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A new approach to personalised care in SAPA 5

Connecting Health Communities in Sheffield

November 2022

Sheffield Futures SF

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Authorship and acknowledgements

This case study has been written by Katie Turner, based on interviews carried out with stakeholders involved in the SAPA 5 Personalised Care Team.

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Terminology

Additional Roles Reimbursement Scheme (ARRS) The Additional Roles Reimbursement Scheme entitles Primary Care Networks (PCNs) to access funding to support recruitment across a range of reimbursable roles - clinical pharmacists, social prescribing link workers, wellbeing coaches, physician associates, physiotherapists and paramedics. Some of the roles in the SAPA 5 Personalised Care Team (PCT) are funded through this scheme.

Integrated Care System (ICS) is a partnership and collaboration system between the NHS, local councils and others, that manages resources collectively to deliver NHS standards and improve the health of the population in their area.

Personalised Care Teams (PCTs) vary from neighbourhood to neighbourhood depending on population needs, although they would typically include a range of clinical staff and roles employed through the voluntary sector - for instance, social prescribers, health and wellbeing coaches (also referred to as 'Wellbeing Coaches'), etc.

Primary Care Networks (PCNs) are networks of GP practices within local geographies (covering a neighbourhood or whole town) that are working together with community, mental health, social care, pharmacy, hospital and voluntary services to deliver health and wellbeing services. For the purposes of this case study, SAPA 5 will be referred to as the identified 'Primary Care Network' (or PCN) - the specific area of interest. Each PCN in Sheffield tends to include between 3-8 GP surgeries.

SAPA 5 is a neighbourhood area in Sheffield consisting of a population of around 34,000.

SOAR is a community regeneration charity that provides a range of services designed to improve a person's health, wellbeing and employability. They provide strategic insight and operational support to the Personalised Care Team (as well as employing some of the staff in the team)

Sheffield Futures is a young people's charity. Supporting young people to achieve their full potential in learning, employment and life to secure a positive future. As well they employ a member of staff in the team.

Social prescribing link workers are also referred to as 'social prescribers'.

Introduction

This case study forms a part of wider work being carried out with colleagues across Sheffield as part of the Institute for Voluntary Action Research's (IVAR) **Connecting Health Communities** programme. It aims to demonstrate what can be achieved when strong relationships are formed in local partnerships between health and voluntary sector workers to address local needs.

To enable the development of practical responses to local health and wellbeing issues, we have been facilitating cross-sector partnerships across England for over 17 years. Our current focus is on supporting partnerships addressing specific health inequalities issues in their area. Between 2021-2022, we have been working with eleven geographies – one of which is Sheffield. Within the city, we are working with four PCNs: GPA1, Heeley Plus, Townships 1 and SAPA 5.

People can have complex needs when it comes to their health and wellbeing. As society's understanding and recognition of this evolves, so too has our response to meeting these needs. In the UK, this includes an increasing emphasis on 'personalised care'.

NHS England describes personalised care as a health care system that can respond to peoples' 'individual strengths and needs'[1] rather than prescribing a one-size-fits-all solution. It believes this will happen through establishing, 'a new relationship between people, professionals and the system' and making the most of 'the expertise, capacity and potential of people, families and communities.'[2]

But what does this look like in practice at a neighbourhood level? And what does it take to establish these kinds of relationships?

This case study looks at the work of the Personalised Care Team (PCT) in the SAPA 5 neighbourhood of Sheffield[3]. It explores SAPA 5's approach to developing a personalised healthcare system that brings together the combined experience of the health and voluntary sector. We look at what working in this way has achieved, some of the challenges encountered along the way, and what is required to sustain and build the work of the PCT.

[1] https://www.england.nhs.uk/personalisedcare/
[2] https://www.england.nhs.uk/personalisedcare/what-is-personalised-care/
[3] Neighbourhood in the North-East of Sheffield comprising of seven GP surgeries

Whilst this case study focuses on a specific neighbourhood within Sheffield, the aim is to also draw out insights that may be relevant to other geographies – at a neighbourhood and city-wide level – about what it takes to do this work and deliver better outcomes for residents.

> *'I think there's something really special about the partnership ... the voluntary sector can do stuff that the NHS can't, and all the sectors have something different to offer. I think it's about figuring out how we work together, which is what we're doing.'*
>
> NHS worker

SAPA 5 Personalised Care Team

The SAPA 5 PCT has been in formation for the last three years, borne out of ongoing partnership working between SOAR and health sector colleagues in SAPA5 over the past ten years.

