Shared Decision Making Programme
Embedding Shared Decision Making in routine commissioning systems and processes

Report by Capita Group Plc
1 Executive Summary

This document is a report to the Department of Health’s National Shared Decision Making (SDM) Programme. It outlines Capita’s activity and progress since January 2012 in embedding SDM within routine commissioning systems and processes.

In particular, this report focuses on:

- Our activity to support health economies to implement patient decision aids within their commissioning processes;
- Lessons learned from this activity and wider engagement;
- Learning and recommendations for the SDM Programme, NHS Commissioning Board, CCGs, and other relevant organisations for the future implementation of SDM.

Implementing SDM and related interventions in the UK may reduce the use of discretionary surgery, where clinically appropriate, ensure informed decision making, reduced unwarranted practice variations and achieve the right intervention rate, thereby reducing costs.

Capita’s primary objective was to recruit two local health economies and work closely with them to test out the framework and methodology and to effect system change, working with specific clinical pathways (as agreed locally). During the programme, Capita worked with three health economies as outlined in the table below.

Table 1: Health economies and PDAs of interest

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Number of CCGs</th>
<th>Start date</th>
<th>PDAs of interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Berkshire West PCT</td>
<td>4</td>
<td>April 2012</td>
<td>Osteoarthritis of the hip</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Osteoarthritis of the knee</td>
</tr>
<tr>
<td>NHS Southampton</td>
<td>2</td>
<td>April 2012</td>
<td>Lower Urinary Tract Symptoms (LUTS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PSA screening</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Osteoarthritis of the hip</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Osteoarthritis of the knee</td>
</tr>
<tr>
<td>NHS East Riding</td>
<td>1</td>
<td>July 2012</td>
<td>Cataracts</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Osteoarthritis of the knee</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lower Urinary Tract Symptoms (LUTS)</td>
</tr>
</tbody>
</table>
Our approach and supporting resources are outlined in more detail in this report. We have identified a number of lessons for future implementation of SDM:

- **Consistent project leadership is required at a local level:** To focus on engagement, monitor and maintain progress and to make the most of opportunities to align SDM with other projects and programmes of work. Clinical leads’ time was limited and spread between clinical practice and competing projects.

- **Engagement with clinicians is critical:** A lead GP, taking clinical ownership and leadership of SDM within the CCG, is essential in adding weight to the programme. It was most successful where the clinical lead provides support to the project from prioritisation of pathways through to training/educating peers in SDM and leading discussions around use of Patient Decision Aids (PDAs).

- **Organisations should prioritise the adoption of PDAs where there is a specific interest:** For example strong clinical engagement or focus on pathway redesign. Our experience suggests that affecting change in and engaging with more than three pathways was too complex and challenging.

- **Whole pathway involvement is required:** All services involved in the pathway need to be engaged with and supportive of SDM, not only the clinicians who are promoting PDAs directly to patients.

- **Clinicians need to have confidence in the quality and content of PDAs.**

- **Format of SDM sheets needs to reflect clinical and patient needs:** Materials need to be concise for clinicians to feel they can use them within a patient facing consultation.

- **Tension with 18 week Referral to Treatment Time (RTT):** The system should not constrain patients from having an opportunity to consider the most appropriate treatment for them, even if they have been prompted while they are in an 18 week pathway.

- **SDM needs to be clearly defined in respect to choice of provider:** There is a risk that CCGs may misinterpret their duty to promote the involvement of patients and their carers in decisions about their care and treatment as relating to choice of service and/or service venue, as opposed to involvement in discussion around choice of treatment.

- **Accessibility of information to clinicians is critical:** Clinicians are more likely to utilise SDM if information is easily accessible, in clinical settings. **Availability of information to patients is also a concern to clinicians:** Consideration should be given to producing PDAs in more accessible formats. For example, versions in alternative languages and audio format.

In addition to these lessons, we have made a number of recommendations to the SDM Programme for future policy makers and commissioners. These are detailed in section 6.
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About this report

Capita was commissioned by the Department of Health’s National SDM Programme from January – December 2012 to embed SDM in routine commissioning systems and processes.

This report documents objectives and achievements of this work and includes lessons learnt and recommendations. The audience for this report is the SDM Programme.

2.1  Shared Decision Making: definition and background

SDM positions patients as active partners in decisions about their treatment and care. Clinicians bring expertise on treatment and management options and the benefits and harm; patients bring expertise on their condition and their attitudes, values and preferences.¹

The Government has made a strong commitment to improving decision making in its mandate to the Commissioning Board. It sets an objective to ensure the NHS becomes ‘dramatically better at involving patients and their carers, and empowering them to manage and make decisions about their own care and treatment’. ² It is not just an ethical imperative which drives this commitment to SDM, there are a wider benefits including better health outcomes; improved patient compliance; increased patient satisfaction; and cost savings as patients may choose less expensive and more appropriate options.³

However, SDM is not the norm. Potential obstacles include resistance from clinicians who may be committed to the clinician-centred model of decision-making and who may question the value of SDM and the perceived additional time taken during consultations. Furthermore, many clinicians believe that they are already sharing information and decisions with their patients⁴

2.2  About the National Shared Decision Making Programme

The SDM Programme is a national programme funded by the Department of Health (DH) as part of the Quality Improvement Productivity and Prevention (QIPP) Right Care programme⁴.

