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Evaluating the pilot implementation of UCLPartners Proactive Care Frameworks

Background

- **UCLPartners Proactive Care Frameworks** (PCF), combined with **implementation support**, help people living with long term conditions stay well

- Frameworks for **six conditions**: Hypertension, Type 2 Diabetes, Cholesterol, Atrial Fibrillation, Asthma, COPD

- The UCLPartners framework and implementation support rolled out in 1st **wave since Jan 2021** and in 2nd **wave since Oct 2021**

- **Evaluation of 1st wave pilot implementation** in four national sites plus 2 additional sites across England conducted by Centre for Healthcare Innovation Research at City, University of London between June and November 2021

PCF key principles

Risk stratification and prioritisation to support treatment optimisation and help manage clinician workload

Use of the wider workforce and digital resources to support a step change in self-management, remote care, and personalisation of care

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Evaluation Approach

- Mixed-method comparative case study approach

- **Six implementation sites:** North Central London; North East London; Cheshire & Merseyside; Leicester, Leicestershire & Rutland, Lakeside Health Care Group (East Midlands); West of England

- Guided by **Theory of Change**, co-developed with pilot implementation stakeholders

- Data sources:
  - Semi-structured **interviews with 41 staff members** at AHSNs, CCGs/ICSs, PCNs, and general practices
  - Documents, including progress reports
  - Survey on implementation progress among AHSNs

Evaluation topics

Patient care process changes

Work process changes & workforce experience

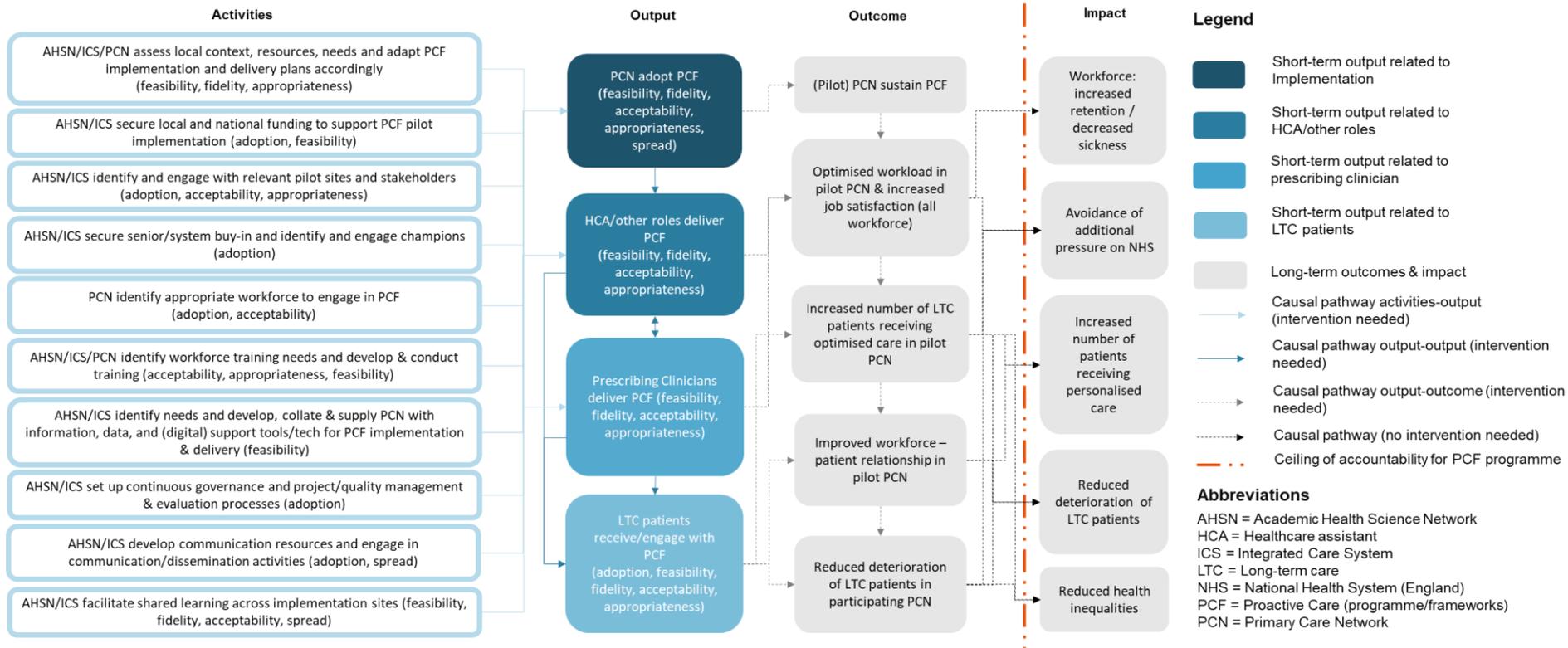Patient experiences and engagement (indirectly reported)

Health inequalities

Implementation process

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Theory of Change

Theory of Change diagram.

