditions.

Project 1: Outcomes based commissioning

As part of the SPQS, 56 GP practices agreed to focus on the needs of people with long-term conditions. 18 organisations used the PAM with patients when making care plans. The initial focus was on GP practices that had been trained in the House of Care approach, but this was expanded to include other 'test and learn' sites in Somerset. Around 9,000 copies of the PAM were sent out to use with these patient cohorts. By the end of August 2015, 18 organisations had returned 700 completed questionnaires.

The PAM was completed on paper by patients in the waiting room and both the activation level and the score could be added to the patient record in EMIS. GPs and other health professionals were encouraged to take a flexible approach in using the PAM, with the principle focus on using the results meaningfully with patients to effect positive change.

The 18 organisations who returned data included the West Somerset Living Better project, which aimed to help people with long term conditions to be less isolated by identifying the skills already in existence in the community that could be used to create a community supportive environment that will positively impact on healthcare service usage.

Similarly, the Musgrove Park Hospital Patient Voices project was a small-scale pilot delivered by the voluntary sector to provide personalised care planning and signposting to services at the point of hospital discharge, to ensure better liaison between primary and secondary care. However it was found that patients in hospital really did not want a care and support planning conversation, including completing a PAM survey, when they were more concerned about when they would get home and about getting better. They were far more receptive when they had been settled at home for a few weeks.

The local mental health trust, Somerset Partnership Trust, delivered a group-based, six week MCBT course for people with mental health problems and long-term conditions: 'Reclaiming your Life'. The PAM was used with around 100 patients as an outcome measure. Again, those leading the programme were told to 'play with it' and use it as they saw fit; no training was given for fear of restricting how people viewed the PAM and how they thought about using it.

By 2016, a number of projects were using the PAM across Somerset, including an Age UK led programme using peer-guided conversations. Somerset is a rapidly evolving healthcare landscape; at a strategic level, work is underway to align with the new Sustainability and Transformation Plans (STP), a joint strategic commissioning

board is in place and it is anticipated that there will be two Accountable Care Organisations (ACOs) that will deliver services and have some commissioning functions within them.

Project 2: Symphony

The South Somerset Symphony programme provides additional services for patients with long-term conditions. The aim is to provide integrated care for these patients, using what are known as the 'complex care' and 'enhanced primary care' models. The complex care model involves working with the four per cent of the population who generally have three or more co-morbidities (around 1,500 people), and who account for around 50% of health and social care costs. In parallel to the hubs, GP practices provide 'enhanced primary care', offering, for example, health coaching to patients with less complex conditions. Both the complex care hub and enhanced primary are using PAM.

The South Somerset Complex Care Hub involves Yeovil District Hospital Foundation Trust, Somerset Partnership Foundation Trust, Somerset County Council, Somerset Clinical Commissioning Group and the South West Commissioning Support Unit. It is one of NHS England's 'Vanguard sites', working to deliver an integrated primary and acute care system.

The model is a 'hub' system, with access to doctors, care coordinators and key workers with health and social care backgrounds and skills in health coaching and motivating people to self-manage. Questions from the CS-PAM were included in the recruitment process, so that those who were focused on self-management were selected for the roles. The project aims to enable person-centred and empathetic care across health and social care providers that meets the needs of patients through integrated working. The PAM is an element of the baseline data collected when a patient accesses the service; it will be collected at six and twelve months. The hub team will use PAM scores to tailor their approaches and also to measure increases in the PAM score and other health service utilisation outcomes to understand the effect of the intervention on patients.

Symphony collect and analyse other sources of data in their work, including the 'Symphony score', a numerical representation of concern about the patient which is used as part of their information-gathering, to identify who is most appropriate to work with a patient and the kind of support they might need.