The aim of the Programme is to embed SDM in routine NHS care. This is part of the wider ambition to make "no decision about me without me" a reality; to promote patient centred care; to increase patient choice, autonomy, involvement and empowerment in clinical decision making.

Earlier phases of the SDM Programme focused on developing PDAs hosted on NHS Direct. These have now been replaced as part of the process to develop a new PDA template and editorial process.

⁴ For more information see www.rightcare.nhs.uk
The SDM Programme commissioned three new workstreams from early 2012:

- **Workstream 1**: developing a suite of Patient Decision Aids (PDAs) and to provide a telephone accessible Patient Decision Support Service. This workstream is led by Totally Health.
- **Workstream 2**: Embedding Patient Decision Aids and SDM in routine NHS Systems (commissioning and provision). This workstream is led by Capita.
- **Workstream 3**: Creating a receptive culture among physicians, patients and the general public for SDM. This workstream is led by AQuA.

The SDM Programme seeks to achieve the following benefits for patients, clinicians and commissioners:

**Figure 1: Benefits of SDM**

- **Patients**: Informed choice, increased knowledge, satisfaction and confidence, greater autonomy and involvement in decision making, resulting in a better decision quality (aligned with the patient’s values and preferences), better understanding of risks, reduced anxiety, decisional conflict, regret, and in the long term, better health outcomes.

- **Clinicians**: Better consultations, clearer risk communication, improved health literacy, reduced unwarranted practice variation, safer care, reductions in the uptake of major elective surgical interventions where there is overproduction and increased uptake where there is unmet need, without adversely affecting health outcomes, and likely reduced litigations.

- **Commissioners**: Provision of a new sustainable paradigm for demand management. Implementing shared decision making and related interventions in the UK may reduce the use of discretionary surgery, where clinically appropriate, ensure informed decision making, reduced unwarranted practice variations and achieve the right intervention rate, thereby reducing costs.

### 2.3 Previous work with commissioners on SDM

During 2011/12 the DH Patient and Public Engagement team commissioned work to promote patient involvement in each of the 10 former Strategic Health Authorities areas (SHAs). Some projects focused on SDM including:

- **NHS East of England** - involving Practice Based Commissioning Groups looking at developing patient engaged organisations
- **NHS Yorkshire** – developing three resources for practitioners, teams and commissioners. These are aimed at people who want to learn more about SDM and want to put this approach into practice.

Further information on all of these projects can be found on the NHS Networks website[^5]

In addition, the Health Foundation has been supporting the development of SDM through the MAGIC programme (MAking Good decisions In Collaboration). From August 2010 until January 2012, the programme has worked with NHS provider organisations in Newcastle and Cardiff. Phase 2 commenced in May 2012 and has broadened its focus to include commissioners. Evaluation of the MAGIC programme is currently underway.

6 http://www.health.org.uk/areas-of-work/programmes/shared-decision-making/
3 Embedding SDM in commissioning systems and processes

3.1 Workstream objectives

Capita agreed several objectives for our activity to embed SDM in commissioning and contracting systems and processes. Table 2 sets out the objectives and progress against these.

Table 2: objectives and progress to date

<table>
<thead>
<tr>
<th>Objective</th>
<th>Progress</th>
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<tbody>
<tr>
<td>To recruit two local health economies and work closely with them to test out the framework and methodology and to effect system change, working with specific clinical pathways (as agreed locally)</td>
<td>Achieved</td>
</tr>
<tr>
<td>To develop a framework and methodology for future NHS commissioning bodies to promote SDM and usage of PDAs within their health economy</td>
<td>Achieved</td>
</tr>
<tr>
<td>To develop a matrix for specific clinical pathways, identifying for each PDA the likely relevant patient decision points and the relevant professional groups involved in the pathway, e.g. GPs, midwives, advanced practitioners</td>
<td>Achieved</td>
</tr>
<tr>
<td>To capture learning from our activity in order to support successful wider implementation, with a particular focus on commissioning systems and processes, clinical pathways and the informed consent process</td>
<td>Achieved</td>
</tr>
<tr>
<td>To investigate the potential benefits and approaches of use of SDM to support the informed consent process</td>
<td>Not achieved</td>
</tr>
<tr>
<td>To identify national levers (such as standard contracts) and work with the Department of Health and other relevant bodies to effect change</td>
<td>Partly achieved</td>
</tr>
</tbody>
</table>

In the following section, we provide outline our activity and progress against these objectives, focusing in particular on our work with health economies.

3.2 Recruiting local health economies

Capita committed to working with three health economies (either a PCT or CCG area) to support the embedding of SDM within their commissioning systems.

We recruited the health economies via two routes: through existing Capita networks and engagement with the SHA SDM leads. NHS South was particularly engaged and supportive.

We initially ‘signed up’ Berkshire West and Southampton (in April 2012) with East Riding coming on board in July 2012.

All three organisations were keen to look at specific pathways, agreeing priority areas locally. Pathways were selected according to two considerations:

- The early availability of PDAs, for example osteoarthritis of the knee and osteoarthritis of the hip
- Local priorities, for example, specialties seen as particularly receptive or where
pathway redesign work was planned.

