NHS
Bristol, North Somerset
and South Gloucestershire
Clinical Commissioning Group

Meeting of Primary Care Commissioning Committee (Open)

Date: Tuesday 30th March 2021
Time: 09:30 – 11:30
Location: MSTeams

Agenda Number :	8
Title:	BNSSG Primary Care Strategy: Addressing Health Inequalities Update
Confidential Papers	**Commercially Sensitive**: No **Legally Sensitive**: No **Contains Patient Identifiable data**: No **Financially Sensitive**: No **Time Sensitive – not for public release at this time**: No **Other (Please state)**:
Purpose: For information	
Key Points for Discussion:	
This paper provides an update on the work to date as part of the Primary Care Strategy, with particular focus on the outcome of the steps taken for a pragmatic approach to help general practice identify and manage clinically vulnerable patients over winter. This work was previously approved by the committee in September 2020. The paper will also provide insight for the wider Population Health, Prevention and Inequalities wider system plans.	
Recommendations:	For update only on the work carried out on clinically vulnerable patient proactive identification and management following committee approval in September 2020.
Previously Considered By and feedback :	Primary Care Locality Development Group: February 2021 Primary Care Strategy Board 26th February 2021 GP Collaborative Board GP Membership Meetings March 2021 Primary Care Operational Group 11th March 2021 Building Healthier Communities Delivery Group (BHCDG) 12th March 2021
Management of Declared Interest:	None known.

Risk and Assurance:	A risk for ongoing work in this area is the ability to share data across organisations.
Financial / Resource Implications:	This was a short task and finish piece of work but still required significant resource in terms of project management, clinical expertise, business intelligence, clinical effectiveness, communications and general practice time. This supports the previous risk identified regarding resource for work on health inequalities.
Legal, Policy and Regulatory Requirements:	None
How does this reduce Health Inequalities:	This piece of work is focussed on how we reduce health inequalities through early identification of those most clinically vulnerable and therefore at highest risk for Covid and poorer health outcomes in order to prioritise proactive, preventative care.
How does this impact on Equality & diversity	The system recording of ethnicity was around 50% at the start of this work. The aim was to increase ethnicity recording to gain an improved picture to support system work on equality and diversity.
Patient and Public Involvement:	This builds on work from the development of the BNSSG Primary Care Strategy and incorporates feedback from Listening Events with the disabled people, older people and people from black, Asian and minority ethnic (BAME) communities.
Communications and Engagement:	BNSSG Primary Care Strategy Communication and Engagement Plan Presentation at the groups outlined above. OneCare/CCG twice weekly communications OneCare TeamNet page GP Survey
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Agenda item: 8

Report title: BNSSG Primary Care Strategy: Addressing Health Inequalities Update

1. Background

The BNSSG Primary Care Strategy describes the challenges BNSSG faces in terms of Health Inequalities at a point in time pre-Covid. This work has continued to be built on with the response to Covid, population health management, public health profiling work and establishment of the Population Health, Prevention and Inequalities Steering Group.
In September 2020, the Committee approved the pragmatic approach to help general practice identify and manage clinically vulnerable patients during winter as part of the Phase 3 response to the COVID-19 pandemic.
Vulnerable, for this purpose, refers to those clinically vulnerable and at highest risk of harm from Covid as per the evidence and population health management guidance. The inclusion of the ALAMA score ensured that, unlike other models at that time, deprivation was factored in to the identification.
The Primary Care Strategy Board will continue to support work on the wider determinants of health and impact on health inequalities being taken forward as part of the wider system strategy through the Population Health, Prevention and Inequalities Steering Group and the Building Healthier Communities Delivery Group (BHCDG).
A guidance document was developed for the identification & management of vulnerable patients in the prioritisation of planned activity in general practice (Appendix 1) and circulated to practices. In addition, two lists of 10 patients were sent to practices for review. Group 1 specified individuals with the highest absolute risk of death from Covid-19, and Group 2 specified those individuals with the highest age-specific relative risk of death from Covid-19.
Practices were asked to complete a survey to provide feedback on the guidance and the lists provided and also to support practices to achieve the QOF requirements for population stratification.

In addition the Primary Care Strategy work has focussed on ensuring we are clear on where the health inequalities are, provide opportunities to improve outcomes and embed preventative, personalised, proactive care in partnership with our voluntary and community colleagues as part of integrated care partnerships (ICP) development.

1.1 What are we trying to achieve?

The aim was to:

- Respond to Covid - develop an approach for 3 scenarios that we felt our approach needed to be able to deal with (that were actually borne out):

  - Low level of direct impact of Covid-19 (current state), with many people likely still feeling the after-effects of Covid-19 and/or the effects of lock-down
  - A significant second wave increasing the direct threat from Covid-19
  - A second wave plus a second lock-down and shielding programme
- Support practices on how to prioritise work during Covid 19 in order to prevent the health inequalities gap widening and poorer outcomes
- Minimise all-cause harm, including building people's health resilience against future Covid-19 waves
- Assist practices to identify patients at risk of harm from Covid and provide suggested actions and tools to support proactive and preventative management of the patients in line with QoF requirements
- Continue the work as part of the BNSSG Primary Care Strategy (including the close working with the BHCDG), incorporating feedback from Listening Events with the disabled people, older people and people from black, Asian and minority ethnic (BAME) communities
- Support the set of priorities and principles of the Population Health Management (PHM) programme
- Inform the longer term extensive work required around inequalities across the system.

1.2 What did we do?

We have worked closely with Public Health and PHM as part of the development and delivery of the Primary Care Strategy. This has been built on significantly as PHM work has matured along with the Health Inequalities profiling work. This Primary Care data has been essential to help us be clear on our priorities, identify where the problems are, and the gaps.
This work has provided opportunities for preventative and proactive care to reduce the risk of Covid and ensure new ways of working do not lead to poorer outcomes for patients, especially those with long term conditions.

We combined our approach into an actionable framework for use in primary care with three approaches for prioritisation in general practice

i) Prioritising people; e.g. highest risk of a poor Covid-19 outcome
ii) Prioritising work; e.g. reviews for conditions with high risk or poor short term outcomes
iii) Prioritising populations or communities through other means such as targeted communications or focused outreach schemes

Summary of key pieces of work:

- A RAG rated Primary Care Recovery Prioritisation guide developed in conjunction with GP Clinical Leads and Clinical Cabinet
- A guide for the identification and management of the most clinically vulnerable patients in the prioritisation of planned activity in general practice (Appendix 1)

- Supported practices through generated lists to identify patients at risk. Group 1 specified individuals with the highest absolute risk of death from Covid-19, and Group 2 specified those individuals with the highest age-specific relative risk of death from Covid-19
- Actions and tools to support proactive and preventative management of the patients e.g. remote monitoring through eConsult templates, accuRx Florey/Pathways
- Ethnicity Coding support for identification:
    - agreed on a system standard for ethnicity coding
    - developed and deployed a set of tools and culturally competent communications
    - monitor system-wide improvement
- Learning Disabilities (LD)
    - Guide developed for identification of patients with LD
    - Improved coding and reporting to support increased LD annual health checks
- SMI
    - SMI task and finish group established.
    - EMIS coding and template development work for increased numbers of SMI health checks.

2. What did we achieve?

2.1 Identification of patients: survey response

65 practices completed the survey.

From group 1, 74% of respondents agreed that 7-10 patients listed were at high risk of death from Covid-19. 55% recorded that they had already proactively identified 7-10 of these patients in their practice and that 72% of these patients had been reviewed in the last 6 months.

From group 2, 64% of respondents agreed that 7-10 patients listed were at high risk of death from Covid-19. Of this group only 36% of patients had already been proactively identified by the practice and 62% of these patients had been reviewed in the last 6 months.
76.6% of respondents either agreed or strongly agreed that the Covid-Age lists appeared to be clinically valid in identifying patients of greatest risk of poor health outcomes.

The responses demonstrate that in the main our practices are good at proactively identifying patients at greater risk of poor health outcomes and reviewing them. The lists both have some high risk patients missed by the other methods and weighted towards BMI and ethnicity more than the shielding list does. The search is very valuable indeed for identifying younger people with very high BMI but no other comorbidity who probably are at high risk. Practices welcomed this more specific approach to analysing an individual's risk factors. This work went some way to flag people who do not come up conventionally. This work identified high risk individuals who remain at risk of poor outcomes, but also patients where the appropriate intervention has not already been tried.

In terms of how useful the suggested actions in the guidance were, the provision of smoking cessation advice was recorded as the most useful action from the guidance with 26 selecting that it was done in all cases and 25 selecting done in some cases. The provision of weight management advice, desktop review, remote review or prescribing named medication indicator review were also highlighted as useful in all or some cases.

2.2 Ethnicity Coding

Ethnicity recording has improved from 50% to 75%. This is largely due to reconciling existing codes within records, but we are continuing to work with primary care to improve this further. Practices are recording ethnicity data during covid vaccination clinics and have also been collecting this data at flu clinics, but there are some problems with data being pulled through onto the EMIS system.

2.3 Learning Disabilities

The percentage of Learning Disabilities annual health checks completed has been increasing with the targeted interventions described below. The completion rate stands at 53% achievement as of February 2021. There have been a number of initiatives undertaken by the team leading on this work to improve uptake of the health checks, aimed at both the population and clinicians:

- Developed of a toolkit of AHC resources to support GPs & practices validated by Community Learning Disability Teams
- Launched toolkit with GP practices in October 2020
- Set up an AHC portal with 30 recommended AHC resources hosted on GP platform – Teamnet/Remedy, including easy read invite letters
- Identified lead Learning Disability GPs in every practice to establish a contact list
- Established a BNSSG Learning Disability lead GP Forum.
- Developed and delivered a multi-agency training webinar for GPs on 3rd December – 90 minutes training and discussion attended by 66 GPs.
- Provided guidance on reasonable adjustments, including easy read information, to ensure that health checks are accessible.
- Presented briefing on the importance of AHC to Practice Managers Forum and Locality Leads
- Worked with Healthwatch, service users and carers to develop an easy read ‘Get Ready’ resource to prepare for AHC for roll out to practices in January

Planned actions:

- Simplified Coding flier for practices to address incorrect coding errors to assist with accurate reporting – distribute January
- Working with One Care to establish a process for weekly reporting.
- From the success of the pilot rollout the LD champions programme to all GP practices across BNSSG supported by CLDT staff
- Develop further specific training sessions for practice nurses & other practice staff involved in LD AHC completion

- Learning disability AHCs are included in the Phase 3 primary care prioritisation work and comms sent out to practices
- Ensuring Health Action Plans are produced as a result of the AHC
- Targeted support for practices with high numbers of LD patients
- Targeted support for practices with low AHC compliance
- Engage GP LD Leads and PCN Clinical Directors to support delivery - work with PCNs to set up local LD forums and 'buddy' practices with high compliance with those who are struggling
- Regular prompts and support calls to practices about progress with annual health checks.
- Provide pertinent information on reasonable adjustments, coronavirus issues, vaccine, MCA, best interests decision making and consent etc
- Linking AHC to various quality improvement projects e.g. STOMP and improving uptake of cancer screening (particularly bowel cancer)
- BNSSG will develop one agreed easy read AHC template and put on EMIS
- Develop AHC audit tool with LD GPs – auditing 5 AHC per practice
- Quality Audit of AHC planned for April 2021 - Ensuring that health checks are comprehensive and actions following the health check are identified and followed up.

2.4 People with Severe Mental Illness

Addressing health inequalities and improving the physical health of those people with severe mental illness is a priority for our system. There is a dedicated steering group which sits under the Community Mental Health Programme Board driving this work forward. The work is a priority for locality development and ICP progression and the Phase 1 and Phase 2 approaches have been detailed in the NHSE submission.

A key enabler has been a data sharing agreement between practices and the CCG locally; there has been the same ask from NHSE. We are working with practices to ensure the data can be extracted and support offered where needed to improve uptake for the physical health checks and outcomes for our population. The plan for this is:

- CCG BI team to run monthly extracts of the SMI Search to identify the Practice level outputs against the six components of a physical health check and the resultant percentage.
- BI to collate this information into PCN level outputs removing the data from the practices who have not signed data sharing agreement and assessing the impact of the data removal in terms of percentage of PCN list 'missing'.
- BI to share outputs with the steering group to discuss next steps, including identifying options for support.

3. Lessons Learned

- The guidance document was welcomed by practices and feedback was positive; there is a sense that a real difference was made to patient identification and outcomes. However, this guidance piloted a new approach using Covid age. Because of this new approach, it was important that the CCG and wider system supported this work through a number of different governance routes. The time taken to disseminate this guidance was therefore longer than originally anticipated.

- Some practices had not proactively identified anyone as they had been using the Shielded Patient Lists (SPL) which this work identified did not include all of our most vulnerable
- The SPL was developed early in the pandemic and it was evident was that it did not appear to include younger more vulnerable patients, multiple co-morbidity, obesity or BAME and may have been missed, so running the Covid-Age list alongside practices own searches captured this
- Identifying those most at risk does not mean that there is an easy fix, for example it is incredibly hard to bring someone's weight down
- As part of work on patient activation measures this could support patients to identify themselves as vulnerable and proactively encouraging patients to attend for chronic disease monitoring i.e. for blood tests, blood pressure etc
- To ensure patients are not missed coding needs to be accurate and complete
- This work enables a targeted approach to patients who have not had reviews
- Continued searches could be for people in high risk age/deprivation groups who have not had any contact in past 6-12 months
- Considerable resource is required to look into those patients who do not attend or reply
- Best practice includes identifying high risk patients from the lists to ring as this achieves the best outcome for those people who cannot read or write English

4. Financial resource implications

This was an intense short, task and finish piece of work but still required significant resource in terms of project management, clinical expertise, business intelligence, clinical effectiveness, communications and general practice time. This supports the previous risk identified regarding resource for work on health inequalities. We need to ensure we make the best use of the resources within our system and link this work clearly with the wider piece held within the Integrated Care Steering Group. This would also ensure continued strong ties with our VCSE colleagues.

5. Legal implications

The tool was used as a prompt for prioritisation of work not to inform patient care, therefore, does not fit into the criteria for a medical device.
No further implications identified.