By June 2016, 198 patients had been through the hub service; the relatively low numbers were linked to implementation challenges, but it was felt that many of these have been resolved and that numbers will increase. Challenges included addressing information governance concerns about sharing patient data amongst GPs. Practice engagement, generally, with the new service had been patchy, and it was found that some practices were reluctant to hand patients over to the service. In response to concerns about losing contact with patients, a new version of the model will be tried in the East hub which will be more closely aligned to the ongoing enhanced primary

care program; this model emphasises supporting practices to manage complex patients within their practice.

The Complex Care Hub continues to see a steady increase in referrals. The current area of focus is on ensuring the hub has the systems, process and resource in place to increase the number of patients in the hub, in line with the agreed trajectory for this increase in activity; this work is progressing well. The hub has seen a high number of new starters, who are currently undergoing their induction, including staff who will be covering the East and West of the county. Staff will begin working with practices in the east, from August. Work is ongoing to identify patients who would benefit from being under the care of the central hub, such as patients with high admissions, patients in Nursing homes, as well as patients from our 3 integrated practices, this will be underpinned by a robust plan for on-boarding these patients, Using feedback from Primary Care colleagues communication with practices is improving, with dedicated lines of communication for them to contact the hub now set up, this includes a GP direct phone line, and an email for providing feedback.

On reviewing the PAM scores, the hub team was finding that approximately 70% of the patients were a level 1 or 2 and it was felt that these were the patients who would be most likely to benefit from the level of services that the hub could provide, and so these patients are being targeted.

One of the key issues that Somerset faces arises from the geography of the county; Somerset is large and travel can be problematic for both patients and practitioners. The two hub models differ in that one emphasises seeing patients in their homes and the other (enhanced primary care model), is linked to GP practices where patients see members of the hub team. It is felt that visiting people in their homes offers the opportunity to better understand patients' needs, but at the cost of increased staff travel time. It is hoped that more hubs could go some way to remedy the problem but, as yet, it is not clear which model, or what blend of the two models, will be used going forward.

Efforts have been made to integrate patient information across agencies, but there are some sources of information that are not, as yet, accessible such as social care notes. Some problems with electronic patient record systems are still in evidence; for example, the hub uses the EMIS community model (this is similar to the GP version of EMIS and can be linked to it) and it is thought that some are not familiar with it, and may not be using it optimally. The two versions of EMIS may impact on prescribing as it has been found that sometimes GPs are reluctant to fill prescribing requests from the hub if they are unable to see the patient's records. It has been reported that PAM scores are not necessarily fed back to patients, but are being used to tailor consultations.

Staffing levels in the current hub have been increased. A team member commented that there had been a good deal of interest in the posts, especially amongst younger

members of the workforce, and speculated that that was because many valued the opportunity to spend more time with patients afforded by the new ways of working.

Project 3: Enhanced primary care

The Enhanced Primary Care work in South Somerset is intended to change the way general practice operates; ideally, by allowing GPs to have more time to spend with those patients in most acute need. Enhanced practices offer other services, for example health coaching, to patients whose needs are less acute. How the PAM should be used in this context is still a source of debate, it has not yet been decided whether it should be used with specific patient cohorts or whether it should be used with whole practice populations.

The CCG have been encouraging practices to complete PAMs but, so far, the uptake seems to have been lower than expected. It was reflected that the system for processing the PAM scores - the questionnaires were sent to the commissioning support unit (CSU) for processing - had meant that scores could not be used immediately. An alternative electronic method is being sought as normalising the PAM into practice systems is considered to be key to increasing its use. Should normalisation be successful, it is envisaged that that PAM might be used in a number of ways, as:

- A tailoring tool to inform the approach clinicians might take with patients
- A referral criterion into the complex care hubs
- A higher level outcome measure

It is recognised that work is needed to align the care planning process in enhanced primary care with the work around complex care done by the hubs; the aspiration is to broaden out care planning in enhanced primary care, but it is not felt that using the resource-intensive complex care model is viable. Further, questions remain concerning who, in practices, should undertake care planning and, consequently, what level of investment in training might be needed.