Activities

- AHSN/ICS/PCN assess local context, resources, needs and adapt PCF implementation and delivery plans accordingly (feasibility, fidelity, appropriateness)
- AHSN/ICS secure local and national funding to support PCF pilot implementation (adoption, feasibility)
- AHSN/ICS identify and engage with relevant pilot sites and stakeholders (adoption, acceptability, appropriateness)
- AHSN/ICS secure senior/system buy-in and identify and engage champions (adoption)
- PCN identify appropriate workforce to engage in PCF (adoption, acceptability)
- AHSN/ICS/PCN identify workforce training needs and develop & conduct training (acceptability, appropriateness, feasibility)
- AHSN/ICS identify needs and develop, collate & supply PCN with information, data, and (digital) support tools/tech for PCF implementation & delivery (feasibility)
- AHSN/ICS set up continuous governance and project/quality management & evaluation processes (adoption)
- AHSN/ICS develop communication resources and engage in communication/dissemination activities (adoption, spread)
- AHSN/ICS facilitate shared learning across implementation sites (feasibility, fidelity, acceptability, spread)

Output

- PCN adopt PCF (feasibility, fidelity, acceptability, appropriateness, spread)
- HCA/other roles deliver PCF (feasibility, fidelity, acceptability, appropriateness)
- Prescribing Clinicians deliver PCF (feasibility, fidelity, acceptability, appropriateness)
- LTC patients receive/engage with PCF (adoption, feasibility, fidelity, acceptability, appropriateness)

Outcome

- (Pilot) PCN sustain PCF
- Optimised workload in pilot PCN & increased job satisfaction (all workforce)
- Increased number of LTC patients receiving optimised care in pilot PCN
- Improved workforce – patient relationship in pilot PCN
- Reduced deterioration of LTC patients in participating PCN

Impact

- Workforce: increased retention / decreased sickness
- Avoidance of additional pressure on NHS
- Increased number of patients receiving personalised care
- Reduced deterioration of LTC patients
- Reduced health inequalities

Legend

- Short-term output related to Implementation
- Short-term output related to HCA/other roles
- Short-term output related to prescribing clinician
- Short-term output related to LTC patients
- Long-term outcomes & impact
- Causal pathway activities-output (intervention needed)
- Causal pathway output-output (intervention needed)
- Causal pathway output-outcome (intervention needed)
- Causal pathway (no intervention needed)
- Ceiling of accountability for PCF programme

Abbreviations

AHSN = Academic Health Science Network
HCA = Healthcare assistant
ICS = Integrated Care System
LTC = Long-term care
NHS = National Health System (England)
PCF = Proactive Care (programme/frameworks)
PCN = Primary Care Network

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Findings: Implementation Progress

Implementation of PCF is at an early stage, most sites have been:

- Running **risk stratification searches**;
- Carrying out initial **engagement and training of wider workforce**;
- Implementing one or a small number of frameworks, mainly the hypertension framework, in a small number of PCN/practices, to start with.

Implementation progress and selected PCF frameworks per implementation site

	NEL	NCL	LLR	Lakeside	C&M	WoE
Engaged	10 PCN	7 PCN 2 practices	6 PCN	4 PCN	12 PCN	2 practices
Planned	48 PCN		25 PCN			25-30 practices
Interested						20-40 practices
Frameworks selected for implementation	Hypertension Diabetes Asthma	Hypertension	All	All	Hypertension Asthma COPD Cholesterol Atrial Fibrillation	Diabetes Asthma

Engaged = currently implementing PCF; planned = committed to implementation; interested = expressed interest in implementation
NEL = North East London; NCL = North Central London; LLR = Leicester, Leicestershire and Rutland;
C&M = Cheshire and Merseyside; WoE = West of England

Findings: Patient care process

- PCF has been welcomed by PCN/practices, as **valuable improvement to LTC management**,

- **Risk stratification** was highlighted as very useful new way of ensuring **patients receive right care at right time**,

> Two big benefits, that the right patient sees the right clinician, therefore that frees up time for the more experienced and skilled physicians to see the more complex patients, and it also allows us to decide who to focus on first, or who to focus on in a certain way.
> **GP, pilot site 1**

> We managed to get another 650 more cervical smears done in one of our sites [...] Every site reached over 90 per cent of their learning disability checks. [...] We managed to reduce the length of [the nurses'] consultations.
> **GP, pilot site 5**

- PCF was perceived as providing an appropriate structure supporting the introduction and integration of **wider workforce** roles leading to **more capacity for patient care** and **optimised care by matching patient needs with appropriate workforce**,

- PCF was seen as supporting both the **operationalisation of the personalised care agenda** and **transition towards a more holistic care** approach.