6. Risk implications

Risk Title	Mitigation
A risk for ongoing work in this area is the ability to share data across organisations.	PHM group currently working on renewal of data sharing agreement. Support will be required for ongoing challenges with organisational barriers to data sharing.
There is a risk that there is insufficient resource and capacity for the wider, longer term piece of work which may result in widening the gap in health outcomes and access to services	We may need to review the way we need to allocate financial resources in order to reduce health inequalities and improve overall value. We also want to make the best use of our resources within our system and link this work clearly with the wider piece held within the Integrated Care Steering Group. This would

between parts of our community	ensure strong ties with our VCSE colleagues.

7. How does this reduce Health Inequalities

This piece of work is focussed on how we reduce health inequalities through early identification of those most clinically vulnerable and therefore at highest risk for Covid and poorer health outcomes in order to prioritise proactive, preventative care.

8. How does this impact on Equality and Diversity?

The system recording of ethnicity was around 50% at the start of this work. The aim was to increase ethnicity recording to gain an improved picture to support system work on equality and diversity.

9. Communication and Engagement

The previous paper outlined how we built on the Primary Care Strategy communication and engagement plan to develop the work. This included learning from the Citizens Panel, RAPCI Reports, the flu programme and listening events. It also involved collaborative work with population health management and the BHCDG data mapping to identify vulnerable and shielded individuals and households.

The work was disseminated through presentations to the system groups outlined above, the weekly GP communications and the OneCare TeamNet page.

The development of the GP Survey provided the opportunity for those using the guidance to provide feedback and to understand the impact of the work.

10. Summary

This paper provides an update on the work carried out on clinically vulnerable patient proactive identification and management following committee approval in September 2020.

This piece of work was ahead of its time and delivered on what it set out to do – provide support to our practices on prioritisation of work and clinically vulnerable patient identification and management at a time of great need and in the absence of any other guidance.

Subsequently, national guidelines on prioritisation have been published, as well as the introduction of the QCovid tool. There appears to be significant correlation with our work and QCovid along with the Charlson score. Given this, and the need to understand the impact of the vaccinations programme, further iterations of patient lists will not be generated.

The Primary Care Strategy Board will continue work to support our population, general practice, and wider Primary Care with decreasing the health inequalities gap and achieving better health outcomes. The key areas for focus in the next period to do this and build the ICP approach are:

- Continue to work closely with public health, PHM, BCHDG and wider system to address health inequalities
- Continue to support our practices, PCNs, and localities with:
    - Restoration of services including QoF
    - Work prioritisation, building on the RAG rated Primary Care Recovery Prioritisation guide developed in conjunction with GP Clinical Leads and Clinical Cabinet
    - Developing that comprehensive personalised care model for our ICPs which resonates strongly with system partners

Appendices

Appendix 1: Guidance for the identification & management of vulnerable patients in the prioritisation of planned activity in general practice

PDF
Guidance on
identification + mana

Appendix 2: Comprehensive model of personalised care

PDF
universal-personalise
d-care.pdf

Glossary of terms and abbreviations

ALAMA	Association of Local Authority Medical Advisors
BAME	Black, Asian and Ethnic Minority
BHCDG	Building Healthier Communities Delivery Group
COPD	Chronic Obstructive Pulmonary Disease
eGFR	Estimated Glomerular Filtration Rate
EIA	Equality Impact Assessment
FEV1	Forced Expiratory Volume
GP	General Practitioner
HbA1c	Your average blood glucose (sugar) levels for the last two to three months

HF	Heart Failure
ICP	Integrated Care Partnership
ICS	Inhaled corticosteroid
ICSG	Integrated Care Steering Group
IMD	Index of Multiple Deprivation
LA	Local Authority
LAMA AND LABA	long-lasting bronchodilators
LD	Learning Disabilities
LTP	Long Term Plan
MRC	Medical Research Council
PHM	Population Health Management
QoF	Quality and Outcomes Framework
RAPCI	Rapid COVID-19 intelligence to improve primary care response
SMI	Severe Mental Illness
SP	Social Prescriber
UCL	University College London
VCSE	Voluntary, Community and Social Enterprise

BNSSG Guidance for the identification & management of vulnerable patients in the prioritisation of planned activity in general practice

Autumn/Winter 2020/21

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Version	Date	Reviewer	Comment
1	1/10/20	CCG Clinical Leads Workshop Primary Care Strategy Board Clinical Executive Committee Integrated Care Steering Group BNSSG Comms & Engagement Workshop Healthier Together PHM Segmentation and Priority Setting Workshop	First version
2		Exec Team Primary Care Cell Primary Care Commissioning Committee	Document updated following feedback.
7	29/10/20	PCN Clinical Directors/ Test Practices/ GP Collaborative Board/ Locality Development Group	Document updated following feedback.
8-11	16/11/20	BH	Document updated with testing feedback, formatting and coding/survey links
12	23/11/20	BH, GI, CK Quality Committee	Final Version

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1. Checklist of Immediate Key Actions

1.	**Review steps 1a-d (see below)**	
2.	**If you already have a prioritisation process in place or have tried but face barriers, please let us know and share your learning by emailing:** geeta.iyer@nhs.net	
3.	**Access your ALAMA Covid-age lists (2 x 10 people), as per step 1d and once actioned please complete this short 5-6min survey:** https://www.surveymonkey.co.uk/r/TKWQ68W	

2. Introduction

General practice and our populations have experienced substantial and rapid change through the Covid-19 pandemic. One of the consequences has been the pausing or paring back of a lot of what we might consider planned general practice work, such as long term condition reviews. We play a major role in proactive and preventive care within the health system and without such work there is a significant risk to the short and long term health of our population. Guidance from the NHS on whole system recovery[1] and for general practice in particular[2] focuses on prioritising our planned work based on need and addressing inequality, but also in such a way that recognises we can't go back to 'fully normal' just yet.

The aim of the guide is to help with the prioritisation to meet the objectives of building of clinical resilience among those at greatest risk poor health outcomes including from Covid-19, and improving health inequalities over the autumn and winter seasons of 2020/21. It has been designed to work with the current and anticipated QOF requirements (page 9). This is not a set of targets, but an improvement approach to attempt to bring together in one place guidance, contractual information and evidence-informed priority setting based on local consensus.

We understand that prioritisation work within individual practices may already be under way, for example in the way people are prioritised for long term condition reviews or influenza immunisation. We are keen to learn about the prioritisation approaches already being taken. We are equally keen for feedback on the guidance, which can be shared by email geeta.iyer@nhs.net which will continue to evolve as learning is shared and practices support each other.

This guidance is broken down into two main steps:

Step 1: initial short term prioritisation of work; further broken down by:

a. Priority groups
b. Priority areas of QOF work
c. Influenza QOF targets
d. Trial high risk Covid groups (multi-factorial risk model – currently based on the ALAMA Covid-age model[1])

Step 2: medium to long term prioritisation

3. Prioritisation Steps

2.1 Step 1. Initial short term prioritisation of work

This guidance is purely a suggestion for practices to start to respond to the QOF and Phase 3 letter. Stage 1 prioritisation is aligned to the flu vaccination cohorts, but we are also suggesting reviewing those patients on the Learning Disabilities and Severe Mental Illness registers as these patients typically have worse physical health outcomes. Nationally and locally we have identified these cohorts as priority groups. There is a DES to support the delivery of LD Health Checks, and we are developing an approach to support health checks for those patients with severe mental illness. We are also trialling a Covid-19 risk assessment tool and are asking practices to review a small number of patients identified using this method and providing feedback via a survey: https://www.surveymonkey.co.uk/r/TKWQ68W

The tables below outlines the priority categories and groups in much more detail along with the rationale and associated actions. It is acknowledged that this has the potential to generate a not insignificant numbers of patients which will require a varied approach to management (see section below) and involvement of the wider practice team.

2.1.1 Step 1a: Priority groups

Group	Rationale	Actions
People with learning disabilities, prioritised first by people with high risk long term conditions**	Group that experiences some of the greatest inequity in health outcomes[3]	As per latest guidance – see for further details[4] ○ review and update the current registers of people with a learning disability (EMIS in folder EMIS Library\SNOMED Searches\EMIS Administration\National LD searches, uptake and housekeeping) (Ardens in folder Ardens\3.Ardens main searches\learning disability\NHSE Guidance 001030) ○ annual health checks – which may be partly or fully remote (Ardens in folder Ardens\9.Ardens Manager National Contract reports\Contracts| current financial year|PCN DES\IIF\Clinical Activity\HI01-LD health checks) ○ aim (not a target) for at least 75% influenza immunisation coverage ○ record the need for, and the type of reasonable adjustments[5] ○ review all Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) (Search could be written to find pts with LD with DNACPR decision in place) ○ Where appropriate review the 'prescribing named medication indicators' (appendix 1)

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[3] http://www.bristol.ac.uk/sps/leder/

[4] https://www.england.nhs.uk/wp-content/uploads/2020/09/C0713-202021-General-Medical-Services-GMS-contract-Quality-and-Outcomes-Framework-QOF-Guidance.pdf

		○ Indicators: QILD007 and QILD008 – QI work focussed on the actions listed above
People with severe mental illness (QOF – Mental Health)	Group that experiences some of the greatest inequity in health outcomes[5]	○ Smoking cessation and weight management advice/offer of support if available – make use of opportunities for very brief intervention[6] and consider other methods e.g. text messaging ○ Desktop review of people with high risk long term conditions**(would need search written); followed by: ○ Remote or in-person (where absolutely necessary) review, focussed on what matters to that person where the clinician feels personal health promotion or timey disease management is required ○ Where appropriate review the 'prescribing named medication indicators' (appendix 2)
Others who may not be coded for in the electronic record, but may be well known to practice staff; e e.g. homeless, people with problematic drug and alcohol use, commercial sex workers, refugees	These groups often experience severe adverse conditions and experience some of the greatest inequity in health outcomes[7]	

*As per QOF registers: Cancer in the past 5 years, COPD, stroke/TIA, diabetes, CKD, heart failure, obesity, secondary prevention of coronary heart disease/previous acute coronary syndrome

2.1.2 Step 1b: Priority areas of QOF work

Early cancer diagnosis (QOF)	As per QOF guidance; supports important system objective and helps deliver on local change initiative	Indicators: QIECD005, QIECD006 – QI project on implementation 'addition of qFIT testing to colorectal 2ww pathway' by March 31st 2021[8]
Cervical screening (QOF)	As per QOF guidance; important for early cancer detection and prevention	Aim to achieve QOF indicators: CS005 and CS006 (cervical smear catch up programme)
End of life and palliative care (QOF)	Highly important area of care	• Maintain the palliative care register as per indicator: PC001 • Use BNSSG EMIS ReSPECT templates and forms to capture and communicate decisions relating to DNAR decisions and treatment escalation plans
Prescribing safely (QOF)	Important patient safety issue and risk to risk of iatrogenic harm. Work likely to carry over into 2021/22 and therefore relevant for the full restarting of QOF	Focus QI work as per indicator: QI001 on high risk drug monitoring as part of ongoing Covid response and restoration work, linking in with medicines optimisation work.

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[5] https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing

[6] https://www.guidelinesinpractice.co.uk/smoking-cessation/very-brief-advice-can-be-used-for-smokers-who-want-to-quit/335442.article

[7] https://www.thelancet.com/action/showPdf?pii=S0140-6736%2813%2960355-4

[8] https://remedy.bnssgccg.nhs.uk/suspected-cancer-2ww/lower-gi-2ww/

2.1.3 Step 1c: Influenza

Influenza immunisations (QOF)	As per QOF guidance; groups associated with high risk of severe Covid-19 illness	Aim to achieve QOF indicators: COPD007, DM018, STIA009 and CHD 007
Influenza immunisations	Important for improving/ensuring high uptake among populations at high need/risk of underserving, e.g. people with BAME ethnicities	Engage with the system-wide communications plan, which might involve using the practice text messaging system or hosting promotion material online and in-practice – details of this will be communicated when ready
Influenza immunisations	Based on a holistic understanding of risk of severe Covid-19 illness	Target other high risk groups as part of the Healthier Together immunisation strategy

2.1.4 Step 1d: Trial high risk Covid groups

From the start of the pandemic there have been attempts to identify and protect people vulnerable to Covid-19; most notably through the shielded patient list (SPL) – which is coded within EMIS and includes factors related to medical diagnosis and their treatments. Notable factors not included in the SPL criteria include age, sex, ethnicity, deprivation and multi-morbidity. However, a multi-factorial risk model known as 'Covid age'[9], produced by the Association of Local Authority Medical Advisors (ALAMA) combines a wide range of diagnoses based on the best available evidence with some of those factors missing from the SPL criteria[10], which gives a more holistic and complete picture of risk. A very good explanation for this model is available on the ALAMA website (link in footnotes).

We have used the system wide dataset hosted at BNSSG CCG to understand how these scores apply to our population and OneCare have calculated these scores for use by practices. We have used Covid-age in two ways:

1. Using the 'full model' including biological age to produce a score that predicts the **absolute risk** of death from Covid-19 – this produces a high risk cohort characterised by older age and multimorbidity
2. Using the model but without including biological age to produce a score that predicts the **age-specific relative risk** of death from Covid-19 – this produces a high risk cohort younger than the full model, characterised by multimorbidity and deprivation and ethnicity

This is a novel approach which we think will help to address the issues of prioritising and being sensitive to factors such as age, ethnicity and deprivation as set out in national guidance. As a novel

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[9] https://alama.org.uk/covid-19-medical-risk-assessment/

[10] We have added in a conservative weighting for the effect of deprivation, based on evidence from the OpenSAFELY study: https://www.nature.com/articles/s41586-020-2521-4?smid=nytcore-ios-share

approach we wish to trial this using a very small cohort of patients (20 people per practice). This will be done by securely sending each practice a list of the 10 highest scoring patients on each list and we ask that you consider the actions suggested in the table below. We would also like to find out more about your thoughts and experience of working with these groups via this survey https://www.surveymonkey.co.uk/r/TKWQ68W:

Group	Actions
Covid-age group 1: Highest absolute risk from Covid-19	○ Smoking cessation and weight management advice/offer of support if available – make use of opportunities for very brief intervention[11] and consider other methods e.g. text messaging ○ Desktop review followed by: ○ Remote or in-person (where absolutely necessary) review, focussed on what matters to that person where the clinician feels personal health promotion or timey disease management is required ○ Where appropriate review the 'prescribing named medication indicators' (appendix 2)
Covid-age group 2: Highest age-specific relative risk from Covid-19	

3. Step 2: Medium to long term prioritisation

We are working closely with system partners to develop our proactive, preventative and personalised approach to care for our population. Our suggested actions below reflect this approach, and we would welcome practices' thoughts on wider resources in use, or that could be developed to support this approach.