SAPA 5's approach to personalised care differs from many other PCNs by developing a workforce who deliver personalised care as a team, rather than as a set of individually recruited and managed roles.

The SAPA 5 PCT currently includes:

- Two Occupational Therapists – one of which is the Senior Clinical Specialist who co-leads the team
- Three Social Prescribing Link Workers – two adult and one young person's
- Three Wellbeing Coaches, specialising in chronic pain, diabetes and obesity
- A Dietician
- A Care Coordinator

The operational management of the PCT is overseen by SOAR and the Senior Clinical Specialist, (with input from Sheffield Futures), and is supported by the Primary Care Network (PCN) via the Clinical Director. SAPA 5 has also recently appointed a PCN Manager who, longer term, is likely to act as the conduit between the PCT and the PCN.

The different roles that make up the PCT are either employed by SOAR, Sheffield Futures, the PCN or seconded from Sheffield Health and Social Care (SHSC). Some of the roles funded by the PCN are directly recruited and situated within a GP surgery. One of the Occupational Therapists is seconded from SHSC.

Referrals to non-health roles in the PCT team, e.g. Social Prescribers or Wellbeing Coaches, come from the GP surgeries in SAPA 5, either through GPs, nurses, reception staff or other allied health professionals.

These referrals are usually made when a patient goes to their GP and has a query related to a health or wellbeing issue that can be served by looking at preventative measures, e.g. diet. Referrals made to health professionals in the PCT are for people with complex needs, e.g. mental health, diabetes, that cannot be met by existing services. With the PCT's combined knowledge and skills, they can work together to identify what they can do for the individual and what services and support they can signpost them to:

> *'The team provides a collective memory bank (of individuals requiring support and the services and organisations available in Sheffield). This is essential, as there is no way individuals can physically remember every case and things change all the time in terms of services to refer into.'*
>
> VCSE worker

1. What has been achieved?

1.1 Success in collaboration

The team has been successful in helping to build a more responsive health and wellbeing workforce in SAPA 5 who support residents with complex needs. Good relationships already existed between health and voluntary sector colleagues prior to the establishment of the PCT. The health sector colleagues clearly understood the rationale for the PCT and the role of voluntary sector colleagues within this:

> *'It was like a breath of fresh air when we had that very first conversation, because you didn't have to battle, you didn't have to be defensive.'*
>
> VCSE worker

Since that time, the team has built the PCT in partnership from the ground up, growing and adapting in response to identified needs, across sectors and institutions:

> *'I've worked in other places where people will say, "No, you can't change it," and that's not what's happening here. In SAPA 5, it's, "OK, we need to change it, how do we change it?"'*
>
> NHS worker

This unified, coordinated approach has strengthened the team's work in two ways:

- It ensured that the PCT could draw on the collective knowledge, experience, relationships and networks from several organisations and industries.
- It helped to connect the different conversations that were already happening within specific health and voluntary sector organisations

1.2 A smoother patient process

Patients have benefitted from smoother, more consistent referrals thanks to the joined-up approach taken by PCT team members.

For the PCT, the focus is on understanding what the community needs are and working as a team to work out, *'How can we provide a service?'* and taking a person-centred approach. This involves knowing what is already available and working out how to adapt and signpost to these services, as well as creating something new when required. For example, using the health walks already taking place to build in a focus on mental health as well as physical.

The PCT also uses team meetings to review and reflect on what works and what requires adaptation. For example, they recognised that patients would prefer to access all available services through their own GP surgery, rather than be sent to a different surgery to access a particular service. The team therefore looked at how they could host a range of services within each GP surgery.

Joint working in practice

One of the PCT's Occupational Therapists was working with a person with significant mental health issues who was a risk to themselves. The individual could not leave the house alone and was reluctant to accept visitors, so had not engaged with their appointed Social Prescribing Link Worker (SPLW) or Wellbeing Coach.

The Occupational Therapist worked on a graded plan to enable the person to leave the house more independently and increase their physical activity and confidence. The OT went to the individuals' home. On the first week, they encouraged the individual to step outside of the house; on the second week they progressed to walking down the street with the OT, staying within sight of the house. On the third week, they were happy to go for a walk accompanied by their Wellbeing Coach instead, with the Occupational Therapist available by phone to offer support as and when needed.