Figure 2 below show the specific PDAs each local health economy focussed on embedding within their care pathways.

Figure 2: PDAs prioritised by health economies

3.3 National context and impact on health economies

The changes in the national NHS commissioning system over 2012/13 have been both a challenge and an opportunity for SDM. There has been strong support (for example, in legislation and the CCG authorisation process) for patients to take a more active role in the clinician-patient relationship. However, it has been a challenging environment in which to make short term gains, due to the level of structural, personnel and organisational changes taking place.

SDM is closely aligned to initiatives such as personalisation, including personal budgets and personal care planning. All three health economies we worked with had progressed personalisation projects in the previous two years. For the health economies we have partnered with (a self selected and enthused group), involving patients in decision about their health and treatment options is something commissioners have been actively engaged with for some time.

Due to changes to the NHS, commissioning systems are in the process of a radical overhaul. Responsibility for commissioning is passing from Primary Care Trusts to Clinical Commissioning Groups (CCGs) and leadership of the system is passing from Strategic Health Authorities to the NHS Commissioning Board (NHS CB) and NHS CB Area Teams. There has been increased focus on organisational structure and form as CCGs go through the process of authorisation in preparation for taking responsibility of £65 billion from 1 April 2013.

CCGs have been largely inward facing during 2012; with their membership either broadly focussed on governance arrangements or in managing Quality, Innovation, Productivity and Prevention (QIPP) schemes. Their high priority QIPP schemes have been mainly focussed
on managing the unscheduled care system.

While the CCG authorisation process asks CCGs to show evidence of involving patients in decisions about their care and treatment, the significant time commitment required to achieve authorisation has been seen by many in the NHS as a significant distraction from the day job of commissioning. Despite a positive intention to involve patients, the authorisation process has proved all-consuming for many CCGs.

Many PCTs have struggled to retain a full staffing complement during 2012. The focus of management has been to develop the transition arrangements and to support CCGs to meet the requirements around authorisation. Structural changes, locally and nationally, have caused significant and protracted staffing changes within commissioning teams in the health economies with which we worked.

3.4 Our approach with health economies

Capita produced a commissioning resource pack (detailed in section 4) to enable our partner health economies to progress SDM. The resource pack includes a number of templates and documents to support planning and implementation.

Our contract start date did not allow us to support CCGs before NHS contracts were agreed for 2012/13. Therefore our work focused on supporting CCGs to prepare for implementation of these contractual measures in 2013/14 – given considerations around the availability of the PDAs and the readiness of CCGs.

However, NHS Berkshire West had agreed a CQUIN to incentivise their acute trust to implement SDM and planned to use the QOF QP incentive to engage primary care in SDM in the 2012/13 contracting period. More detail on these incentives is included in section 3.5.1.

Whilst we did not adopt a one size fits all approach to implementation, we followed a structured approach which is summarised below.

Table 3: Development approach

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>Identify a lead manager and lead clinician for SDM</strong></td>
<td>Managerial and clinical leadership is critical to driving change. In some cases both roles have been fulfilled by the same individual, a practicing clinician with managerial responsibility in the CCG.</td>
</tr>
</tbody>
</table>
| **Select pathways or conditions to focus on as early adopters** | Key considerations here are:  
  - Is a PDA available for the condition?  
  - Are clinical teams likely to be receptive and enthusiastic?  
  - Are there are other factors which may limit the ability to drive culture change?  

An information gathering template and prioritisation criteria are included in the commissioning resource pack, under Project Initiation. |
| **Identify relevant stakeholders and partners and get them on board** | This involved several of the following: GPs, primary care teams, community services/ tier two services, acute care, patients and carers.  
We attempted to engage with the health and wellbeing boards; however, these groups are intended to set the local strategic vision for health and social care and do not engage directly with operational service improvement projects. |
<table>
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<tbody>
<tr>
<td><strong>Target GPs as advocates for change</strong></td>
<td>GPs are key agents in promoting patient involvement in decisions about their care and treatment.</td>
</tr>
</tbody>
</table>
| **Review opportunities to support patients in taking an active role** | Where possible organisations should work with patient groups in order to promote the SDM project and to encourage patient activation.  
Supporting patients as change agents is important in creating the right pull; Clinicians can encourage SDM but patients need to be responsive and take a more active role in their care. |
| **Use commissioning levers to support SDM** | Examples include QOF Quality Premium (QOF QP), Local Enhanced Service (LES) and secondary and community incentives such as Commissioning for Quality & Innovation Framework (CQUIN). |
| **Identify other system enablers that could support awareness raising implementation** | For example, Map of Medicine may be helpful in encouraging the use of PDAs through enabling easy access for clinicians and use of READ codes can support the recording and auditing of SDM activity. |
| **Ensure support from regional networks** | Through good relationships with regional leads in NHS South we were able to support a wider SDM activity across this region. This involved supporting engagement events and delivering a series of roadshow events to share best practice and disseminate tools and learning from our work (in partnership with AqUA). |
3.5  Case Studies

We have written up our activity with each health economy as a short case study. This section sets the context for our lessons learnt and recommendations, in sections 4 and 6 respectively.