Group	Rationale	Actions
People on the QOF Depression register	Deterioration in mental health during the pandemic is a major health risk and likely to impact deleteriously on other aspects of health	Bulk messaging advising on supported self-help resources
People with higher risk long term condition parameters, such as: ○ MRC dyspnoea 4+ (HF, COPD) ○ HbA1c >=100 (diabetes) ○ home_oxygen ○ FEV1 <50% predicted ○ eGFR <15 ○ Organ transplant recipients	At higher risk of poor health outcomes, including from Covid-19 and therefore represents potentially greatest need. It is noted that in some cases health states may be irreversible	○ Smoking cessation and weight management advice/offer of support if available – make use of opportunities for very brief intervention[12] and consider other methods e.g. text messaging ○ Desktop review of people with high risk long term conditions*; followed by: ○ Remote or in-person (where absolutely necessary) review, focussed on what matters to that person where the clinician feels personal health promotion or timey disease management is required ○ Where appropriate review the 'prescribing

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[11] https://www.guidelinesinpractice.co.uk/smoking-cessation/very-brief-advice-can-be-used-for-smokers-who-want-to-quit/335442.article

[12] https://www.guidelinesinpractice.co.uk/smoking-cessation/very-brief-advice-can-be-used-for-smokers-who-want-to-quit/335442.article

People with a high risk long term condition** without an annual review in the past year	Associated in some cases with higher risk of poor health outcomes[13]	named medication indicators' (appendix 2)
Shielded patient list people with high risk long term conditions**	Original list estimated to be at greatest clinical risk from Covid-19[14]	
Isolated and vulnerable, including frail elderly; identified from local knowledge +/- searches for people based on factors such as housebound	At risk of being less able to seek help and/or engage with healthcare	

*As per QOF registers: Cancer in the past 5 years, COPD, stroke/TIA, diabetes, CKD, heart failure, obesity, secondary prevention of coronary heart disease/previous acute coronary syndrome

4. Practical steps on how to go about prioritisation

In order to support practices carry out this prioritisation exercise we suggest the following steps:

4.1 Generating lists

- In the first instance the One Care analytics team will send a list of 20 patients to each practice. This list will contain the 10 highest scoring patients in terms of absolute risk and age-specific relative risk.
  These will be sent as a password encrypted spreadsheet to practice managers via NHS mail. The password will be sent in a separate subsequent email.
  The spreadsheet will contain a further list of the next 180 highest scoring patients, giving the 200 patients in each practice with highest absolute risk and age-specific relative risk. If you would like access to this list, please get in touch with your practice manager. If they have not yet received a list or are unable to find it please contact the One Care analytics team.
  (Please note, patients were identified from registered lists on 01/10/2020 and therefore may contain deceased patients.)
- Help with accuracy of your list by ensuring LD coding and ethnicity coding is as accurate as possible https://teamnet.clarity.co.uk/Library/ViewItem/6ce48ef7-53d7-4468-9d14-ac6300df7f85
- See table 2.1.1 and section 5 for current specific reporting links
- Use your in-house searches
- See guidance to generate searches:
    - CSU training website: https://training.scwcsu.nhs.uk/training-programme/core-clinical-system/emis-core-clinical-system

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[13] https://www.nature.com/articles/s41586-020-2521-4?smid=nytcore-ios-share

[14] https://digital.nhs.uk/coronavirus/shielded-patient-list

  - EMIS Now support page for reporting https://emisprod.service-now.com/csm?id=kb_article_view&sysparm_article=KB0063234&sys_kb_id=856898d3db5a185035643452399619f5&spa=1
  - BNSSG EMIS Teamnet page - https://teamnet.clarity.co.uk/onecare/Topics/View/Attached/7873c172-5ab6-4ea5-b307-aaf0008bd7a9
- Contact BNSSG CCG for further support bnssg.pc.contracts@nhs.net

4.2 Management of patients

Depending on the number of patients your search generates you may want to use a variety of methods and staff to manage patients including but not limited to:

- Health promotion options e.g. flu campaign, weight loss, smoking cessation https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing https://www.guidelinesinpractice.co.uk/smoking-cessation/very-brief-advice-can-be-used-for-smokers-who-want-to-quit/335442.article
- Telephone calls
- Texts
- Surveys e.g. using accuRx or eConsult LTC review templates

5. Key points from the BMA/NHS 2020/21 QOF guidance

- Revised our approach to QOF for 2020/21 to reflect the impact of COVID-19
- Practices will need to reprioritise aspects of care not related to COVID-19 and have modified the QOF requirements for 2020/21 to support this and help release capacity in general practice to focus on COVID-19 recovery
- Absent to national agreement to the contrary, QOF will be reintroduced fully from April 2021 and will include agreed changes set out in contract
- COVID-19 has had a disproportionate impact upon some of our most vulnerable patients
- The revised approach to QOF in 2020/21 aims to release capacity within general practice to focus efforts upon the **identification and prioritisation of people at risk of poor health** and **those who experience health inequalities** for proactive review including:
  - Those most vulnerable to harm from COVID-19; evidence suggests that this includes patients from BAME groups and those from the 20% most deprived neighbourhoods nationally (LSOAs)
    (No EMIS library searches for ethnicity – but easy search to write.
    Ardens: - reports in folder Ardens\9.Ardens Manager National Contract reports\QoF 2020-revised COVID19 Dashboard\BAME)
  - Those at risk of harm from poorly controlled long-term condition parameters
    (EMIS QoF searches
    Ardens: - reports in folder Ardens\9.Ardens Manager National Contract reports\QoF 2020-revised COVID19 Dashboard\

    Ardens diabetes search in Ardens\3.Ardens Main searches\Diabetes care\Ardens diabetes care prioritisation searches)
  - Those with a history of missing annual reviews
    (EMIS Qof Searches
    Ardens: - reports in folder Ardens\9.Ardens Manager National Contract reports\QoF 2020-revised COVID19 Dashboard\
    Ardens diabetes search in Ardens\3.Ardens Main searches\Diabetes care\Ardens diabetes care prioritisation searches)
- The changes also aim to support practices to restore vital care delivery in areas such as
  - screening
    (Ardens in folder Ardens\9.Ardens Manager National Contract reports\Contracts| current financial year|PCN DES\Cancer)
  - implementation of early cancer diagnosis referral guidance
  - care for patients with a learning disability, with a specific focus upon proactive health checks and seasonal influenza vaccination
    (EMIS in folder EMIS Library\SNOMED Searches\EMIS Administration\National LD searches, uptake and housekeeping
    Ardens in folder Ardens\3.Ardens main searches\learning disability\NHSE Guidance 001030)
- This support to vulnerable patients also requires a greater sensitivity to risk factors for complications of COVID-19 such as age, gender, ethnicity and disability, long-term conditions and modifiable risk factors such as weight.
- Many of these patients will also be eligible for vaccination against seasonal influenza and again the revised QOF requirements detailed below seek to recognise both the challenges involved with the delivery of the annual flu programme in the current operating climate and the increasing importance of maximising vaccination opportunities
- Stakeholder engagement concluded that for many BAME groups a "lack of trust in NHS services and health care treatment resulted in their reluctance to seek care on a timely basis, and late presentation with disease".

Changes for 2020/21:

- Some indicators will continue to be paid on the basis of practice performance:
  - The four flu indicators targeted on patients with coronary heart disease, COPD, stroke/TIA and diabetes – these indicators will have the number of points attached to them doubled;
  - The two cervical screening indicators, which will also have the number of points attached to them doubled.
  - Register indicators and eight indicators related to optimal prescribing of medications to manage long-term conditions.
- The requirements of the Quality Improvement (QI) domain have been amended to focus upon care delivery and restoration of services using QI tools
- The remaining 310 points will be subject to income protection based upon historical practice performance and subject to practices agreeing an approach to QOF population stratification with their commissioner [see introduction]

We are proposing that this guide supports practices in the QOF population stratification as set out in the 2020/2021 QOF guidance above. In order for practices to be able to qualify for the 310 income protected points, we require each practice to fill in the short survey below. This will enable you to affirm on the eDEC that your practice is complying with the 2020/2021 QOF guidance and receives the income protection.

Please click here to complete the survey: https://www.surveymonkey.co.uk/r/TKWQ68W

6. Appendix

6.1 Appendix 1: GP Survey - Feedback on Covid-Age lists

Please click here to complete: https://www.surveymonkey.co.uk/r/TKWQ68W

We would like to collect feedback on the value of the two patient prioritisation lists sent to you.

This brief survey will cover both Group 1 (individuals with the highest absolute risk of death from Covid-19) and Group 2 (those individuals with the highest age-specific relative risk of death from Covid-19).

The survey will take about 5 minutes to complete.

The information you provide via Survey Monkey will be stored securely on a password-protected server. This server can only be accessed by the relevant staff at the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG).

The survey is open until 14th December 2020, but please respond as soon as possible.

Thank you for your time.

---

1. Practice Name

2. You were sent two lists of 10 patients. Group 1 specified individuals with the highest **absolute risk** of death from Covid-19, and Group 2 specified those individuals with the highest **age-specific relative risk** of death from Covid-19.

   Please select how many patients in each group:

	Group	0	1-3	4-6	7-10
you agree are high risk	1	☐	☐	☐	☐
	2	☐	☐	☐	☐
had already been proactively identified by your practice	1	☐	☐	☐	☐
	2	☐	☐	☐	☐
had been reviewed in the last 6 months by your practice	1	☐	☐	☐	☐
	2	☐	☐	☐	☐
Were duplicates (i.e. appeared on both lists)	n/a	☐	☐	☐	☐

2. **To what extent do you agree that the Covid-Age lists appear to be clinically valid in terms of identifying patients at greatest risk of poor health outcomes?**

   strongly agree / agree / disagree/ strongly disagree

3. **Have the Covid-Age lists made a difference to how you prioritise patients for reviews?**

   ☐ Yes

   - In what way? (free text)

   ☐ No

   - Please provide more information (free text)

   ☐ We do not prioritise patients for review

4. **How useful are the suggested actions in the guidance?**

	Useful	Not useful	Neutral
Provision of smoking cessation advice	☐	☐	☐
Provision of weight management advice	☐	☐	☐
Desktop review	☐	☐	☐
Remote review	☐	☐	☐
In-person review	☐	☐	☐
Prescribing named medication indicators review	☐	☐	☐

5. **What other actions, if any, do you think could be included in the guidance?**

   Free text – large box

6. **How do you feel overall about using a risk model such as Covid-Age to prioritise patients for proactive intervention?**

Very positive / positive / neutral / negative / very negative

7. **Are there any risks about using a model such as Covid-Age to prioritise patients for proactive intervention that concern you?**

   ☐ Yes

   - Please explain (free text)

   ☐ No

8. **Please use this box to suggest any improvements to this approach to increase its usefulness to general practice and/ or patients.**

   Free text – large box

<<DONE>>

Thank you so much for your important contribution to this work

6.2 Appendix 2: Example table of roles and responsibilities

The below table starts to populate an example of how practices can allocate roles and responsibilities to tasks related to this guidance:

Role	**Admin**					**ANP**	**Pharmacist**	**Social prescriber**	**GP / ANP**	**GP / ANP**
(Opportunity for smart use of SMRs for people who are at the top of this list.)	Review register	Flu	Smoking Cessation	Weight	Alcohol	Review	Prescribing	Social prescribing (e.g. People at top of list could be reviewed by social prescriber for eligibility and referral and work down)	Review advance care plan including DNA-CPR	Comments
People with learning disability who have high risk long term conditions**						Health Check				Review reasonable adjustments
All other people with learning disability										
Serious mental illness										
Etc.										

6.3 Appendix 3: Prescribing named medications

Indicator ID	**Indicator wording**	**Points**	**Payment thresholds**
AF007	In those patients with atrial fibrillation with a record of a CHA_2DS_2-VAS_c score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy	12	40-70%
CHD005	The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	7	56-96%
HF003	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB	6	60-92%
HF006	The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, who are currently treated with a beta-blocker licensed for heart failure	6	60-92%
STIA007	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken	4	57-97%
DM006	The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	57-97%
DM022	The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years)	4	50-90%
DM023	The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin	2	50-90%
	Total	**44**	

Universal Personalised Care

Implementing the Comprehensive Model

#Personalisedcare www.england.nhs.uk/personalisedcare

Publications Gateway Reference: 08193 Version:1

Document purpose: To set out our ambitions for the delivery of personalised care

Publication date: January 2019

Target audience: All

Description: For many years the NHS has talked about the need to shift towards a more personalised approach to health and care so that people have the same choice and control over their mental and physical health that they have come to expect in every other part of their life. And as local health and care organisations work together more closely than ever before, they are recognising the power of individuals as the best integrators of their own care.

This document sets out how the NHS Long Term Plan commitments for personalised care will be delivered. It introduces the comprehensive model for personalised care, comprising six, evidence-based standard components, intended to improve health and wellbeing outcomes and quality of care, whilst also enhancing value for money. Implementation will be guided by delivery partnerships with local government, the voluntary and community sector and people with lived experience.

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Classification: Official

This information can be made available in alternative formats and may be available in alternative languages, upon request. Please contact the personalised care team at england.personalisedcare@england.nhs.uk

Foreword

Chapter one of the NHS Long Term Plan makes personalised care business as usual across the health and care system.

For many years the NHS has talked about the need to shift towards a more personalised approach to health and care. A one-size-fits-all health and care system simply cannot meet the increasing complexity of people’s needs and expectations.

The NHS Long Term Plan is clear the time has come to give people the same choice and control over their mental and physical health that they have come to expect in every other part of their life.

As well as being morally the right thing to do, a growing body of evidence shows that better outcomes and experiences, as well as reduced health inequalities, are possible when people have the opportunity to actively shape their care and support. And as local health and care organisations work together more closely than ever before, they are recognising the power of individuals as the best integrators of their own care.

This document is the delivery plan for personalised care. It establishes the Comprehensive Model for Personalised Care, comprising six, evidence-based standard components, and the detailed 21 actions to achieve its systematic implementation, right across the country. Implementation will be guided by our delivery partnerships with local government, the voluntary and community sector and people with lived experience.