At the end of this process, the individual had engaged well with their Wellbeing Coach, and had spoken with their SPLW and other PCT staff about avenues of support and meaningful activities available:

'It was about going at their pace and getting everyone [in the team] *to respond. I couldn't have done it on my own. It was done by all of us, and the individual trusting us and experiencing a system that was responsive to their needs when they needed it'.*

1.3 A more holistic understanding of care

The PCT has helped both health and voluntary sector colleagues to identify connections between social conditions and poor health, and the need to tackle the former to improve the latter:

> *'If your average person in SAPA 5 with obesity and diabetes followed NHS guidelines, it would not be affordable for them to put those guidelines into action. These are lifestyle illnesses because it is the only lifestyle that some individuals can lead due to affordability of healthy food, etc.'*
>
> NHS worker

Some of the Wellbeing Coaches come from the communities that they are working with. Being of the community helps them to identify localised solutions and connect with patients based on common ground. This often enables them to have a more straightforward, open and 'non-medical' conversation with the individual seeking help and identify solutions suited to their situation. GPs and health staff are based in communities but are sometimes less well-placed to have non-medical conversations:

> *'The wellbeing coaches are more on the level of the people they are helping. The dietician will look for affordable options that are sustainable for the individuals they are supporting.'*
>
> NHS worker

2. What could be improved for the future?

2.1 Develop the PCT through better resourcing

As the PCT has evolved and grown, it's evident that it requires adequate resourcing for governance, leadership and workforce development for it to function at its best. SOAR has taken on a coordinator role in this partnership, working alongside the Senior Clinical Specialist, to provide strategic and operational oversight of the PCT. This role (and associated activities) is not officially part of SOAR's duties. The activities include supporting the team's engagement in a range of activities, such as all-team training sessions, e.g. Mental Health First Aid training, and in strategic design conversations about the PCT:

> *'Workforce development is absolutely key … Every opportunity we can, we bring that team together because it's based on relationships. And that's what we do really, really well in the sector [voluntary]: we think about collaboration.'*
>
> VCSE worker

The Senior Clinical Specialist, in addition to doing their clinical work, helps the team to navigate health systems. For example, they understand the process for requesting to use a GP's room to meet with a client to have a consultation with them. They also oversee the team's health and safety, and quality control. When this support comes from a clinically trained, senior team member, the rest of the team is better equipped to work with people who have more complex health and social needs. The Senior Clinical Specialist can also hold some of the risk that comes from dealing with these patients and help others in the team to manage risks as they arise.

SAPA 5 PCN also rent an office space within SOAR's Learning Zone for dedicated PCT use, for in-person team meetings and/or somewhere to do administration work. This was due to there not being enough non-clinical space within GP surgeries.

SOAR and the Senior Clinical Specialist provide governance and leadership support to the team that is not part of their funded roles. They have taken this work on because, as the team has grown, the need for it to have dedicated governance and leadership support has become greater. However, unfunded managerial and coordination work limits the ability to further strengthen the operational model of the team, for example, improving the alignment of referral processes, something which they can only give limited attention to within the remit of their existing duties. Initial conversations are underway between the PCN and SOAR about recruiting a dedicated role – a Development Coordinator – that would have responsibility for helping develop the PCT's operational processes and systems. This would be a time limited role and has yet to be finalised.

The fact that the management and strategic oversight of the PCT sits between the voluntary sector (VCSE) and health (PCN) was felt to be key to its strength – enabling each sector to make best use of the specific knowledge, assets and skills of the other:

> *'There are no NICE guidelines or rigid procedures that you can follow when developing a PCT. It is something that's organic and it develops based on relationships … and it's about empowering staff.'*
>
> VCSE worker

However, to make the PCT work, it requires *'mutual accountability'* between VCSE and health colleagues for the actions and strategic direction of the PCT, with structures in place to facilitate this, e.g. identified leads, aligned referral processes, etc. One suggested avenue being discussed is a PCT management team, involving SOAR, the Occupational Therapist and SAPA 5's Network Manager, that would provide a conduit between the PCT and SAPA 5 strategic steering group.

2.2 Aligned policies and processes

One of the challenges the team faces is the fact that individual roles are funded by and report to different organisations. Some are employed by a GP surgery, on behalf of the PCN, whilst others are employed by SOAR or Sheffield Futures. Team members are responsible for adhering to a different set of policies and procedures and this has presented some challenges in terms of consistency. For example, differences in the procedures for referrals, where each organisation or institution holds their own waiting list and have a different process for how referrals are made and prioritised.