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Findings: Work processes & workforce experiences

- It was **too early to gather feedback from workforce on the routine use of PCF**.

- Clinicians, particularly in strategic roles, were generally very **enthusiastic** about PCF.

- **Some practices and workforce were reluctant to engage with implementing PCF** as they perceived it as not feasible with **current primary care pressures**, particularly during the pandemic.

- Wider workforce engagement varied depending on practice size, capacity of existing and recruitment status of new staff.

- Clinical staff felt they can **build more on wider workforce strengths and skills**, and wider workforce felt more integrated in practice teams.

Workforce roles engaged in PCF per site

Workforce roles	NEL	NCL	LLR	Lakeside	C&M	WoE
GP	x	x	(x)	x	x	(x)
Practice nurse	x	x	(x)	x	x	(x)
Advanced nurse practitioner	x			x	x	
Nursing assistant	x					
Nursing associate		x				
Physician associate	x				x	
Clinical pharmacist	x	x	(x)	x	x	
Pharmacist technician		x		x		
Health care assistant	x	x		x	x	(x)
Social prescribing link worker	x			(x)		(x)
Care coordinator	x	(x)				
Health and wellbeing coach	x			x		
Paramedic		(x)		x		
Administrative roles	x	x	(x)	x	x	
Community pharmacists	x				x	

X = involved at present; (x) = planned

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Findings: Indirect patient experiences & engagement

- **Sites were starting to engage with patients**, particularly inviting them to **reviews** based on the risk stratification searches, and in terms of **self-monitoring**, mainly as part of the hypertension framework to obtain blood pressure readings.

- Staff reported that **patients felt particularly positive about more streamlined, and more personalised and holistic care approach**.

- Patients reportedly felt generally **confident and motivated about using self-monitoring technology**, referring in most cases to blood pressure monitors.

- While some patients had difficulties engaging with digital technology to submit their self-monitoring readings, **self-monitoring in combination with alternative means of submitting readings was preferred by many patients as an alternative to attending a face-to-face appointment**.

> One of the main feedbacks that we've had is around the education side of it; that they've really loved that she's actually sat down and listened to the patients, treated them as an individual and listened to their concerns. I think it's been really nice to be able to incorporate that type of thing in this, so it was more of a personalised approach. **AHSN operational staff member, pilot site 3**

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Findings: Health inequalities

- PCF was perceived as providing an **opportunity to tackle health inequalities**, for example by:
  - supporting **implementation in PCNs/practices with greatest deprivation**,
  - **including wider patient characteristics in the risk stratification searches** next to clinical characteristics,
  - offering a **holistic and personalised care** approach.

- In terms of **digital exclusion** arising from increased application of remote monitoring, practices were offering a **hybrid engagement model** with the option of
  - using remote care **alongside face-to-face appointments**, and
  - alternative means of providing self-monitoring **readings, e.g., by phone or on paper**.

> We can use the social prescriber resource, I think it's just helpful for clinicians; they're going to help people find the tools that help them improve for themselves and those tools are not necessarily about medication or losing weight. They might be about loneliness; they might be about debt resolution. So there's a whole set of things that make a difference to people's lives that aren't about medicine.
> **PCN clinical staff/GP, pilot site 2**

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Findings: Implementation process

- **Practice recruitment** was mostly following a **voluntary** approach, i.e. call for expression of interest. One pilot site **directly invited additional practices** who might benefit the most from PCF. Some **PCNs/practices approached** their local AHSN, ICS/CCG or the national team.

- **Practice engagement** was led mostly by **senior PCN/CCG leads**. One pilot site engaged mid-career primary care clinicians to lead practice engagement.