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NHS England worked in partnership with the following organisations to produce this document:

- Academy of Medical Royal Colleges
- Association of Directors of Adult Social Services
- Association of Directors of Public Health
- Care Quality Commission
- Coalition for Collaborative Care
- Council for Disabled Children
- Disability Rights UK
- Healthwatch England
- Health Education England
- Local Government Association
- National Voices
- Nesta
- NHS Digital
- NHS Improvement
- Public Health England
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Occupational Therapists
- The Richmond Group of Charities
- Skills for Care
- Skills for Health
- Think Local Act Personal
- Voluntary Organisations Disability Group

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Executive summary

Chapter one of the NHS Long Term Plan[1] makes personalised care business as usual across the health and care system. This document is the delivery plan for personalised care. It sets out how, working with people with lived experience and partners in local government and the voluntary and community sector, we will systematically implement the Comprehensive Model for Personalised Care to reach 2.5 million people by 2023/24 and then aiming to double that again within a decade (by 2028/29).

Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths, needs and preferences. This happens within a system that supports people to stay well for longer and makes the most of the expertise, capacity and potential of people, families and communities in delivering better health and wellbeing outcomes and experiences. This is one of the five major, practical, changes to the NHS service model in the NHS Long Term Plan. It recognises that personalised care is central to a new service model for the NHS, including working through primary care networks, in which people have more options, better support, and properly joined-up care at the right time in the optimal care setting.

This shift represents a new relationship between people, professionals and the health and care system. It provides a positive change in power and decision making that enables people to feel informed, have a voice, be heard and be connected to each other and their communities.

The approach learns from the experience of social care in embedding personalised care in everyday practice. Local government has shown that personalised care at scale is possible: for example, 156,000 people now have a direct payment or part direct payment[2] in order to purchase the support they need. It also builds on progress made more recently in health through the implementation of personalised care interventions, such as personal health budgets (PHBs). Personalised care takes a whole-system approach, integrating services including health, social care, public health and wider services around the person. It provides an all-age approach from maternity and childhood, through living with frailty, older age and end of life, encompassing both mental and physical health and recognises the role and voice of carers. It recognises the contribution of communities and the voluntary and community sector to support people and help build resilience.

The Comprehensive Model for Personalised Care has been co-produced with people with lived experience and a wide range of stakeholders and brings together six evidence-based and inter-linked components, each of which is defined by a standard, replicable delivery model. The components are:

1. Shared decision making
2. Personalised care and support planning
3. Enabling choice, including legal rights to choice
4. Social prescribing and community-based support
5. Supported self-management
6. Personal health budgets and integrated personal budgets.

Through these standard models we seek to create the balance between specifying a national, consistent standard and enabling flexibility for local adaptation and implementation. We also seek to align to or build on existing personalised approaches that have been adopted by both social care and health in many areas.

Evidence has shown that to realise the full benefits from personalised care, the six components should be delivered together and in full, alongside key enablers which embed the necessary culture change, including strong system leadership, co-production and workforce engagement and development across the health and care system, and in partnership with the voluntary and community sector.

The deployment of these six components will therefore deliver:

- Whole-population approaches to supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build community. resilience, and make informed decisions and choices when their health changes.
- A proactive and universal offer of support to people with long-term physical and mental health conditions to build knowledge, skills and confidence and to live well with their health conditions.
- Intensive and integrated approaches to empowering people with more complex needs to have greater choice and control over the care they receive.

Significant progress has already been made in delivering the Comprehensive Model for Personalised Care, with over 32,000 PHBs in place and over 204,000 people benefitting from a personalised care approach in 2018. Nearly 69,000 people have also benefitted from a social prescribing referral in the past 12 months.

The evidence base (see technical appendix) for personalised care demonstrates a positive impact on people, professionals and the system. Shared decision making about tests, treatments and support options leads to more realistic expectations, a better match between individuals' values and treatment choices, and fewer unnecessary interventions. In a recent independent survey, 86% of people with a PHB said that they had achieved what they wanted with their PHB and 77% of people would recommend them to others. PHBs in NHS Continuing Healthcare (CHC) have also been shown to achieve an average 17% saving on the direct cost of home care packages. While we do not expect this 17% saving to be repeated in a system operating at scale, it provides further support of the policy that PHBs should be used as the default mechanism for delivering CHC home care packages. From tracking over 9,000 people with long-term conditions across a health and care system, evidence has shown that people who are more confident and able to manage their health conditions (that is, people with higher levels of activation) have 18% fewer GP contacts and 38% fewer emergency admissions than people with the least confidence. The evidence of the impact of personalised care continues to grow. Personalised care also has a positive impact on health inequalities, taking account of people's different backgrounds and preferences, with people from lower socio-economic groups able to benefit the most from personalised care.

Given this basis, we now intend an exponential expansion in the roll-out of personalised care so that it becomes business as usual in the health and care system. A total of 2.5 million people will benefit from personalised care by 2023/24, aiming to double this to five million people within a decade (2028/29). Primary care networks will be a key delivery mechanism for this expansion: we want social prescribing and shared decision making to be mainstreamed in primary care, and personalised care and support plans to be rapidly expanded to 2.5 million people with long-term conditions and complex needs.

As the Long Term Plan sets out, personalised care will underpin maternity care for pregnant women and for people with dementia, as well as drive improvements in end of life care. It is also fundamental to the NHS's ambitions for cancer: by 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support, all delivered in line with the Comprehensive Model for Personalised Care. And personalised care supports the intent to offer a 'digital first' option for most: people, clinicians and carers will have technology to help them and enable care to be designed and delivered in the place that is most appropriate for them.

Alongside this, and drawing on the work of Think Local Act Personal and the Coalition for Collaborative Care on Making it Real,[3] we want to ensure that the quality of personalised care matches the scale of our ambition. It is the combination of quantity and quality that ensures the maximum gains in people's outcomes, experiences and value to the system, as well as improved experiences and wellbeing for the workforce, are achieved through personalised care.

When this is in place, we will see how personalised care is an irreducible element of the integration work being done at the level of the system, neighbourhood and place through sustainability and transformation partnerships (STP), integrated care systems (ICS) and primary care networks (PCNs) respectively. Personalised care will enable people to be the best integrators of their care.

We do not underestimate the challenge in delivering this scale of ambition even over a 5- to 10-year time horizon, but there are already excellent examples across the country of this happening at a scale and pace never seen before, with associated impact. Work that has been undertaken through the Integrated Personal Commissioning (IPC) programme with our partners in the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA), as well as the new care models vanguard sites, in the ICSs and STPs, and in the Realising the Value programme,[4] has additionally demonstrated just what is possible by working with people and communities in a different way. We also recognise that the shift in culture represented by personalised care has already begun to happen; we acknowledge the excellent and diverse work being delivered across the frontline of health and care. This plan seeks to build on what has gone before, and to accelerate and scale that progress.

To meet the challenge and practically deliver personalised care by 2023/24 and beyond, we have set out 21 clear actions that will enable the Comprehensive Model to be delivered:

Overall objectives

1. Deliver universal implementation of the Comprehensive Model across England. This will fully embed the six standard components across the NHS and the wider health and care system and will reach 2.5 million people by 2023/24. The aim is then to double this by 2028/29.
2. Demonstrate early, full delivery of the Comprehensive Model across a number of ICSs and STPs.
3. Co-produce a National Impact Statement for Personalised Care, setting out the quantified difference we plan to make to people's outcomes and experiences, workforce experience and wellbeing, and to the system, including net value. This will aggregate the impact of each of the six components of the Comprehensive Model to develop a clear measure for the impact of personalised care.

Delivering the six components

4. Develop workforce skills by embedding shared decision making and personalised care and support planning in pre- and post-registration professional training. This includes through all GP training through the Royal College of General Practitioners (RCGP) from 2019/20 (subject to General Medical Council approval), and from 2020/21 for other professionals, including nurses and allied health professionals.
5. From 2019/20, roll-out a new interactive face-to-face training programme to develop professional skills and behaviours to deliver shared decision making and personalised care and support planning as fundamental ways of working across health and care staff. At least 75,000 clinicians will be trained by 2023/24.
6. Expand the shared decision making programme in 2019/20, developing decision support tools and e-learning resources to embed shared decision making in 30 specific clinical situations. Personalised care will also be at the heart of work on 'rethinking medicine'.
7. Embed effective mechanisms to enable people to exercise choice and control in elective care.
8. Fund the recruitment and training of over 1,000 social prescribing link workers to be in place by the end of 2020/21, rising further so that by 2023/24 all staff within GP practices have access to a link worker as part of a nationwide infrastructure of primary care networks, enabling social prescribing and community-based support to benefit up to an estimated 900,000 people.
9. Work with partners in the voluntary and community sector, as well as local and central government, the wider public sector, the Big Lottery Fund, Public Health England and other arm's-length bodies to explore the best models for commissioning the local voluntary and community sector that support sustainable models of delivery and scaling of innovative provision.
10. Continue to support the development of programmes and initiatives that seek to increase the knowledge, skills and confidence of people to better self-manage their long-term conditions.
11. Exceed our PHB Mandate goals to deliver at least 40,000 PHBs by March 2019 and at least 100,000 PHBs by 2020/21.[5] Complete the transition from the wheelchair voucher scheme to personal wheelchair budgets. Subject to the final evaluation findings, expand Personal Maternity Care Budgets (PMCBs) to support 100,000 women per year by 2021/22.
12. Ensure all people receiving home-based NHS CHC have this provided as a PHB by default by 2019/20, benefitting around 20,000 people a year. We will also

explore PHBs in Fast Track NHS CHC-funded home care packages as well as children and young people’s continuing care, and consider moving to a default position by 2021/22.

13. Following publication of the consultation response, work with the Department of Health and Social Care (DHSC) to implement new rights to have a PHB for people with ongoing health needs. In 2019/20 we will explore new rights to have PHBs in five further areas: end of life care, equipment, dementia, carers and neuromuscular diseases.
14. Innovate in developing the PHB model, including by exploring the potential of multi-year PHBs, one-off proactive ‘grants’, and portability of support.
15. A total of 200,000 people will be supported by PHBs by 2023/24.

Underpinning actions

16. NHS Personalised Care will be a national centre of excellence for personalised care to: (1) support local delivery, (2) provide national infrastructure services, (3) set policy and quality standards, (4) learn and evaluate what works.
17. Establish a consistent digital platform for payment, management and monitoring of PHBs, and for personalised care and support planning, aligning this with digital and data standards and the work of the Empower the Person digital transformation work of NHS England.
18. Train up to 500 people with lived experience to become system leaders by 2023/24. Empower people with lived experience to access personalised care by providing good quality information and explore supporting people with a legal right to a PHB to have access to advocacy.
19. Develop a personalised care dashboard, with key metrics on uptake embedded in routine NHS Digital data collections, and local and national planning and performance frameworks. We will introduce indicators of quality and show progress against our goals.
20. Use incentives such as the revised GP Quality and Outcomes Framework (QOF), and further embed personalised care into the Care Quality Commission (CQC) regulatory framework.

Personalised care in wider public services

21. Make the case for the Comprehensive Model to become a basis and chassis for wider public services integration around people, including by working with the Department for Work and Pensions (DWP), the Department for Education (DfE), the Ministry of Housing, Communities and Local Government (MHCLG) and DHSC.

These actions have been co-produced with people with lived experience, and consulted on with clinicians, professionals, local government, local areas, the voluntary and community sector, clinicians, academics and representative bodies. They also build on work that was undertaken through our IPC programme, which was developed in partnership over the course of three years, including through a series of collaborative development groups that directly engaged over 120 representatives from local government, the voluntary and community sector and the NHS.

To deliver these actions, we recognise the need to further commit to continuing our partnership approach. The Personalised Care Advisory Board, co-chaired by NHS

England and the LGA, will ensure all perspectives shape and contribute to the work required.

These are our national ambitions for delivering personalised care across the NHS over the next decade. They will be developed with partners into a detailed delivery plan.

1. Introduction

1.1 The case for change

The NHS has existed for 70 years. It is an institution that has stood the test of time and is a source of national pride.[6] Whilst health and care has evolved significantly since 1948, the fundamental principles of the NHS remain reassuringly constant.[7] For all major conditions, the quality of care and the outcomes for patients are now measurably better than a decade ago: cancer survival rates are at their highest, early deaths from heart disease and stroke are down, and life expectancy has been growing by five hours a day.[8]

Whilst the NHS is undoubtedly a towering achievement, the foundations on which the health and care system were built and evolved contain a number of divides running through them: between health and social care;[9] between physical and mental health;[10] between children's and adults' services;[11] and between community-based care and hospital-based services.[12]

More fundamentally, there has also been a cultural divide between the professional and the person. This reflects a medical model of health over one that also gives proper consideration to wider determinants of health.[13]

Whilst the health and care system has been changing, the population itself has also changed. People are living for longer with more complex health and care needs.[14] People with one or more long-term condition now make up 30% of the population, account for 50% of all GP appointments, 64% of all outpatient appointments, and occupy 70% of hospital beds.[15] Of the population aged 65 or over, 15% are moderately or severely frail.[16] Some 70% of the health service budget is now spent on people who are living with long-term conditions.[17] The number of children with profound and multiple learning difficulties has increased by 40% since 2004.[18] By 2035 two-thirds of adults are expected to be living with multiple health conditions and 17% will have four or more conditions.[19]

There is also a wider change in the relationship between citizens and public services. Citizens have higher expectations and more diverse demands of public services. Virtually every aspect of modern life has been, and will continue to be, radically reshaped by technology and innovation: through digital and the mobile phones in our pockets we are completing many tasks for ourselves – recognised and reflected in chapter 5 of the NHS Long Term Plan and the work of Empower the Person, NHS England's roadmap for digital health and social care services.[20] We are taking advantage of precision medicine to treat or prevent ill health in ways that are specific to only us.[21] We are also more often seeking information and using stronger and quicker feedback loops to engage with public services and let them know how they are doing.[22] We expect a more responsive and personalised experience from public service than we are currently being offered.