3.5.1  NHS Berkshire West

Engagement process

NHS Berkshire West were particularly interested in how SDM could be used in their Musculoskeletal (MSK) pathway. There is an active MSK group, made up of a clinical lead from each of the four constituent CCGs and secondary care clinicians. The Group agreed to proceed with the implementation of the PDAs relating to osteoarthritis (OA) of the knee and OA of the hip as part of a locally redesigned pathway for hips and knees.

Implementation support was provided by a Commissioning Manager at NHS Berkshire West as part of her established role. Capita provided support to tailor an implementation plan and developed a virtual SDM training programme, which each G.P. practice was asked to undertake. SDM was also promoted through the CCG’s shadow board meetings.

Contractual levers

Incentives were put in place with primary care and the acute provider to encourage and promote the use of PDAs in both in primary and in secondary care settings.

In primary care all practices were incentivised through QOF Quality Premium (see appendix 1) to:

- Familiarise themselves with the PDAs for OA hip and OA knee
- Review historical referrals against the referral criteria and report on trends and lessons learnt
- Insert a READ code into the primary care information system for all patients signposted to use the PDA for hip or knee.

In secondary care, a CQUIN (see appendix 2) was agreed in the 2012/13 contracting round with the main acute provider. The CQUIN states that all patients who have not already used the relevant PDA during the previous six months should be encouraged to utilise the tool before being listed for surgery.

What worked well

Engagement with lead GPs through the existing MSK group provided a simple, well established governance structure and meetings were held regularly, allowing for good clinical engagement.

The incentivisation of GPs through QOF QP leveraged wide clinical engagement in SDM; however the extent of this engagement will not be evaluated by Berkshire West until April 2013. An evaluation of the CQUIN in secondary care is due to take place in early 2013.

NHS Berkshire West are in the process of agreeing a QIPP scheme for 2013/14 for a reduction in orthopaedic procedures relating to usage of the PDAs for OA of hip and knee. This reduction in activity will be monitored through 2013/14.
Issues

Staff changes made it difficult to sustain relationships and engage routinely with commissioning management leads. At key stages in the project these staffing changes compromised momentum.

Progress in key areas was limited e.g. patient engagement and activation. There were also delays in promoting the online training to GPs.

3.5.2 NHS East Riding

Engagement process

NHS East Riding were keen to understand how variation in procedures of limited clinical value (PLCV) procedures could be reduced using SDM and through improving the information available to patients.

Their Service Redesign group agreed to take forward SDM. This Group operates as the CCG’s Medical Forum and agreed that the three localities in East Riding would each implement a different PDA, according to local clinical priorities and interest. The Forum nominated clinicians with relevant interests to provide leadership and support to the implementation of each of the PDAs. The PDAs selected were Cataracts, OA of knee and LUTS. Management support was provided by the CCG Locality teams.

Contractual levers

No contractual levers were put in place by the CCG. The focus was communication and implementation within the locality focusing on the cataract PDAs. CCG locality meetings were the main source of support for GP practices implementing SDM. A communication plan was developed by the CCG management lead with support from Capita to promote the use of SDM and PDAs. Communications were developed and delivered by Capita and then cascaded by key managerial staff to practices.

The clinical lead developed a one page summary sheet on cataract risks for GPs to use within a 10 minute consultation which also pointed patients towards the PDA and telephone coaching service. The clinical lead felt that the Short Form PDA (designed for use in consultations) was too long and detailed for GPs to use in appointments with patients.

The acute trust clinicians and managers were advised that the GPs were implementing the cataract PDA prior to referral.

What worked well

Leadership from CCG clinical leads has worked well as they have taken ownership and championed the use of PDAs with their peers. This has also allowed for access to locality meetings and supported clear communication plans with practices.

Communication with locality management leads and practice champions through webinars successfully focussed on briefing staff on PDAs and agreeing how they will be implemented.

A methodology for measuring SDM through use of the SURE score was agreed in January. This will be rolled out through practices in February 2013.
Issues

The current scope of work has been limited to cataract PDAs; the other PDAs will be implemented following the roll out of Cataracts across all practices.

Further work to better understand levers in the General Ophthalmic Services Contract is planned for 2013. The CCG are keen to understand what could be done to incorporate the Cataract PDA at this stage of the pathway as the majority of patients with cataracts are referred by their optician to an ophthalmic surgeon.

3.5.3 NHS Southampton

Engagement process

The governance body of NHS Southampton City and the shadow boards of NHS Southampton CCG and West Hampshire CCG approved the SDM programme of work in June 2012 and agreed the following objectives:

- To encourage clinicians in all settings of care to participate in or facilitate SDM
- To encourage patients to actively participate in decision making about their care, thereby leading to better health outcomes
- To encourage re-orientation away from acute care where appropriate, towards prevention, self-care and more consistent standards of primary care
- To develop a cohort of facilitators/trainers who have the knowledge, skills and confidence to support organisations to participate in SDM.

There were a number of discussions at the Southampton GP forum about use of the PDAs. GPs identified key clinical pathways where they feel better information would support better consultations and more informed patients. Several clinical areas were prioritised for implementation of SDM in community and secondary care including OA of hip and knee, cataracts, LUTS and PSA screening.

