NHS Tower Hamlets CCG

Overview of site and work

NHS Tower Hamlets CCG comprises 36 GP practices in eight commissioning networks and has responsibility for commissioning services for around 254,000 people. They are one of NHS England's 14 pioneer sites, and one of their priorities is developing a more integrated approach to care within the borough.

Initially Tower Hamlets envisaged using the PAM for long term conditions like COPD, cardiovascular disease (CVD) and diabetes, forming part of the care planning process for long-term condition care packages. However, as there was a plan to reconfigure care packages more widely in 2015-16, this was put on hold and the PAM used in three pilot projects and to contribute to one commissioning initiative. All pilot projects were run with the Integrated Care team and delivered with the voluntary sector. The CCG is interested in ensuring sustainability at scale based on the pilot work conducted and commissioned an independent organisation to evaluate the pilot projects. The projects were:

1. Esteem Self-management, led by Community Options with healthcare service provider partners, working with ~220 people with long-term conditions and mental health conditions.
2. Your Move, led by Green Candle dance company, with healthcare service provider partners, working with ~55 older adults, some with long-term conditions, to improve exercise levels.
3. Managing your health and well-being, led by Ability Bow with healthcare service provider partners, working with ~75 people with long-term conditions or uncontrolled symptoms (e.g. high blood pressure) to improve self-management.
4. Commissioning for diabetes education, integrating the PAM into current education programmes with the aim of helping to tailor and structure educational interventions.
5. Care planning.

The PAM was used as an outcome measure (used at the start and end, and possibly also in the middle) and as a tailoring tool, helping service providers to meet individual's needs. The majority of projects were provider-referral (activation scores were not used as a referral criterion although once referred to a pilot, an initial PAM score could be used to tailor support to individuals). As the projects were diverse, a

mix of clinical and voluntary sector providers were involved in delivering the interventions and administering and interpreting the PAM. The majority of questionnaires were delivered face-to-face, using patient advocates to translate if needed, and to access the questionnaire in community languages. Throughout the process, there have been concerns about the impact of this mediated completion on validity.

Projects 1-3: Self-management pilots

Using the PAM as an outcome measure in the self-management pilots (projects 1-3) encountered initial teething problems, but is considered to have proceeded relatively smoothly from the CCG perspective. The pilots were slow to get going because of problems recruiting staff and patients. Many services had to undertake extra outreach work into communities to recruit relevant cohorts as recruitment via general practices was challenging. One of the reasons cited for recruitment problems was that practices were generally inundated with information and, therefore, tended to refer to the services that they were familiar with, and it took time for new services to raise their profiles. As a result of the delays, it was decided to extend the pilots by three months.

Relevant personnel in each pilot were given training in how to administer the PAM. A spreadsheet was provided to collate individual scores and the independent local evaluation team collected the scores. In total, the projects used 693 PAM licences. Data collected as part of the evaluation of these, including the PAM scores, will be used to inform commissioning decisions.

In keeping with the findings of the independent local evaluation, our data shows that administering the PAM was often problematic, particularly amongst groups with learning difficulties and amongst non-native English speaking groups. Further, administering the PAM was felt, by some service providers, to be too time consuming and could eat into intervention time. It was commented that the PAM was one item in ‘a myriad of paperwork at the beginning and at the end as well (of an intervention)’.

Recruitment numbers, and some projects over-running the due date of the independent evaluation report, have impacted on the evaluation and it has not been possible to realise statistically robust evidence of long term improvements arising from the pilot interventions. Despite this, there was some indication that the pilot projects had given rise to increases in activation scores and the procurement of some services is expected to go ahead.

Project 4: Commissioning for diabetes education

Discussions did initially take place to introduce PAM within the service, but it was decided to continue using the existing questionnaire from the X-pert patient programme.

Project 5: Care planning

NHS Tower Hamlets CCG, in collaboration with Barts Health NHS Trust, East London NHS Foundation Trust and London Borough of Tower Hamlets, has been awarded vanguard site status by NHS England, focused on providing integrated care. As part of this integrated care work, the CCG plan to deliver the PAM from October 2015 with around 1,000 patients in general practice as part of their person-centred care planning work. The aim is to tailor care and support based on PAM level. This work has been running since April 2015, but implementation of the PAM has been slow to start, with some concerns from GPs about capacity to complete the PAM, coupled with a lack of awareness about the potential benefits of doing so. There are no plans to use the Carer-PAM as yet, but doing so may be explored in the future. Discussions about how to engage diverse populations, including those who do not speak English, patients with learning difficulties, patients with serious mental health problems and children, are also on-going.

The use of PAM in care planning in general practice was incentivised and around £5 was offered for a PAM, and a one year follow up PAM on patients with complex needs. Despite the financial incentives, uptake was low. It was discovered that completing the PAM required a GP to log out of EMIS and into another system, thus putting pressure on consultation times. Further, it had been noted that, often, clinicians did not understand the rationale for using the PAM and how it offered the potential to tailor consultations and streamline service delivery. It has been recognised that increased training in the use of, and rationale for the PAM could improve the uptake of it, although no firm plans are in place for this at the moment.

Mediated completion (for example, by translators, carers and administrators) remains an unresolved problem. Although attempts have been made to find solutions; for example, the PAM was translated into Bengali but, in that instance, attempting a literal translation resulted in an overly formal and stilted questionnaire that was not well received. In the short term, it was suggested that GPs should try to target those who can complete the English version of the PAM.

To support the roll out of PAM in primary care for the financial year 2016-17, GP practices have received funding via the GP networks to implement PAM. This funding has been attached to the Integrated Care Network Incentive Scheme (NIS) in Tower Hamlets, whereby GP networks had to submit a plan that covered the following areas:

- how clinicians will be trained in the use of PAM,
- how networks will complete a minimum of 100 PAM questionnaires, and
- how the effectiveness of PAM will be evaluated.

The CCG will be monitoring the delivery of the plans. Evaluation reports from each of the networks should be available towards the end of the financial year.