A complex health and care system cannot always deal with this increasing complexity. This can result in poorer outcomes for individuals:

- People with learning disabilities die 15-20 years earlier than the general population[23], as do people with severe and prolonged mental illness[24]
- One million people over the age of 65 report being lonely. Such loneliness and social isolation, which affects people of all ages, leads to poorer health, higher use of medication, increased falls, and increased use of GP services[25]
- Clinicians and people routinely overestimate treatment benefits by 20% and underestimate harms by 30%.[26,27]

It can also result in poorer experiences for people using services and managing their conditions:

- Only 40% of adults report that they have had a conversation with a healthcare professional in their GP practice to discuss what is important to them[28]
- Only 7% of adults have been given (or offered) a written copy of their care plan[29]
- Only 55% of adults living with long-term conditions feel they have the knowledge, skills and confidence to manage their health and wellbeing on a daily basis[30]
- The experience of living with multiple health conditions is often "just one thing after another", rather than supporting people to live better lives for longer.[31]

Whilst overall quality of care and outcomes remain high, there is also evidence of increasing dissatisfaction of both people and professionals:

- 84% of GPs say that their workload is unmanageable or excessive and can prevent quality and safe care[32]
- In 2017 people's satisfaction with the NHS was 57% – a drop of 6%.[33]

And these issues also impact on the efficiency and productivity of the system through the way in which resources are used:

- In 2018 an average of 41% of people who arrive at Accident and Emergency Departments could have accessed different parts of the system to meet their needs[34]
- Just 5% of people with long-term conditions account for more than 75% of unscheduled hospital admissions[35]
- Social workers report spending nearly 80% of their time on paperwork.[36] GPs have estimated that potentially 27% of all appointments are avoidable.[37]

Even if the health and care system had the appropriate level of funding, it would still face many of these challenges.[38] As the World Health Organisation[39] has concluded:

"The focus on hospital-based, disease-based and self-contained "silo" curative care models undermines the ability of health systems to provide universal, equitable, high-quality and financially sustainable care. [Health systems] are often unaccountable to the populations they serve and therefore have limited incentive to provide the responsive care that matches the needs of their users. People are often unable to make appropriate decisions about their own health and health care, or exercise control over decisions about their health and that of their communities."

1.2 Creating a new relationship

Our approach to health and care can be different, as the pioneering disabled people's Independent Living Movement in the 1970s and 1980s has shown us. Under the banner of 'nothing about us, without us', disabled people called for greater choice and control so they could be the authors of their own lives. The imperative for services to be responsive to people's rather than system needs led to the introduction of direct payments in social care, amongst other advancements, enabling people to take control over the funding for their care.[40]

Alongside this foundation, continual progress has been made by disabled and non-disabled people alike, including work to embed person-centred care in the NHS, in public health, and introducing personalised care as standard practice in social care. This culminated in Chapter two of the *Five Year Forward View*[41] and the Care Act (2014).[42] These both recognised that many people have the knowledge, skills and confidence to manage their health and wellbeing, or have the capacity with support to develop these, and want to make choices and have control when they want to of the care and support they receive. Both therefore established a challenge to the conventional way and places in which health and care services were delivered.[43]

Meeting this challenge, personalised care represents a new relationship between people, professionals and the health and care system. It enables people to stay well for longer and provides a positive shift in power and decision making that enables people to have a voice, to be heard, and to be connected to each other and their communities. It means people have the opportunity to choose how best to live their lives with the support to do so. This happens both individually as well as collectively, through co-production. The '#HelloMyNameIs'[44] and 'What Matters to You?'[45] campaigns also both demonstrate innovative people-driven responses to a system that is not yet universally embracing personalised care.

Put simply, personalised care provides a foundation for the next 70 years of the NHS. As the World Health Organisation[46] summarises:

"Developing more integrated [personalised] care systems has the potential to generate significant benefits to the health and health care of all people, including improved access to care, improved health and clinical outcomes, better health literacy and self-care, increased satisfaction with care, improved job satisfaction for health workers, improved efficiency of services, and reduced overall costs."

Jackie's story

Jackie became disabled following an attack whilst she was on duty as a Metropolitan police officer. Jackie's PHB has enabled her to access a higher specification wheelchair (through joint funding) and pays for ongoing support from her assistance dog, Kingston. As a result of her PHB, Jackie's mental health has improved, she requires less support from the NHS, and is able to take more responsibility for managing her health and wellbeing. Kingston costs only £3,000 per year, compared to a previous package of £120,000 per year, and in addition has prevented over 60 ambulance trips in one year alone.

There is more information about Jackie’s story at www.england.nhs.uk/personal-health-budgets/phbs-in-action/patient-stories/jackie-and-kingstons-story/ and https://www.youtube.com/watch?v=hjEy4TmO6GA

More stories on the difference personalised care has made to people and professionals are available here: https://www.england.nhs.uk/personalisedcare/evidence-and-case-studies

2. What is personalised care? A definitive description for the NHS

2.1 Introduction to personalised care

Personalised care means people have choice and control over the way their care is planned and delivered, based on ‘what matters’ to them and their individual strengths, needs and preferences. This happens within a system that supports people to stay well for longer and makes the most of the expertise, capacity and potential of people, families, and communities in delivering better health and wellbeing outcomes and experiences. This is one of the five major, practical, changes to the NHS service model in the NHS Long Term Plan. It recognises that personalised care is central to a new service model for the NHS, including working through primary care networks, in which people have more options, better support, and properly joined-up care at the right time in the optimal care setting.

In the following section, we set out – for the NHS, and working with partners in local government and the voluntary and community sector – how we can achieve this.

Over the past three years we have been developing – in partnership with local government, local areas, clinicians, professionals, providers, the voluntary and community sector, and people with lived experience – a robust model for personalised care. The model builds on the success of six individual, evidence-based but previously separate components. These components are:

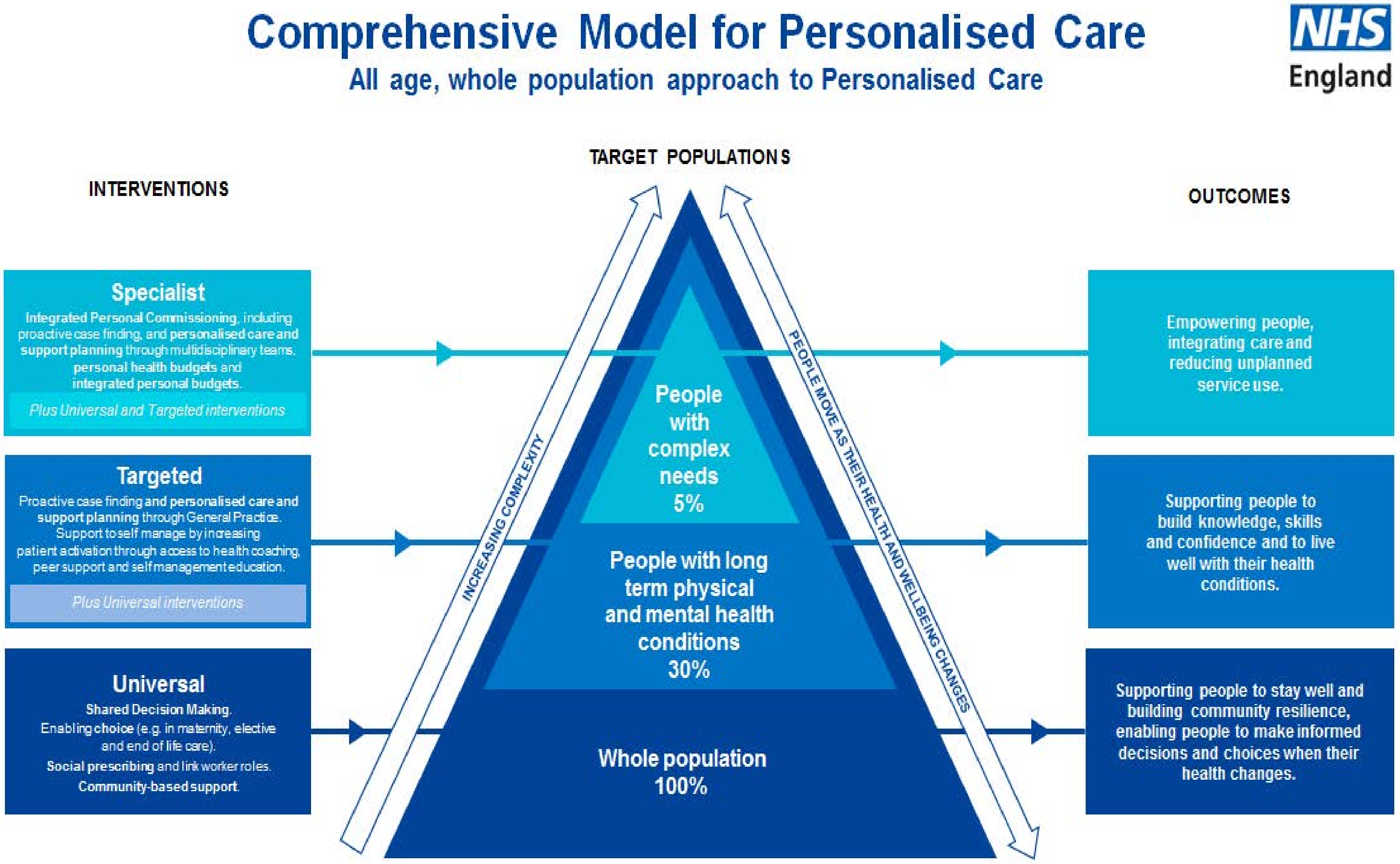
1. Shared decision making
2. Personalised care and support planning
3. Enabling choice, including legal rights to choice
4. Social prescribing and community-based support
5. Supported self-management
6. Personal health budgets and integrated personal budgets.

Based on learning and evidence, including from the significant Realising the Value programme[47] and implementation through the IPC Programme and the Empowering People and Communities (EPC) workstream of the new care models programme, these different components have been brought together into a single, co-produced, Comprehensive Model for Personalised Care which provides universal coverage across the health and care system – see Figure 1. This is the definitive description of personalised care for the NHS.

Through delivery of these six components, personalised care therefore achieves:

- Whole-population approaches to supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build community resilience, and make informed decisions and choices when their health changes.
- A proactive and universal offer of support to people with long-term physical and mental health conditions to build knowledge, skills and confidence and to live well with their health conditions.
- Intensive and integrated approaches to empowering people with more complex needs to have greater choice and control over the care they receive.

Figure 1: Comprehensive Model for Personalised Care



Comprehensive Model for Personalised Care

All age, whole population approach to Personalised Care

Specialist

Integrated Personal Commissioning, including proactive case finding, and personalised care and support planning through multidisciplinary teams, personal health budgets and integrated personal budgets.

Plus Universal and Targeted interventions

Targeted

Proactive case finding and personalised care and support planning through General Practice. Support to self manage by increasing patient activation through access to health coaching, peer support and self management education.

Plus Universal interventions

Universal

Shared Decision Making.

Enabling choice (e.g. in maternity, elective and end of life care).

Social prescribing and link worker roles.

Community-based support.

People with complex needs 5%

People with long term physical and mental health conditions 30%

Whole population 100%

Empowering people, integrating care and reducing unplanned service use.

Supporting people to build knowledge, skills and confidence and to live well with their health conditions.

Supporting people to stay well and building community resilience, enabling people to make informed decisions and choices when their health changes.

When personalised care is fully in place people will have a better experience of health and care. The key features of personalised care set out below have been co-produced with people with lived experience and describe what this experience will be.

Everyone should:

- be seen as a whole person within the context of their whole life, valuing their skills, strengths and experience and important relationships.
- experience hope and feel confident that the care and support they receive will deliver what matters most to them.
- be able to access information and advice that is clear, timely and meets their individual information needs and preferences.[48]
- be listened to and understood in a way that builds trusting and effective relationships with people.
- be valued as an active participant in conversations and decisions about their health and well-being.
- be supported to understand their care, treatment and support options and, where relevant, to set and achieve their goals.
- have access to a range of support options including peer support and community based resources to help build knowledge, skills and confidence to manage their health and wellbeing.
- experience a coordinated approach that is transparent and empowering.

2.2 The Comprehensive Model for Personalised Care

The table below sets out more detail on the six, evidence-based components of the Comprehensive Model. This includes a summary of the standard, replicable delivery model for each component that must be in place for that component to meet the key features of personalised care. Through these standard models we seek to create the balance between specifying a national, consistent standard and enabling flexibility for local adaptation and implementation. We also seek to align with or build on existing personalised approaches that have been adopted by both social care and health in many areas.

Note that NHS England will continue to work with partners to refine all components of the model and set out robust quality and process expectations as part of a single dashboard, as outlined in action 19.

Shared decision making: People are supported to a) understand the care, treatment and support options available and the risks, benefits and consequences of those options, and b) make a decision about a preferred course of action, based on evidence-based, good quality information and their personal preferences.
Design principles:

1. People are aware that care, treatment and support options are available, that a decision is to be made and that the decision is informed by knowledge of the pros and cons of each option and ‘what matters to me’.
2. Clinicians are trained in shared decision making skills, including risk communication and appropriate decision support for people at all levels of health literacy and groups who experience inequalities or exclusion.
3. Well-designed, evidence-based decision support tools are available and accessible.
4. Shared decision making is built into relevant decision points in all pathways.

Standard model:[49]

- All people and clinicians are able to access relevant information and patient decision support tools for use before, during and after consultations.
- There is a local ‘Ask 3 questions’ public awareness campaign or equivalent.
- The workforce involved in shared decision making have received accredited training and have access to associated learning resources to maintain their knowledge.
- There are clinical champions for personalised care, including shared decision making, in the local area.
- There is a peer-review process in place for assessing and providing feedback to team members on their shared decision making practice.
- Validated shared decision making evaluation and monitoring tools are used, such as the three-item collaboRATE tool. There is also a measure of the financial impact of shared decision making.
- There is visible leadership in place (executive, clinical, voluntary and community sector, lived experience) for shared decision making.

If shared decision making is delivered according to this standard model, our indicative expectation is:

- 80% of people report they were as involved as they would wish in decisions about their care (measured by the GP survey).
- 80% of people report that they were as involved as they would wish in decisions about their care (measured by the CQC inpatient survey).
- 90% of clinicians involved in decision making with people have had access to accredited personalised care training, which includes shared decision making.

Personalised care and support planning:[50] People have proactive, personalised conversations which focus on what matters to them, delivered through a six-stage process and paying attention to their clinical needs as well as their wider health and wellbeing.

Design principles: People who have a personalised care and support plan will:

1. Be central in developing their personalised care and support plan and agree who is involved.

2. Have the time and support to develop their plan in a safe and reflective space.
3. Feel prepared, know what to expect and be ready to engage in planning supported by a single, named coordinator.
4. Be able to agree the health and wellbeing outcomes they want to achieve, in dialogue with the relevant health, social care and education professionals.
5. Have opportunities to formally and informally review their care plan.
6. Experience a joined-up approach to assessment, care and support planning and review, resulting in a joined-up personalised care and support plan which takes account of all their needs.