Clinical Leadership and Management support was provided by the Planned Care lead and commissioning managers. The Planned Care lead is also a Consultant in Pain Management at the local acute trust.

Contractual and system levers

Prior to the SDM project, clinicians had posted patient decision aids, specifically option grids, on the localised Map of Medicine to encourage GPs to use with patients. As the SDM Programme’s PDAs were published the PDA short form was added Southampton’s localised Map of Medicine. Map of Medicine has been a key enabler for SDM in Southampton as it allows GPs to access the PDA in a consultation. Between October and December 2011, there were 110 separate GP accesses to MoM for the four pathways prioritised for SDM.

The CCG also engaged local patient groups, including LINKs and Patient Forum members to raise awareness of the tools and the concept of SDM. The groups expressed total enthusiasm for the concept and a patient lead was identified to support the programme.
What worked well

Engagement with key clinical teams and patient organisations has been critical. A MSK service lead has attended the SDM Train the Trainer sessions run by NHS South and two MSK services have been trained on SDM techniques and are routinely using other materials developed by the SDM Programme such as the Ask 3 Questions leaflets and the Shared Score measurement tool. They are also utilising the patient business cards developed by Capita to promote PDAs to patients. In the Orthopaedic Choice services in New Forest all patients are send a copy of the Ask 3 Questions leaflet before attending an appointment. The acute Orthopaedic team are also supportive of SDM and are implementing it in OA of knee and OA of hip pathways initially.

NHS Southampton CCG produced a case study on SDM as part of their CCG authorisation evidence portfolio, summarising progress made and their future plans to support the use of further PDAs.

Capita supported the development of a community services SDM CQUIN (This is included in the Commissioning Resource Pack, see section 4). Discussions are currently ongoing with the community services providers in relation to adopting this as part of the 2013/14 contracting round.

Commissioners are keen to utilise Map of Medicine functionality to allow them to understand how many clinicians are accessing the PDA short forms over 2012/13. Longer term measurement of use of SDM and PDAs will be taken forward through the CQUIN.

Issues

There was a time lag between approval of the SDM project (June 2012) and patient decision aids becoming available (September 2012). This affected the momentum of the project and required increased efforts to keep stakeholders interested and engaged.

To support NHS Southampton we facilitated a discussion with DH regarding 18 weeks and SDM. The view from DH was that there should not be a ‘pause’ in the pathway where patients may want some time to consider their options; Patients time to consider their options should either be included in the 18 week pathway or patients should be referred back to their GP and a new 18 week pathway would commence.

The interpretation of 18 weeks guidance was seen as a barrier to engagement with secondary care around SDM as there are pressures on certain pathways, such as MSK. The acute trust felt that where possible SDM discussions should be held earlier in the pathway, prior to a referral being made to secondary care. However, there has been successful engagement with secondary care via the Map of Medicine pathway localisation process (where secondary care, community services and primary care agree the pathway).
Lessons learned

This section provides a summary of the lessons learned from both the work with the three health economies and from wider engagement activity, including a series of road show events to share best practice and disseminate tools and learning from the Programme.

4.1 Project Management

Competing Priorities and Management Support

Consistent project leadership is needed from within the organisation to focus on engagement, monitor and maintain progress and to make the most of opportunities to align SDM with other projects and programmes of work. It is also important for the lead to be completely committed to SDM, as the level of input required to effectively implement SDM as a commissioning project should not be underestimated.

Clinical leads’ time was limited and spread between clinical practice and competing projects. Where clinical leads are also CCG leads, this was compounded by the clinical practice/commissioning workload balance.

Clinical leads need ongoing support to enable them to have the confidence to act as an effective agent of change and to ensure best use of time available to support the project. This includes engaging with other clinicians, both within and beyond the CCG.

Engagement with clinicians

Clinical ownership and leadership of SDM from a lead GP within the CCG is essential in adding weight to the programme. This is most successful where the clinical lead provides, training and educating peers in SDM and leading discussions around use of PDAs.

Where clinical leads had been involved in the development of the PDAs, they (unsurprisingly) felt a sense of ownership. In some cases, where they had not been involved in the development of the tools, clinicians needed to discuss the PDAs with a clinical representative of the SDM Programme or feedback their comments. It is critical that in the early stages clinicians feel that they can have confidence in the tools and the evidence processes underpinning them.

Governance Processes

Project approval and governance processes varied between organisations. Decision making processes during this period of reconfiguration have been complex, especially in emerging CCG structures and incumbent PCT structures. Where SDM implementation focussed on an existing PCT and CCG clinical priority, the governance processes generally proved simpler.

4.2 Implementing PDAs

Prioritisation

Where there is a clinical interest or pathway redesign is underway, Capita found it valuable to link implementation of the PDAs to those workstreams.

Our experience of working with the 3 health economies suggests that affecting change in and engaging with, more than three pathways at once was too complex and challenging.
Demonstrating the value of the PDAs early on will add momentum to any subsequent implementation. Positive feedback from patients and positive feedback from clinicians on PDAs and SDM is one of the most important factors in gaining support for wider roll out of SDM.