- The ability to **adapt PCF to local needs and contexts was key to implementation**, and it was crucial that PCF was flexible enough to allow this.
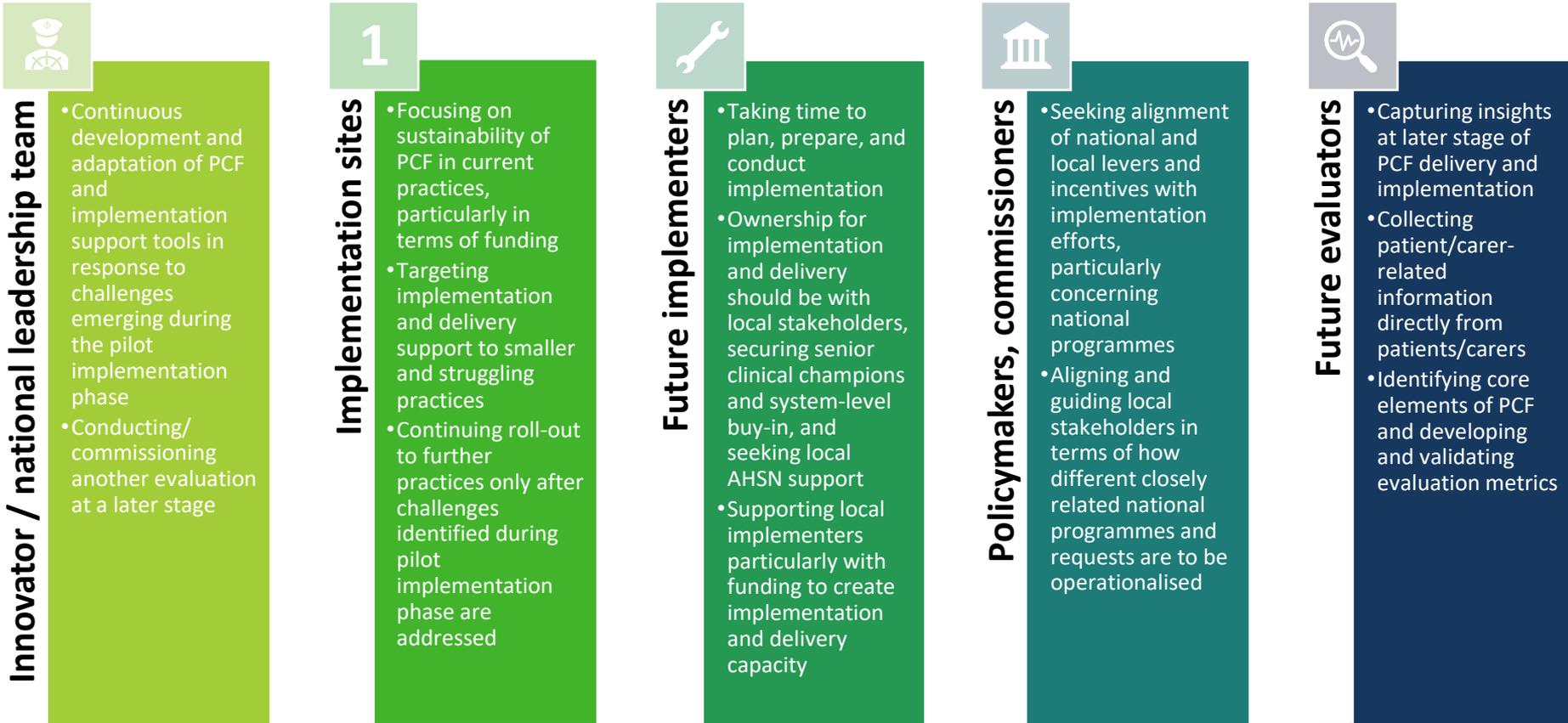
Key enablers

- Benefits and advantages of PCF in terms of optimising patient care and work processes, and enabling operationalisation of the personalised care agenda,
- Motivation of and support by senior local stakeholders, particularly clinical champions and CCGs/ICSs,
- Flexibility of PCF, allowing for local tailoring and adaptation to fit local needs and context,
- Continuous and responsive implementation support, particularly as provided by the local AHSNs and the national leadership team, and
- The opportunity to share learning within and across implementation sites.

Key barriers

- Limited capacity of primary care workforce, particularly during pandemic,
- Limited maturity of PCNs which are in the early setup phase in some areas,
- Challenge of aligning PCF with the requirements of Quality and Outcomes Framework and local/national incentive schemes,
- Issues with coding patients as part of the risk stratification and review process.

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Conclusions & Recommendations

Emerging insights show that PCF can achieve its objectives and workforce and patients are starting to experience its benefits in terms of optimised and personalised care.

Innovator / national leadership team

- Continuous development and adaptation of PCF and implementation support tools in response to challenges emerging during the pilot implementation phase
- Conducting/commissioning another evaluation at a later stage

Implementation sites

- Focusing on sustainability of PCF in current practices, particularly in terms of funding
- Targeting implementation and delivery support to smaller and struggling practices
- Continuing roll-out to further practices only after challenges identified during pilot implementation phase are addressed

Future implementers

- Taking time to plan, prepare, and conduct implementation
- Ownership for implementation and delivery should be with local stakeholders, securing senior clinical champions and system-level buy-in, and seeking local AHSN support
- Supporting local implementers particularly with funding to create implementation and delivery capacity

Policymakers, commissioners

- Seeking alignment of national and local levers and incentives with implementation efforts, particularly concerning national programmes
- Aligning and guiding local stakeholders in terms of how different closely related national programmes and requests are to be operationalised

Future evaluators

- Capturing insights at later stage of PCF delivery and implementation
- Collecting patient/carer-related information directly from patients/carers
- Identifying core elements of PCF and developing and validating evaluation metrics

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Thank you

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