Standard model: The common framework for personalised care and support planning is in place:[51]

- Map all existing assessment, planning, decision making, and review pathways and processes.
- Identify all workforce who are part of these existing pathways and processes.
- Train identified staff and provide ongoing support, which is co-delivered by people with lived experience. This will be a mix of face-to-face, online, and peer learning.
- Each person has a single, named care coordinator.
- Each person has a single summary care and support plan in a digital format where possible, which can be edited by the person.
- Establish champions for personalised care, including personalised care and support planning.
- Include reflection on personalised care and support planning in one-to-one supervision and team meetings.

If personalised care and support planning is delivered according to this standard model, our indicative expectation is:

- 85% of people with a personalised care and support plan were involved as much as they wanted to be in creating that plan.
- 80% of people with a personalised care and support plan find it useful.
- 90% of staff involved in personalised care and support planning have had access to accredited personalised care training, which includes personalised care and support planning.

Enabling choice, including legal rights to choice: Enables choice of provider and services that better meet people's needs, including legal rights to choice in respect of first outpatient appointments, and suitable alternative provider if people are not able to access certain services within the national waiting time standards.

Design principles:

1. People are aware of their choices, including their legal rights.
2. GPs/referrers are aware of and want to support people in exercising the choices available to them.

3. People and GPs/referrers have relevant, good quality information to help people make choices about their care, treatment and support.
4. Commissioners and providers build choice into their commissioning plans, contracting arrangements and provision.
5. Choice is embedded in referral models, protocols and clinical pathways.

Standard model: All Clinical Commissioning Groups (CCGs) complete the CCG Choice Planning and Improvement Guide, including the following minimum standards:[52]

- Information on patients' legal rights to choice is accessible and publicised and promoted.
- NHS e-Referral Service (e-RS) Directory of Service and NHS.uk website contain accurate and up-to-date information about providers' services, and comply with the provider profile policy set out at www.nhs.uk.
- There is engagement with providers where referral, activity and choice trends are discussed and actions agreed/monitored.
- There are regular reviews to understand how choice is benefitting patients and to consider extending choice beyond the established legal rights, where patients would benefit.
- For any services where patients have legal rights to choice, any provider of these services that meets the relevant criteria is made available for patients to choose from.
- Patients are offered a choice of provider and team for a first appointment upon referral to an elective service.
- Providers must make appointments available on e-RS.
- All contracted providers accept all of their clinically appropriate referrals.
- Where notified that a patient will not be treated within maximum waiting times, commissioners ensure that the patient is offered an appointment with a suitable alternative provider(s).

If the legal right to choice is delivered according to this standard model, our indicative expectation is:

- 75% of people who booked hospital outpatient appointments online felt that they were able to make choices that met their needs (measured by e-RS).
- 100% of elective referrals take place through e-RS.
- 100% of CCGs are compliant with the minimum standards in the Choice Planning and Improvement Guide.[53]

Social prescribing and community-based support: Enables all local agencies to refer people to a 'link worker'[54] to connect them into community-based support, building on what matters to the person as identified through shared decision making / personalised care and support planning, and making the most of community and informal support.

Design principles: A local social prescribing scheme must:

1. Be appropriately funded and supported by local partnerships of commissioners and primary care networks.
2. Receive referrals from all local agencies, including General Practice.
3. Involve a one-stop social prescribing connector service, typically located in primary care, which employs link workers to give people time and personalised support, connecting them to community support, based on what matters to the person
4. Connect people to community groups and voluntary organisations that are supported to receive referrals.
5. Put in place operational protocols about expected priority groups, expected numbers of referrals, workforce, costs, and effectiveness.
6. Have access to a range of community-based approaches providing peer support, advice, increased activity and access to community-based support.[55]

Standard model:

- Social prescribing connector schemes are commissioned collaboratively, with primary care networks, local authorities, CCGs, other local agencies, the voluntary and community sector and people with lived experience all working together.
- There is a clear and easy referral process from GPs, GP practices and other channels, to social prescribing link workers. Self-referral is also supported.
- Link workers are typically located in primary care through primary care networks, as part of a wider network team.
- Link workers receive accredited training and ongoing development to support their role.
- Link workers give people time and start with ‘what matters to you?’ They co-produce a simple plan or a summary personalised care and support plan as per the standard model (see above), based on the person’s assets, needs and preferences.
- There are up to five link workers per primary care network, supporting up to 3% of the local population, or around one full-time equivalent link worker per 10,000 local population.
- Link workers work with people on average over 6-12 contacts, and hold a caseload of a minimum of 200-250 people per year.

Local areas should have:

- A clear understanding and map of existing communities, community assets, high impact interventions and gaps.
- A whole-system strategy to develop community-based approaches.

If social prescribing and community-based support is delivered according to this standard model, our indicative expectation is:

- 100% of GPs and GP practices are able to involve link workers in practice meetings and making referrals to them.
- 90% of link workers have received accredited training and feel confident in carrying out their role.
- 80% of people take up their social prescription after referral
- There is a positive impact on GP consultations and A&E attendances and wellbeing for those referred, achieving:
  - 14% fewer GP appointments
  - 12% fewer A&E attendances.

Supported self-management: Increasing the knowledge, skills and confidence (patient activation) a person has in managing their own health and care through systematically putting in place interventions such as health coaching, self-management education and peer support.

Design principles:

1. Understand a person’s level of knowledge, skills and confidence, using tools such as the Patient Activation Measure (PAM) or equivalent
2. Health and care professionals tailor their approaches to individual assets, needs and preferences, supporting people to increase their knowledge, skill and confidence
3. Interventions are systematically in place: health coaching, self-management education, peer support and social prescribing focussed on, though not limited to, those with low activation to build knowledge, skills and confidence, and take account of any inequalities and accessibility barriers

Standard model

- Proactive identification of people’s knowledge, skills and confidence, paying particular attention to those who may have low levels, within the population through:
  - Routine review of hospital discharge
  - Risk stratification and segmentation
  - Review of priority groups of people
  - Review of local data and demographics and the wider determinants of health
  - Tacit knowledge of primary care team
- Measure people’s knowledge, skills and confidence via an appropriate tool, such as the Patient Activation Measure (PAM), long-term condition patient-reported impact measure (PRIM) or self-efficacy scales, for all people with long-term conditions
- Staff are trained in administering PAM or other specific approaches through e-learning, webinars and group training
- A person’s support needs are identified through shared decision making or personalised care and support planning. These are carried out by relevant staff

– healthcare assistants, link workers, health trainers, general practice nurses, district nurses, specialist nurses or GPs, depending on the person's level of activation and complexity
- The impact of an intervention on people's levels of knowledge, skills and confidence is measured within six months, for at least 75% of people still in the local area.

People can be referred to the following support, tailored to their levels of knowledge, skills and confidence:

- Quality assured, evidence-based health coaching or structured group coaching course
- Quality assured, evidence-based self-management education approaches (face-to-face and virtual), which include disease-specific, generic and online self-management courses
- Peer support through a link worker (see above)

If supported self-management is delivered according to this standard model, our indicative expectation is:

- Increase in knowledge, skills and confidence of people with long-term conditions for at least 75% of people with measured patient activation levels of one or two by 15 points.
- There is a positive impact on GP consultations, hospital readmissions, and A&E attendances for those with activation levels one or two, achieving:
  - 9% fewer GP appointments
  - 19% fewer A&E attendances

Personal health budgets (PHB) and integrated personal budgets (IPB).[56] An amount of money to support a person's identified health and wellbeing needs, planned and agreed between them and their local CCG. May lead to integrated personal budgets for those with both health and social care needs. This isn't new money, but a different way of spending health funding to meet the needs of an individual.

Design principles: A person will:

1. Get an upfront indication of how much money they have available for healthcare and support.
2. Have enough money in the budget to meet the health and wellbeing needs and outcomes agreed in the personalised care and support plan.
3. Have the option to manage the money as a notional budget, a third-party budget, a direct payment or a mix of these approaches.
4. Be able to use the money to meet their outcomes in ways and at times that make sense to them, as agreed in their personalised care and support plan.

Standard model:[57]

- Set out clearly-defined trajectories for PHBs with a written delivery plan setting out how this trajectory will be achieved, including reflecting PHBs in commissioning intentions.
- Put in place a robust financial governance framework and a robust clinical governance framework to support people to use PHBs in a variety of ways to meet their needs.
- Implement a clear budget setting model, with a sustainable approach consistent with existing service offer costs.
- Provide information about PHBs in a variety of formats, meeting the Accessible Information Standard, and provide additional support for people who need it, e.g. advocacy or independent advice.
- Provide a clear, published local offer of what is available through a PHB with local examples of PHB use.
- Put in place a timely and personalised needs assessment process.
- Carry out personalised care and support planning in line with the standard model. In addition, use a personalised care and support plan template which incorporates budget information, risk management, contingency planning and training provision.
- Set out a clear process for signing off a PHB and make a dispute resolution process available.
- When someone is in receipt of a direct payment, put in place a care coordinator.
- Make available good quality information, advice and support to recruit and employ personal assistants; training for PHB holders and personal assistants; and independent support or brokerage.
- Implement a system for financial monitoring of PHBs and a proportionate process for reviewing the budget and support plan, in line with statutory requirements.

If PHBs / IPBs are delivered according to this standard model, our indicative expectation is:

- PHBs/ IPBs are made available to at least four cohorts by a CCG, moving to a position where no single cohort makes up more than 50% of all PHB / IPB holders in a local area.
- At least 40% of PHBs in a local area are managed as a direct payment or third-party budget (note that this excludes personal wheelchair budgets. It ensures a mix of approaches in a local area, but all individuals still have the choice to manage the money as a notional budget, a third party budget, or as a direct payment).
- 80% or more of people with a PHB/IPB would recommend one to someone else.
- On a scale of 1-10, people on average rate their experience of having a PHB/IPB at least seven.

- At least 85% of CHC home care packages in a local area are delivered through a PHB.
- The wheelchair voucher scheme has been replaced by personal wheelchair budgets.

2.3 Integration and bringing it all together: the operating model

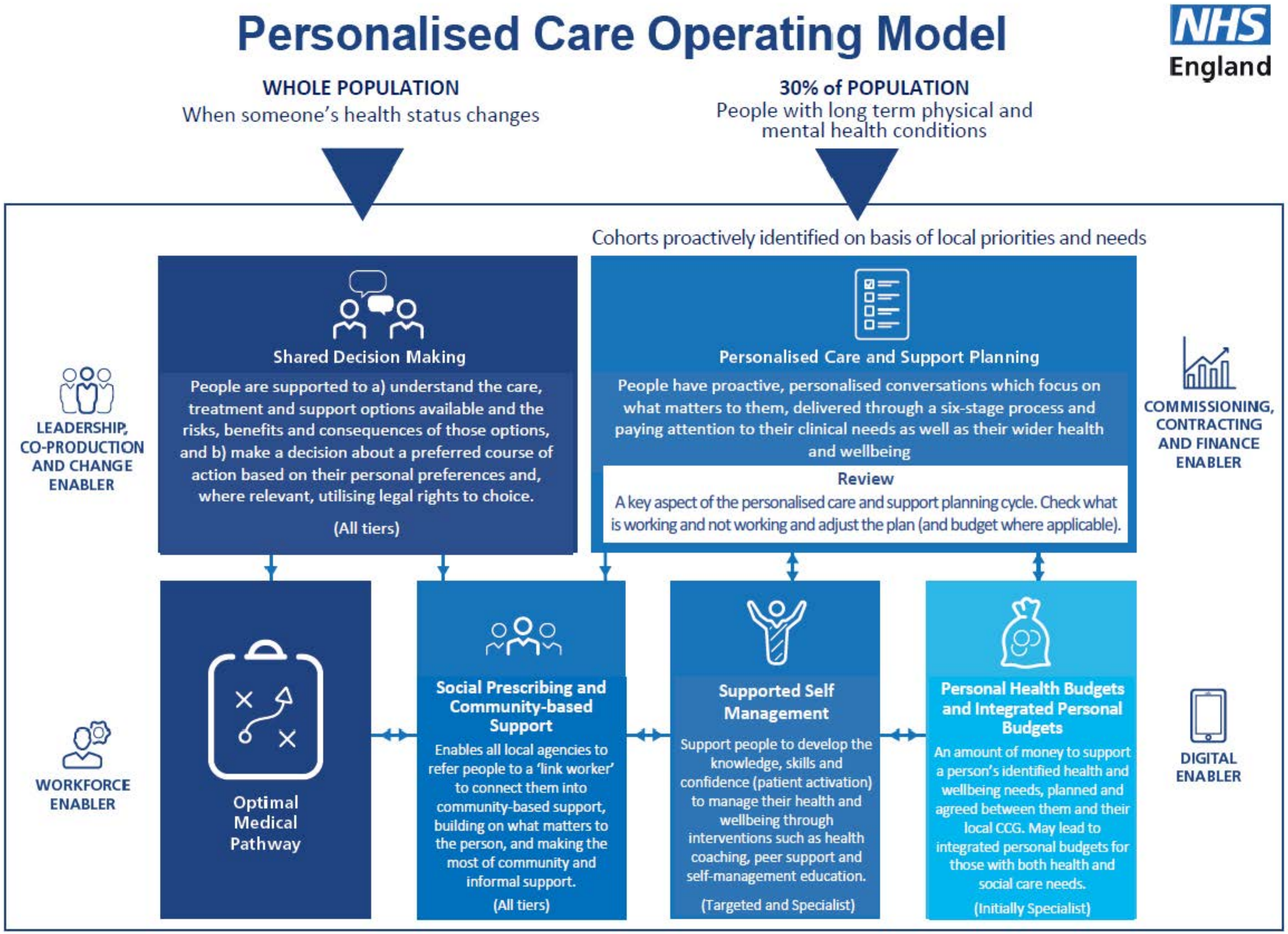
IPC was the operational approach developed to support the delivery of personalised care specifically for people with long-term conditions and complex needs. It integrated health and social care (and education and prevention, where relevant) around a person's needs. Alongside IPC, the EPC programme focused on supporting the systematic implementation of support for self-management (including PAM), social prescribing and community-based approaches.