**Whole pathway involvement**

All services involved in the pathway need to be engaged with and supported, not only the clinicians who are promoting PDAs directly to patients. Clinicians along the pathway need to be aware of the PDA implementation and be supportive of it. This task can be time consuming and requires significant effort around communication. If clinicians in primary care are promoting the use of PDAs to patients but clinicians in secondary care have not adopted an SDM approach then the efforts of primary care may be undermined.

It is useful to incorporate PDAs into referral guidelines. Reviewing or implementing referral guidelines provides an ideal opportunity to include PDAs as part of the pathway.

**Identifying the most appropriate point in pathway to promote PDAs**

From our work with health economies Capita has developed a number of Decision Point Maps, included in the Commissioning Resource Pack (see section 4). These can be used to identify where key decisions are made and in which services.

The most appropriate points in the pathway to promote PDAs will vary according to the condition and the configuration of local services. An example is outlined below.

- **PSA screening:** PDA best promoted in primary care when a patient presents requesting a PSA screen with no other symptoms.
- **Osteoarthritis of hip or knee:** PDA promoted in primary care prior to referral to acute services, or by tier 2 services, where these exist locally.

### 4.3 SDM materials

**Quality and content of PDAs**

Clinicians need to have confidence in the quality and content of PDAs. In some cases, we received feedback from GPs who are supportive of SDM as a concept, but initially questioned the accuracy of some information, for example, inclusion of osteotomy as a treatment option for osteoarthritis of the knee.

In order to addressed differences in clinical opinion it was important to share information on the evidence base and the editorial process underpinning the PDAs. It is important that a feedback loop on the host website is maintained to allow clinicians to pass on any comments on the content of PDAs to the editorial team.

Encouraging clinicians to go through the PDA as if they were a patient and trying out the telephone decision support service, has been effective in increasing confidence in the products.
Format of SDM sheets
Clinicians have limited consultation time with patients and therefore materials developed for use in during a consultation need to be concise. In two of the three health economies we are working with a number of clinicians have fed back that they feel the SDM sheets are too lengthy and a one page summary should be introduced.

Capita understands the SDM Programme has made changes to the SDM sheets in response to these concerns but do not currently intend to produce single page format sheets as the format and content has been designed with decision making expert advice to support patient understanding. The evidence base for the format and content should be made available at the PDA host website.

4.4 SDM and national policy
18 week Referral to Treatment Time (RTT) target
There was a perception amongst some clinicians and managers of tensions between the 18 week RTT target and implementation of SDM. The NHS Operating Framework for 2012/13 retains the RTT operational standards that 90 per cent of admitted and 95 percent of non-admitted patients should start consultant-led treatment within 18 weeks of referral. Acute providers have expressed concerns that if they adopt SDM and PDAs, they may breach the 18 week RTT target if a patient wishes to take time to think about treatment during the pathway. Capita sought clarification from the DH on this point.

Feedback from DH was that a ‘pause’ in the patient pathway is not appropriate once the 18 week pathway has commenced. It is expected that pathways are designed to allow time for such patient decisions. In order to avoid this tension it is advisable to prioritise use of SDM as early in the patient pathway as possible.

Choice and SDM
Unfortunately some CCGs have interpreted the duty to promote the involvement of patients and their carers in decisions about their care and treatment as relating solely to choice of service and/ or provider, rather than patient involvement or discussion around choice of treatment.

The NHS CB guidance should provide further clarity for CCGs on the focus of the guidance as there is a risk around misinterpretation of policy direction in this area.

4.5 Accessibility of tools and resources
Accessibility of information to clinicians
Clinicians are more likely to utilise SDM if information is easily available in clinical settings. Capita was also commissioned to lead on activity to ‘embed’ decision aids in clinical systems and we have reported on this activity separately.

As part of our work with health economies, we developed business cards for GPs to pass to patients as a ‘referral’ to the SDM website. Clinicians are keen to look at adding a link to PDAs and the SDM short forms as part of their practice management system. As responsibility for local information systems passes to CCGs this could be something that CCGs could request from system providers in the future.
Map of Medicine is one enabler we have seen used locally to support SDM through increasing clinicians’ awareness of PDAs for specific pathways.

**Availability of information to patients**

Consideration should be given to PDAs being produced in more accessible formats. For example, versions in alternative languages and audio format (particularly the cataract PDA). This has been fed back by patients, GPs and stakeholders in all health economies we have engaged with.

There are additionally opportunities to engage with the voluntary sector around promotion of PDAs, especially with disease specific organisations including Diabetes UK or Macmillan.
5 The commissioning resource pack

As part of our work with health economies, we developed a resource pack for commissioners. This is intended to support commissioners in embedding SDM across a health economy. It is a resource that could and should be developed over time to reflect learning and experience locally.

5.1 Overview of the Resource Pack

The resource pack was developed as we worked with the three health economies to embed SDM. It provides practical support and guidance through a number of stages of implementation, from project initiation through to evaluation.

The resource pack is broken down into broadly sequential stages of embedding SDM, as follows:

- Project Initiation;
- Coordination, Leadership and Stakeholder Support;
- Engaging Patients and Carers;
- Engaging Staff;
- Resources;
- Securing and sustaining change;
- Evaluation.