The question was raised as to whether it would be possible to use a single set of policies and procedures, potentially drawing on existing NHS procedures as the foundation. In some situations, this has begun happening and the team have agreed adaptations to procedures between them in order to better meet client needs. For example, where one organisation's policy states their staff are not to make in-person visits to clients in their homes, they have agreed instead that they can make in person visits when accompanied by an NHS colleague (whose policies support in-person visits). However, as addressed in section 2.1, issues remain around a lack of resource to undertake the work required to align policies and procedures.

2.3 Greater mutual understanding of roles

It was felt by both voluntary and health sector colleagues that within NHS England, there needs to be better and more consistent understanding of the role of the voluntary sector within the delivery of health and wellbeing services and support. This knowledge is important because it has a trickledown effect to how the health and voluntary sector work together at a local level:

> *'There is something about having to kind of prove your* [voluntary sector's] *worth and value before you start negotiating* [with health sector]. *Because of the power dynamics and power imbalances, we're not coming from a strong negotiating position as the voluntary sector.'*
>
> VCSE worker

One of the tangible ways voluntary sector colleagues felt the NHS could help to bridge this gap was ensuring that, when the NHS is delivering professional and leadership training to leaders in the health and wellbeing sector, it is also offered to voluntary sector colleagues taking on health leadership roles.

Alongside the above, it requires the buy-in and support of senior leadership within the voluntary and health sector. Both the buy-in from senior leadership within the voluntary sector to invest in opportunities to upskill them in navigating health and care systems, and the buy-in from senior leadership within the NHS to support the integration of the voluntary sector into health and care systems.

One NHS representative said that '*The demand is just overwhelming'* on GP surgeries. They cannot manage the level of demand and range of needs on their own, and that having PCTs in place that can provide this vital aspect of social care is the only way to do this.

3. Conclusion

Over the last few years, SAPA 5 PCT has developed rapidly to respond to growing needs within the local community, and a recognition that meeting these needs requires the combined knowledge and skills of health and voluntary sector workers. The bed rock of this partnership has been the level of trust and relationships built between health and voluntary sector colleagues in SAPA 5 over the last ten years.

By clinical and non-clinical (Additional Roles Reimbursement Scheme funded) staff working as part of a single team, it has led to a more joined-up approach for patients where they are able to receive both the medical and broader health and wellbeing support required for their specific health and wellbeing needs, without a time lag between interventions. The team is also better able to identify solutions that will work for individual patients, according to their lifestyle and wider social context.

The benefits of the governance and leadership of the PCT being provided jointly by the voluntary and health sector were felt to be significant to their success. Making the most of existing personalised care assets; bringing a deep understanding of the connections between social conditions and poor health; and building on established health and voluntary sector relationships and experiences were required to collaborate well.

Whilst the PCN and the voluntary sector have been quick to recruit staff into the PCT to do the work on the ground through the Additional Roles Reimbursement Scheme, finding and making the case for funding to resource the strategic and operational oversight of this work has been challenging. Yet this work is essential to enable the team to work in a coordinated way, plan for the future workforce and to operationally evolve in response to growing and changing needs within SAPA 5.

Whilst some of the actions required to help strengthen the work of PCTs like SAPA 5 are within the gift of local actors, such as the PCN, other shifts require a change in mindset and approach within the NHS. For example, helping to facilitate collaboration from the top down, by opening up NHS training and development programmes to voluntary sector leaders, or providing more support on the ground at a neighbourhood level for PCNs and the voluntary sector to work together.

There is a need to recognise voluntary sector colleagues as equal partners in the delivery of health and wellbeing services. This is of course a two-way process which requires voluntary sector colleagues to be exposed to and helped to understand NHS systems and how to work within and alongside these.

At the time of writing this case study, conversations are already underway within SAPA 5 about how to support and strengthen the work of the PCT in the some of the ways talked about here. Our hope is that through sharing a full and transparent account of what it takes to do this work, it will also provide useful thinking for other areas looking at how to develop their approach to personalised care.

We know through IVAR's wider CHC work that collaboration across sectors and systems takes time, patience, and a willingness to try, fail and adapt along the way, but the benefits for individuals in terms of improved health and care services and support can be significant.