IPC and EPC taken together form the original basis for the Comprehensive Model, providing a whole-system change through the systematic implementation of each component detailed above. This approach of integrating around the person and making the most of the potential of people and their communities cuts through organisational silos and provides a practical way for people themselves to be the best integrators of their care. We want to put personalised care at the core of the system's integration efforts, through the work of primary care networks, ICSs and STPs and working with partners in local government and public health.[58]

The Comprehensive Model recognises the significant experience and learning from local government, through Putting People First and in the way it has implemented the Care Act (2014), and the Special Educational Needs and Disability (SEND) reforms of the Children and Families Act (2014). There are 156,000 people with a direct payment or part direct payment in social care; over 285,000 personalised care and support plans (Education, Health and Care Plans) are in place for children and young people.[59] These experiences showed that successful delivery of personalised care also involves focusing on key system enablers, such as workforce and commissioning, as well as stronger partnerships between communities, the voluntary and community sector and services,[60] and co-production with people, families, and carers.

Making personalised care an everyday reality for people therefore requires a whole-system change through the systematic implementation of the six evidence-based components, supported by key enablers that deliver the necessary redesign to make the model a reality. Figure 2 shows how the six components and these enabling factors all fit together.

Figure 2: Personalised care operating model



Personalised Care Operating Model

NHS England

WHOLE POPULATION
When someone's health status changes

30% of POPULATION
People with long term physical and mental health conditions

Cohorts proactively identified on basis of local priorities and needs

LEADERSHIP, CO-PRODUCTION AND CHANGE ENABLER

Shared Decision Making

People are supported to a) understand the care, treatment and support options available and the risks, benefits and consequences of those options, and b) make a decision about a preferred course of action based on their personal preferences and, where relevant, utilising legal rights to choice.

(All tiers)

Personalised Care and Support Planning

People have proactive, personalised conversations which focus on what matters to them, delivered through a six-stage process and paying attention to their clinical needs as well as their wider health and wellbeing

Review

A key aspect of the personalised care and support planning cycle. Check what is working and not working and adjust the plan (and budget where applicable).

COMMISSIONING, CONTRACTING AND FINANCE ENABLER

WORKFORCE ENABLER

Optimal Medical Pathway

Social Prescribing and Community-based Support

Enables all local agencies to refer people to a 'link worker' to connect them into community-based support, building on what matters to the person, and making the most of community and informal support.

(All tiers)

Supported Self Management

Support people to develop the knowledge, skills and confidence (patient activation) to manage their health and wellbeing through interventions such as health coaching, peer support and self-management education.

(Targeted and Specialist)

Personal Health Budgets and Integrated Personal Budgets

An amount of money to support a person's identified health and wellbeing needs, planned and agreed between them and their local CCG. May lead to integrated personal budgets for those with both health and social care needs.

(Initially Specialist)

DIGITAL ENABLER

2.4 Growing momentum: what has been delivered and the difference it has made

Personalised care has growing momentum across the health and care system. Figures 3 to 6 summarise the scale of personalised care across the health and care system. Figure 7 summarises the difference it has made.

Figure 3: expansion of personalised care over the last three years

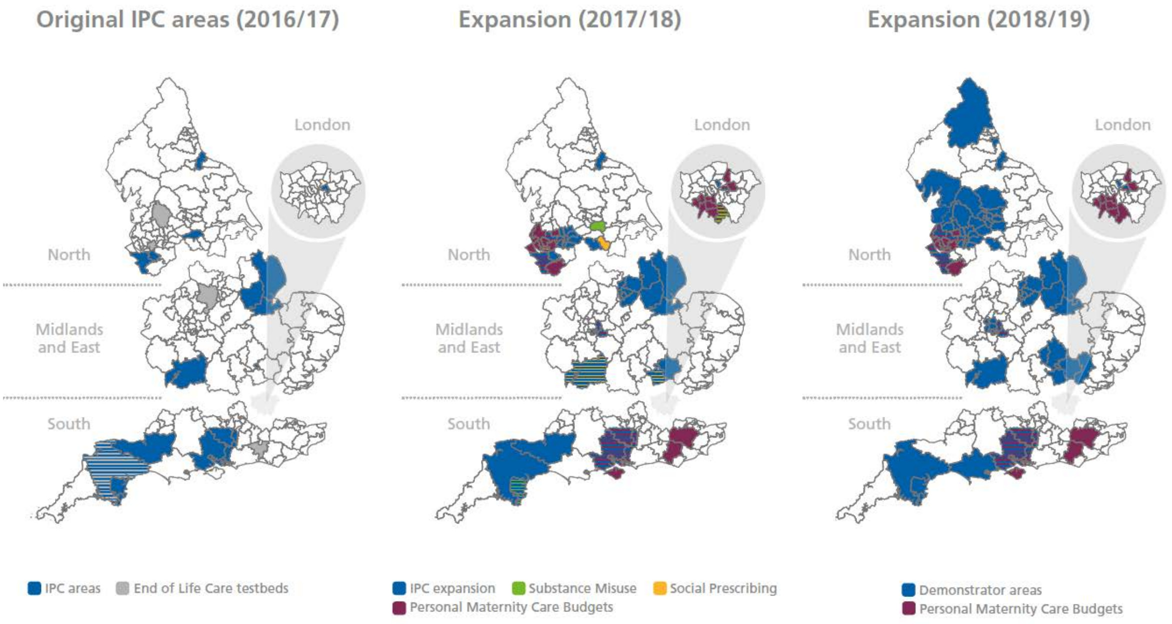
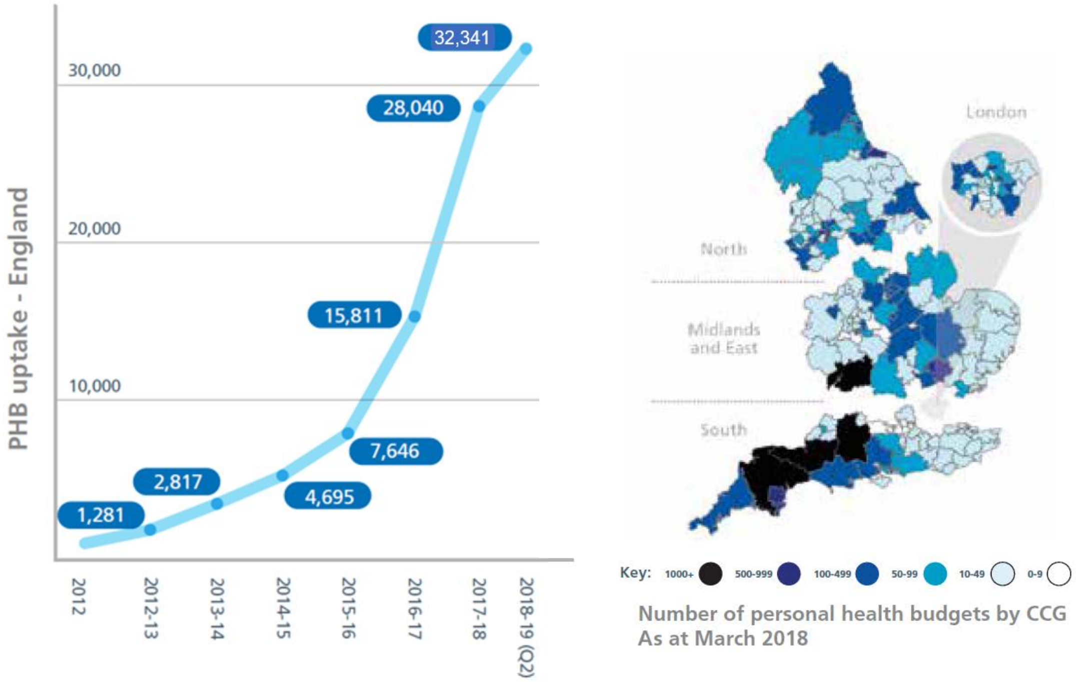


Figure 4: the spread of personal health budgets



Number of personal health budgets by CCG
As at March 2018

Figure 5: people who have benefitted from personal health budgets in 2018/19

*Data based on voluntary reporting. Total does not add up to 32,341.

Figure 6: significant delivery of personalised care

Shared decision making

- In 2017/18 SDM was embedded into:
  - Musculoskeletal elective care pathways across 13 CCGs
  - Respiratory elective care pathways in 8 CCGs

Personalised care & support planning

- 142,904 people had a personalised care and support plan between April 2017 and September 2018
- Over 204,000 people supported by integrated, personalised approaches

Enabling choice

- 97% of CCGs have now completed Choice Planning and Improvement self-assessment
- Of these 85% report compliance with at least 5 (of 9) choice standards

Social prescribing and community-based support

- 68,977 referrals
- 331 link workers employed in local areas

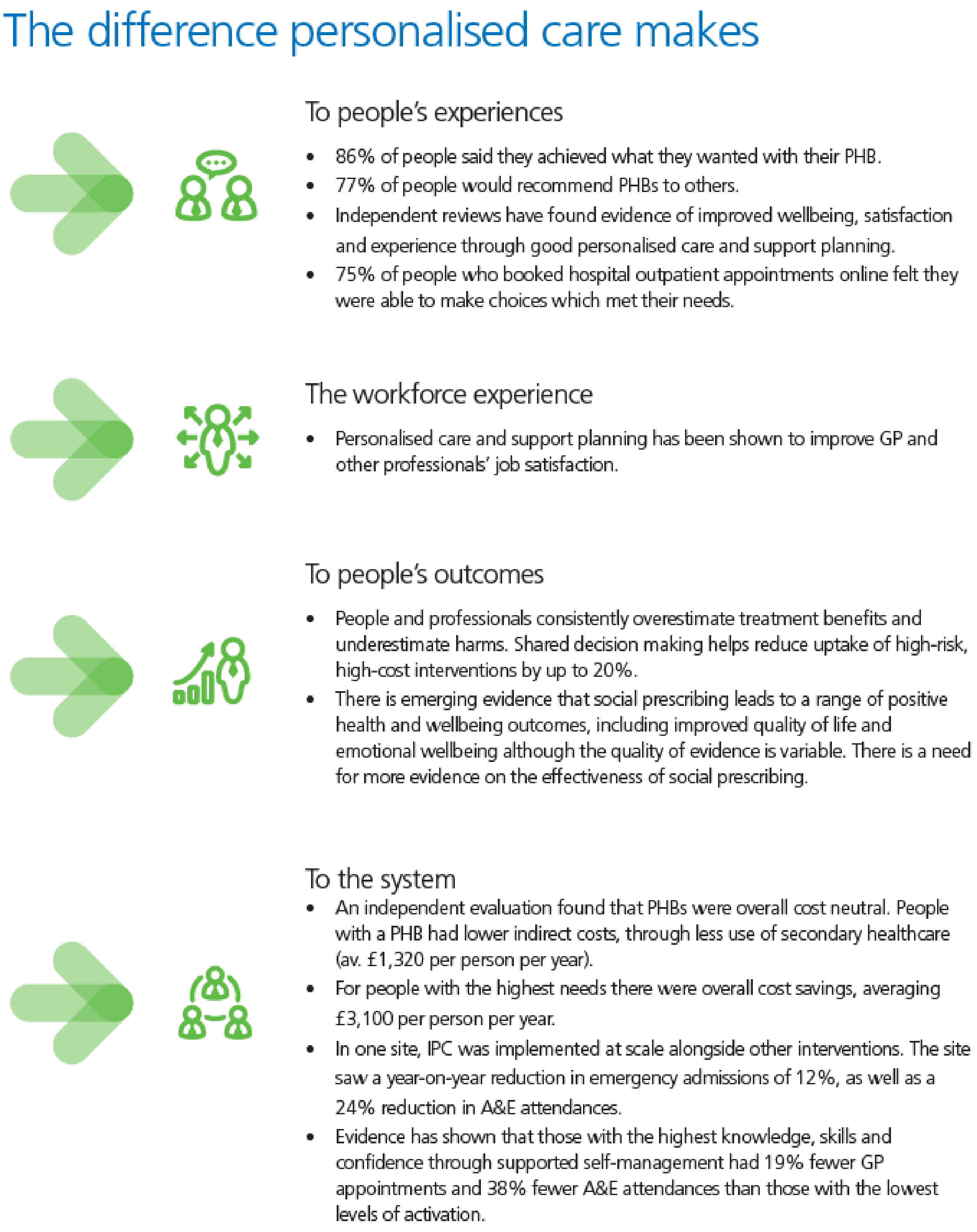
Supported self-management

- 101,637 patient activation assessments by September 2018
- Over 44,093 people referred to community-based support
- Over 59,545 people referred to self-management education or health coaching

Personal health budgets and integrated personal budgets

- 32,341 PHBs by September 2018
- Up 110% year-on-year in 2018 (to end Q2)
- 23% jointly funded by social care
- 55,511 PMCBs delivered by September 2018 across 36 CCGs

Figure 7: the impact of personalised care



The difference personalised care makes

To people's experiences

- 86% of people said they achieved what they wanted with their PHB.
- 77% of people would recommend PHBs to others.
- Independent reviews have found evidence of improved wellbeing, satisfaction and experience through good personalised care and support planning.
- 75% of people who booked hospital outpatient appointments online felt they were able to make choices which met their needs.

The workforce experience

- Personalised care and support planning has been shown to improve GP and other professionals' job satisfaction.

To people's outcomes

- People and professionals consistently overestimate treatment benefits and underestimate harms. Shared decision making helps reduce uptake of high-risk, high-cost interventions by up to 20%.
- There is emerging evidence that social prescribing leads to a range of positive health and wellbeing outcomes, including improved quality of life and emotional wellbeing although the quality of evidence is variable. There is a need for more evidence on the effectiveness of social prescribing.

To the system

- An independent evaluation found that PHBs were overall cost neutral. People with a PHB had lower indirect costs, through less use of secondary healthcare (av. £1,320 per person per year).
- For people with the highest needs there were overall cost savings, averaging £3,100 per person per year.
- In one site, IPC was implemented at scale alongside other interventions. The site saw a year-on-year reduction in emergency admissions of 12%, as well as a 24% reduction in A&E attendances.
- Evidence has shown that those with the highest knowledge, skills and confidence through supported self-management had 19% fewer GP appointments and 38% fewer A&E attendances than those with the lowest levels of activation.

Full details are in the technical appendix.