The resource pack includes several templates, guides and documents including an outline project plan, template letters to stakeholders, a communication matrix, an agenda for an SDM workshop and a CQUIN template. The resource pack also refers to other Programme resources developed by AQuA and Totally Health.
6 Recommendations

Based on our work to date with health economies, we have outlined a number of recommendations to the SDM Programme, Commissioning Board, policy makers and commissioners relevant to future activity to support the implementation of a SDM approach by health economies.

6.1 Recommendations for the SDM Programme, Commissioning Board and policy makers

Through supporting health economies to embed SDM in the commissioning system we have recognised the potentially far reaching benefits of SDM. However within a short timescale it is difficult to demonstrate these – either locally or nationally. Longer term work is required to support the development of a thorough NHS business and clinical case for change. The transition to alternative programme arrangements may make this complex but it is important to maintain the momentum the SDM Programme has built.

Information should be easy to access for both clinicians and patients/carers

PDAs and other SDM resources need to be readily available at the most effective point of use for both clinicians and patients. If clinicians are required to locate resources as part of the short consultation, they will not use them.

Discussions have been progressed with system providers, but without strategic direction which is resourced, changes to clinical systems are unlikely to happen.

Access to PDAs should be included within any re-procurement of centrally commissioned systems such as NHS Choices and Choose and Book.

Better articulation of policies is required to set expectations

There needs to be better articulation and coordination between policies and guidance. For example, how does SDM relate to the wider Individual Patient Involvement agenda? What is the relationship between choice and Individual Patient Involvement? Beyond what has been set out in the White Paper and more recently, the mandate, national policy has not been clearly articulated.

Future direction of the SDM programme needs to be clarified

The future direction of SDM and the SDM programme, beyond its transition to the NHS Commissioning Board is not clear. Whilst this is the case, commissioners may find it difficult to commit to this work.

Consideration needs to be given to the future of PDAs, including those produced by other programmes, including the commissioning, updating and accreditation of tools.

Consider encouraging use of SDM approach through other health system incentives

There are no current national incentives for adopting Individual Patient Involvement as best practice.

The DH describes Best Practice Tariffs (BPT) as “one of the enablers for the NHS to improve quality, by reducing unexplained variation and universalising best practice. With best practice defined as care that is clinically and cost effective, these tariffs will also help
the NHS deliver the productivity gains required to meet the tough financial challenges ahead. The aim of the tariffs that are structured and priced appropriately both to incentivise and adequately reimburse providers for the costs of high quality care⁷.

The use of BPT should be explored to understand whether this can be used as an enabler for incentivising adoption of SDM and use of PDAs.

**Review SDM and other national policy areas, in particular 18 week Referral to Treatment (RTT) targets**

As the use of SDM and PDAs develops, RTT rules need to consider the impact of time on the patient pathway especially if patients decide to think about treatment options in the secondary care pathway. The system should not constrain patients from having an opportunity to consider the most appropriate treatment for them, even if they have been prompted while they are in an 18 week pathway.

**Better understand the national picture on SDM**

It would be helpful to better understand CCGs’ current approach and progress with Individual Patient Involvement including any plans for focussing on SDM in 2013/14. This would support the Commissioning Board to plan for future programmes of work to support commissioners and/ or providers to roll out SDM.

**Understand opportunities around Informed Consent more fully**

During our work with health economies we found limited support for SDM to be more closely linked to informed consent processes. In part, this was because we worked with commissioning organisations, rather than providers. Some further work may be required specifically with secondary care providers to better understand if there is potential joint benefit in this area.

### 6.2 Recommendations for Commissioners

**Plan and resource for a change management programme**

Organisations need a committed clinical champion to lead local implementation supported by committed management support. Where possible, use existing governance structures as opposed to setting up new processes.

**Plan by pathways**

Prioritise areas for implementation and consider a realistic pace of change in those pathways. Ensure services are supported by providers and the voluntary sector. Plan how you will monitor and measure impact in order to highlight benefit as early as possible.

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**Involve patients**

Consider patient involvement in every key process and decision in the project and use existing patient networks, expert patient programmes and advocates as change agents. CCGs have a number of opportunities to harness the role of patients through their lay members and patient engagement structures.

**Stakeholder engagement**

Engender support from stakeholders across the whole pathway, not just those healthcare staff who you are asking to promote PDAs. Regular engagement and updates are vital in ensuring everyone is aware of progress and in communicating benefits and outcomes.

Engagement with providers around the development of training programmes for patient facing staff is vital to support cultural change and will have the greatest impact in changing behaviour. Contractual levers can support this change.
Quality and Productivity Indicators in QOF 12/13: Guidance for Practices re Out Patient Referrals

<table>
<thead>
<tr>
<th>Summary of QOF Guidance regarding out-patient referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>QP6</td>
</tr>
<tr>
<td>QP7</td>
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<tr>
<td>QP8</td>
</tr>
</tbody>
</table>

Orthopaedics (Hips and Knees) A key priority area in 12/13. The whole MSK pathway is currently under review by the CCG orthopaedic leads and work is ongoing to increase clinical engagement with secondary care. In addition a CQUIN has been developed encouraging the use of hip and knee PDAs in secondary care. The audit of primary care referrals using newly developed referral proformas, described below, is an important element of this work.

