Shared Decision Making
CASE STUDY

Pennine MSK Partnership Ltd

Programme Budgeting for Shared Decision Making

A team from Pennine MSK Partnership Ltd based in Oldham has been using Shared Decision Making to help its Osteoarthritis (OA) knee and hip patients' experience.

The team work alongside the clinical teams across maternity, renal and musculoskeletal (MSK) specialities currently taking part in the Advancing Quality Alliance's (AQuA) National Shared Decision Making Collaborative, part of a Government funded national programme which aims to involve patients in making decisions about their care.

"Pennine MSK is unique and has been a very successful model, it's such an efficient model when it comes to trying to align clinical and financial accountability and it does make a really big difference to how clinicians and patients perform together," explains Dr Alan Nye, Pennine MSK Partnership Ltd Director and Clinical Lead for AQuA's Shared Decision Making programme.

The Pennine MSK Partnership provides an integrated service for all MSK patients in Oldham.

Crucial to its success has been the way it is structured, it has a single contract with the commissioner and takes responsibility for providing the full range of services from within the same organisation and provides non-admitted care in elective care pathways in orthopaedics, rheumatology and MSK pain.

The partnership is structured around programme budgeting, which delivers better clinical outcomes from commissioning spend because providers are incentivised to reduce waste and deliver high quality care. This also encourages investment in primary care, Shared Decision Making and supports self-care as a means of delivering optimal care in the right setting to demonstrate best value for money.

"In a traditional system, a provider is rewarded for activity rather than quality. With programme budgeting you are rewarded for quality, not just activity," adds Dr Alan Nye, who is also a practising GP with a special interest in rheumatology.

The service is totally funded by Payment-by-Results and analysis of outcomes from programme budgeting facilitate elimination of treatments with low clinical value.

Based in an integrated care centre in Oldham, Pennine MSK receives referrals from GPs, around 600-800 new referrals each month for orthopaedic and rheumatology services.

The multidisciplinary team chose to focus its Shared Decision Making project on OA knees and hips, the practice is already involved in an OA knees research project with the University of Cardiff with a PhD student looking at Option Grids and how Shared Decision Making affects demand management, so it was a natural fit for the team's Shared Decision Making project.

"When we get our electronic referrals from the GPs, triage nurses were looking out for OA hip or knee patients. They would highlight these patients to office staff, who would then ring or write to the patient and signpost them to the MSK decision aids on the website. We would ask the patient to have a look at them before they come to see us so they can already be thinking about what sort of treatment they wanted," explains Ruth Holden, Pennine MSK's Business Operations Manager.

“In a lot of cases, we can treat and discharge patients back to the GP. There are several orthopaedic consultants working here, so patients can be seen at the integrated care centre or one of our seven sites rather than having to go to hospital. We offer patients a choice of where they want to be seen which fits in with their lifestyle.”

“That’s where Shared Decision Making comes in. If someone said to our staff there’s no point in me going to see a surgeon as I can’t afford to take time off work; there’s lots of things to take into consideration and we just try to help them cope with what they can cope with.”

The team also used the Ask 3 Questions* leaflets, which now go out with every new patient appointment, and put up Ask 3 Questions posters in all clinics. Ask 3 Questions is an AQuA developed resource which encourages patients to take charge of their health consultations by asking: What are my options? What are the pros and cons of each option for me? How do I get support to help me make a decision that is right for me?

“Shared Decision Making is not rocket science it’s all about talking to the patient and between you agreeing the right way to treat them, it’s just about doing your consultation in a different way,” adds Ruth.

All 70 clinical staff at Pennine MSK have been trained in Shared Decision Making from consultants to podiatrists. Ten staff are also taking part in Motivational Interviewing (MI) courses offered by AQuA and two staff are also taking part in AQuA’s Train the Trainer programme for continuous training and spread throughout the practice.

“For many clinicians within our practice, the attitude and response was exactly the same as when I visited many units; they assume they are doing it already. It’s only when you go through what it is and actually get them to measure themselves, do they actually go off and do it properly,” said Dr Nye.

“Shared Decision Making is simply a more efficient way of helping patients and there’s no reason not to do it.”

The team measured the project’s success using the SURE tool, which has four questions to measure how confident patients felt about the decision they had made, and the SURE data collected on clinicians is also helpful in other ways, particularly for a performance management approach used throughout the practice.

“It is simply a question of benchmarking clinicians as to where they are with their peer groups; it’s done in a non-confrontational way, but it has that little sense of competition because people want to perform well. It’s just a great way of doing it and we use it throughout the practice.

“I always find there’s nothing like being able to show people their own data in comparison to others to get them to change; not in an arm twisting way, but in a very genuine supportive way; it certainly works when we are looking at GP referral rates and we find it works during decisional conflict as no-one likes to be at the bottom of the heap.”

Looking to the future, embedding Shared Decision Making within the primary care sector has proved more of a challenge than within secondary care, but Dr Nye hopes next year’s collaborative will address this.

“There is an element due to the way the health service is organised that GPs are loose

practices joined by a PCT or CCG, whereas in secondary care it is organised into units like trusts. If you get a trust on board, they say we're going to do this – but there is no such command and control structure for general practice.

"I think it is the culture of the NHS which has meant it is harder for us to get this embedded within primary care but I am looking forward to the next year. That is going to be a really big change because lots of CCGs now see this as the way forward.

"At the end of the day, it's all about putting patients at the heart of the pathway and empowering patients to make choices for themselves and trying to break down this paternalistic model of health care planning and delivery. The key to achieving this is Shared Decision Making and Self-Management Support.

"The collaborative next year is very much around doing both at the same time."

** Ask 3 Questions has been adapted with kind permission from the MAGIC programme, supported by the Health Foundation.*
Ask 3 Questions is based on Shepherd HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. Patient Education and Counselling, 2011;84: 379-85.