Internal practice Meeting (by end of September)
In order to support this discussion the PCT will, by 30th June, send each practice a pack with the following:-

- Data for Q4 2011/12 detailing the NHS numbers of all practice patients who have had a primary hip or knee replacements, at all hospital providers.
- The MOBB priorities policies 36 & 37 detailing the referral criteria for primary hip and knee joint replacements.
- Copies of the joint RBFT/CCG referral proformas that are being recommended for use for primary hip and knee replacement procedures during 12/13
- Patient information leaflets on primary hip and knee replacements.

At the internal meeting clinicians are asked to:
1. Familiarise themselves with the PDAs for hips and knees, as well as the patient information leaflets.
2. Assess all primary hip and knee procedures detailed in the quarter 4 data supplied against the MOBB referral criteria outlined in polices 36 and 37. Identify and document those patients where the criteria were not fully met, detailing what actions could have been taken to achieve compliance with the criteria and in particular if the use of a PDA may have been appropriate and helpful.
3. Agree to READ code (codes to be supplied by the PCT) all appropriate patients who are signposted to use the PDA for Hips or knees.
### External Peer Review Meeting (by end of October)

1. Discussion about the outcome of each practice’s internal meeting.
2. Discussion about the use of the referral proformas for primary hip and knee replacements (available on choose and book and doctor’s desktop.)
3. Discussion about the use of the hip and knee PDAs, and how their use can help ensure that the agreed referral criteria (policies 36 & 37) are met prior to referral for surgery and are optimised with regard to co-morbidities and general health.
4. How this work could be aligned with other primary prevention work streams within practices such as stop-smoking and exercise promotion initiatives.
5. How best to engage with the CCG orthopaedic lead.

### End of Year Report (by end of Feb 2013)

The report should confirm that the Practice has engaged with the CCG Lead for orthopaedics and demonstrate practice wide engagement with SDM for hips and knees. It should:

1. Confirm that at least one practice member has attended a SDM training event and provided feedback from this to other clinicians in the practice
2. Confirm that the practice has received, discussed and considered any actions necessary following the audit results from the secondary care referral audit (orthopaedic procedures)
3. Include a summary of any key learning points from the audit and suggestions for further improvement
4. Include any other comments and feedback on the use of SDM aids which may assist with future commissioning and service redesign.
5. A list of appropriate NHS numbers to which the Hip or PDA read code has been applied during the period 2012/2013.

The orthopaedics lead for the CCG will be expected to confirm practice engagement in the report to be submitted.
### Example CQUIN between Berkshire West PCT and Royal Berkshire Foundation Trust

<table>
<thead>
<tr>
<th>Goal number</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal name</td>
<td>Reduction in elective admissions</td>
</tr>
<tr>
<td>Indicator Name</td>
<td>Shared Decision Making T&amp;O</td>
</tr>
<tr>
<td>Indicator weighting (% of CQUIN scheme available)</td>
<td>This CQUIN incentivises the use of Patient Decision Aids in secondary care, in patient with knee arthritis and osteoarthritis of the hip where the tool hasn’t already been used in the previous 6 months in Primary Care. Patients will not be listed for surgery until they have completed the Patient Decision Aid. NOTE: This CQUIN relies on GPs noting in the referral proforma that the patient decision aid has been used.</td>
</tr>
<tr>
<td>Description of indicator</td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of patients who have used the osteoarthritis of the hip and knee arthritis patient decision aids in the secondary care environment.</td>
</tr>
<tr>
<td>Denominator</td>
<td>Number of patients eligible (ie not used the patient decision aids in primary care in the previous 6 months) for whom the patient decision aid could be used, specifically in relation to osteoarthritis of the hip and knee arthritis.</td>
</tr>
</tbody>
</table>
| Rationale for inclusion | Shared Decision Making – including the use of Patient Decision Aids – is growing in importance and significance in managing demand for healthcare. It is consistent with the growing focus on patient-centred care, ie ‘no decision about me without me’. It has a particular role in:  
- Management of referrals for procedures of limited clinical value  
- Empowering patients with chronic conditions to be involved in an take control of their future well-being  
- Making inroads into unwarranted variation in service (and in particular referrals to secondary care)  
- Placing patients in a more pivotal position in relation to decisions about their elective treatment  
- Reducing risk where the severity of the condition may not warrant an intervention, at least at the present time  
- Enabling the resources related to interventions to be focused on patients in most (clinical) need |
<p>| Data source |  |
| Frequency of data collection |  |
| Organisation responsible for data collection |  |
| Frequency of reporting to commissioner | Monthly |
| Baseline period/date |  |</p>
<table>
<thead>
<tr>
<th><strong>Baseline value</strong></th>
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<tbody>
<tr>
<td><strong>Final indicator period/date (on which payment is based)</strong></td>
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<td><strong>Final indicator value (payment threshold)</strong></td>
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<tr>
<td><strong>Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)</strong></td>
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<tr>
<td><strong>Final indicator reporting date</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Are there any rules for any agreed in-year milestones that achieve payment?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Are there any rules for partial achievement of the indicator at the final indicator period/date?</strong></td>
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Shared Decision Making Programme

Right Care Shared Decision Making Programme
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