2.5 Addressing health inequalities through personalised care

Despite positive progress towards reducing health inequalities, inequalities persist and are in evidence between groups of people with different characteristics, and across geographies. In England the mortality gap between the richest and poorest areas is over seven years for women and nine for men.[61] This gap may have narrowed in the 2000s, but more recently the gap has been growing again. Our environment and surroundings also play a vital role: the life expectancy gap between the most and least deprived areas in the UK is 19 years.[62] Those living in the most deprived areas are likely to spend significantly longer proportions of their lives in poorer health: the onset of multi-morbidity occurs 10-15 years earlier for people in the areas of greatest deprivation.[63]

A summary of the work to date on personalised care and health inequalities was included in the NHS England Board meeting of May 2018.[64] We have since worked closely with the Empowering People and Communities Taskforce to further explore how personalised care can help contribute to reducing health inequalities.

The evidence below shows how personalised care can contribute to reducing health inequalities.

Most individual long-term conditions are more common in people from lower socio-economic backgrounds,[65] and multiple conditions are disproportionately concentrated in these groups.[66] The evidence shows that levels of knowledge, skills and confidence to manage their health tend to be lower for people with lower incomes and lower levels of education.[67] When people are supported to increase their knowledge, skills and confidence they benefit from better health outcomes, improved experiences of care and fewer unplanned admissions.[68] People in lower socioeconomic groups can therefore benefit the most from personalised care, as it focuses on people with lower knowledge, skills and confidence, and better supports people with multiple long-term conditions as part of the ‘specialist’ tier of interventions in the Comprehensive Model.

A systematic review found that shared decision making interventions significantly improve outcomes for disadvantaged people.[69] Personalised care also tailors shared decision making to health literacy. It ensures staff develop health-literate decision support materials and tailor their conversations to take account of low health literacy by using specific techniques, such as “teach back”, building on the health literacy toolkit.[70] Social prescribing and asset-based approaches complement this to tackle inequalities through improving access to community support.

Health literacy and self-management support (including structured self-management education programmes and health coaching) are critical to empowerment as they increase peoples’ capacity to use health information effectively and to identify the issues that most affect their wellbeing. Between 43% and 61% of working age adults do not understand health information.[71]

Social prescribing contributes to reducing health inequalities by increasing involvement with local communities. Social prescribing enables general practice to identify people who could benefit from additional voluntary and community sector support and refer them to link workers, based in local social prescribing connector schemes. Link workers spend time with people, build rapport, hear what matters most to people and based on the person’s priorities, connect them to community groups. Most local social prescribing schemes also have volunteers who provide a ‘buddying’ role, physically introducing people to community groups, ensuring they are comfortable and included.

Increasing people's level of choice and control, including through PHBs, can enable the system to respond to different backgrounds, for example by supporting children and young people who are faced with considerable health inequalities, such as looked after children, 45% of whom will experience mental health difficulties compared to 10% of all children.[72] PHBs also enable people to choose their own personal assistants who are more aware of their culture or religion. Peer support and strategic co-production can also help to support people from different cultural backgrounds.

As the NHS Long Term Plan makes clear, we want to put health inequalities at the core of the personalised care agenda. We will therefore work with partners across health, local government, the voluntary and community sector and people with lived experience to:

- Identify which groups face the greatest barriers to equally accessing personalised care, and work in partnership to ensure that personalised care is reaching those who could benefit the most. This includes working with the Health and Wellbeing Alliance to develop a working group that will take the following actions forward and develop targeted work around health inequalities and personalised care.
- Commit to implement a self-assessment within personalised care programmes to reduce health inequalities, and develop further research with targeted cohorts (e.g. black and minority ethnic groups); ensuring the involvement of people with lived experience (for example through participatory appraisal methods).
- Work with public health to reduce health inequalities by utilising existing resources, tools and evidence, and co-produce any new materials together with people with lived experience of health inequalities.
- Provide additional support to access personalised care for those who face the greatest health inequalities.
- Ensure that training for the workforce explicitly and meaningfully takes into account health inequalities, in order that positive action and regard to this is consistent and intentional (for example, within personalised care and support planning).
- Together with people with lived experience, develop the quality measures for personalised care in a way which supports efforts to reduce health inequalities. For example, the quality surveys will be developed in a way that enables comparison of experiences across different protected characteristics, as well as utilising PAM scores where possible to track individual's activation and engagement.
- Provide best practice and case study materials that explicitly include people from different groups.
- Ensure that communication strategies take into account the communication needs of people who experience health inequalities, including, for example, people with learning disabilities and those with lower levels of health literacy.
- Explore including a mandatory breakdown of personalised care data by protected characteristics and deprivation, and track change over time to identify opportunities to promote equality and help to reduce health inequalities.

Ollie Hart's story

Ollie Hart, a GP partner in Sheffield, has transformed his practice through using personalised care approaches and working in partnership with people. He has created a model to support an increase in the knowledge, skills and confidence of people to self-manage their conditions, a process that involves identifying people's assets and needs and then offering tailored interventions of social prescribing and health coaching to those who will benefit most – those with lower levels of activation. Offering this personalised approach has bought benefits to people in terms of improved knowledge, skills and confidence (particularly for those with most to gain) and has also eased the pressure on Ollie as he has learned to coach, not to tell and has also learned how to support people to make the most of their community assets. Ollie continues to embed the approach within his GP neighbourhood, patient groups, and practice teams.

3. Delivering a new relationship between people, professionals and the system

3.1 Practical implementation

Though there have been many definitions of personalised care in the past, we now need to move beyond a simple narrative and on to how to put personalised care into practice at a scale never before attempted.

As section 2.4 demonstrates, since 2015 there has been stronger and faster progress across all components of personalised care in health than has been seen before. But we now need to complete the job. As we embark on delivering the NHS Long Term Plan and a new service model for the 21st century, we commit to fully realising the potential of personalised care across the health and care system for the optimal number of people in England.

This commitment builds on the long history of personalised care, including in social care, chapter two of the *Five Year Forward View*, and now the vision reflected in chapter one of the NHS Long Term Plan: to create a new relationship between people, professionals and the health and care system.

To achieve the benefits of personalised care and meet the key features that people with lived experience expect, the Comprehensive Model needs to be delivered in full, with no cherry-picking of preferred components. For example, the PHBs evaluation showed that PHBs are most effective when individuals have full control and flexibility over how to use their PHB and choice of how to manage the budget.[73] In adult social care, there has been criticism of personal budgets where they have been introduced simply as an ‘administrative’ shift rather than being the result of a comprehensive, personalised planning process with the person in control.[74] Similarly, social prescribing is less effective when it is delivered without a complementary approach to shared decision making or personalised care and support planning and understanding people’s knowledge, skills and confidence. In the absence of good conversations, social prescribing is reduced simply to ‘signposting’ people. The full implementation of the Comprehensive Model protects against undermining both the principles and effects of the model.

Furthermore, the Comprehensive Model will also be most effective when embedded in the mainstream health and care system with universal coverage for everyone who could benefit. Personalised care should be business as usual for everyone, not a bolt on for some. Otherwise, we will see dilution of the benefits of personalised care, with some key groups (e.g. those who are most disadvantaged) or components omitted, and key benefits, both for people and the system, not fully realised.

3.2 Personalised care: becoming business as usual

Table 1 sets out the maximum potential scale of the Comprehensive Model. It also sets out that, by 2023/24, and removing duplication for people who will benefit from multiple components, our ambitious but achievable goal is around 2.5 million people in total will benefit from personalised care as business as usual across the health and care system. The aim is then to double this by 2028/29.

Table 1: The maximum potential scale for personalised care

Component	Maximum potential scale	Ambitious but achievable goal by 2023/24
Shared decision making	Any health and care conversation where a decision is to be made, as part of the 'universal' tier of Comprehensive Model	Shared decision making embedded in 30 high-value clinical situations in primary care, secondary care and at the primary/secondary interface where it will have the greatest impact on experience, outcomes and cost
Personalised care and support planning	5-10 million people in total benefitting, across both 'specialist' and 'targeted' tiers of the Comprehensive Model	750,000 people, including people with long-term conditions, people at the end of life and pregnant women
Enabling choice, including legal rights to choice	Whole population benefits through choice of GP and everyone who attends an outpatient appointment, approximately 90 million outpatient attendances per year. Part of 'universal' tier of Comprehensive Model	Legal rights to choice are maintained throughout wider system transformation, with 100% of elective referrals exercising choice through e-RS and 100% of CCGs compliant with the minimum standards in the CCG Choice Planning and Improvement Guide
Social prescribing and community-based support	Around 5% of the population, or around 3 million people, benefit from social prescribing per year as part of the 'universal' tier of the Comprehensive Model	1,000 trained link workers recruited by 2020/21 and 900,000 people referred to social prescribing link workers by 2023/24
Supported self-management	4.6 million people with long-term conditions who also have low levels of knowledge, skills and confidence, within the 'targeted' tier of the Comprehensive Model	Continue to increase the opportunities for people to benefit from supported self-management approaches
Personal health budgets and Integrated personal budgets	2 million people – those with long-term conditions or complex needs – can most benefit. All of these people would have a personalised care and support plan and majority would be in 'specialist' tier	200,000 people benefitting from PHBs or IPBs

The scale of personalised care will be achieved in line with the standard replicable models and measures of quality set out in section 2.2. Drawing on the work of Think Local Act Personal and the Coalition for Collaborative Care on Making it Real,[75] we recognise it is the combination of quantity and quality that ensures the maximum gains in people's outcomes, experiences, and value to the system are achieved through personalised care.

David Pearson's story

David Pearson CBE has been the Corporate Director for Adult Social Care and Health in Nottinghamshire since 2005, and was ADASS President in 2014/15. Since his time as a social worker to his current position, David has been passionate about people having choice and control over their health and wellbeing. Whilst developing the STP in 2016, David recognised the opportunity of working with NHS England and its growing agenda around personalised care, especially embedding joint personalised care and support planning and PHBs and IPBs. This built on the STP's commitment to embedding prevention, self-care and promoting independence, and recognises the importance of improving life chances, the need to work with key agencies, such as housing and employment and the voluntary sector. The growing evidence in Nottinghamshire is that personalised care: brings people back into the centre of their care; is liberating and a breath of fresh air for nurses, clinicians and social care staff; enables the right support for people at the right time; and so saves time and money for the local health and care economy.

3.3 Getting to tomorrow: 21 actions to deliver personalised care at scale

NHS England does not underestimate the challenge in delivering the scale of ambition set out for personalised care.

21 specific and practical actions have been identified to meet this challenge. To develop these actions, NHS England worked with a dedicated reference group – including clinicians, professionals, providers, the voluntary and community sector, academics, and representative bodies. We have also worked closely with local government and local areas, and co-produced all of our work with people with lived experience of personalised care. The funding agreed as part of the Long Term Plan will enable delivery of the actions below to 2023/24. Delivery beyond this to 2028/29 is subject to future planning and agreement.

To deliver these actions, we commit to continuing our partnership approach – including with clinicians, professionals, local government, the voluntary and community sector, academics, and representative bodies, as well as through co-production with people with lived experience. The Personalised Care Advisory Board, co-chaired by NHS England and the LGA, will ensure all perspectives shape and contribute to the work required.

Overall objectives

Action 1: Deliver universal implementation of the Comprehensive Model across England. This will fully embed the six standard components across the NHS and the wider health and care system and will reach 2.5 million people by 2023/24. The aim is then to double this by 2028/29.

- The Comprehensive Model for Personalised Care introduced here will be officially published on the NHS England website in 2018/19.
- Publish simple, standard replicable models for all components of the Comprehensive Model in 2018/19, making the Comprehensive Model accessible for all, and extending the first tranche of standard replicable models published in June 2017.[76]
- To support the official publication of the Comprehensive Model, share information through a variety of communications channels, including blogposts, webinars, events, bulletins and information for people with lived experience. We will do this through existing networks, including those of voluntary and community sector organisations.
- In addition, to achieve the cultural and behaviour change needed for personalised care, we will commission strategic, integrated, targeted multi-year campaigns, underpinned by insight/market research, reflecting the latest best practice and using a range of media, including social media.
- The campaigns will target key public and professional groups via a range of channels from 2019/20, building on the learning from the ‘What Matters to You’ campaign in the UK[77] and the Every Australian Counts campaign.[78] We will co-produce this with people with lived experience and with professionals who have successfully delivered personalised care in order to develop these campaigns and share the messages with their respective peers. This will build on #myPHBstory, where people with PHBs are supported to share their experiences of the difference PHBs have made to them.

Action 2: Demonstrate early, full delivery of the Comprehensive Model across a number of ICSs and STPs.

- In 2018/19 and 2019/20, NHS England will fully embed the Comprehensive Model in ICSs and STPs, as well as the whole of the Greater Manchester devolution area. We will also support other personalised care demonstrator sites, resulting in at least a third of England delivering the Comprehensive Model for Personalised Care against the standards set out in section 2.2. This will be done in partnership between the NHS, local government, the voluntary and community sector, and people with lived experience. Over 300,000 people[79] will benefit from personalised care in these areas by the end of 2018/19.
- Furthermore, we will aim to include personalised care in the ICS accountability and performance framework to ensure that all ICSs reflect personalised care. This will support progress on personalised care becoming an expected element of ICS plans.
- As announced by the then Secretary of State for Health and Social Care,[80] in 2018/19 and 2019/20 three integration accelerators – Gloucestershire,

Lincolnshire and Nottinghamshire – will pilot an approach whereby every person coming forward for a needs assessment under the Care Act (2014) will be offered a proactive and joined-up approach to needs assessment and personalised care and support planning through multi-disciplinary teams. This will be streamlined with the local areas' SEND models to ensure a seamless approach. It will take a whole-family approach, including the needs of carers, with an emphasis on prevention and supporting people to manage their health, including referring people to community-based support through social prescribing. Many people will benefit from an IPB.

- Evaluate the approach to understand the preventative impact on people with lower levels of need, particularly those living with frailty. We will also ensure there is early identification of carers and that the approach takes account of their needs.
- Consider the impact on the Better Care Fund (BCF), to understand how future versions of the Fund can support delivery of the Comprehensive Model. The Government's green paper on the future of social care will set out the next steps on accelerating integration of health and social care, including improvements to the BCF from 2020. We will work with DHSC, the MHCLG, the LGA and the Better Care Support team in 2019/20 to consider if outcome measures could be developed that reflect personalised care.
- Work with DHSC to explore regulatory change which will support greater integration, for example aligning direct payment regulations, and identify opportunities to align funding allocations, system auditing and reporting.

Action 3: Co-produce a National Impact Statement for Personalised Care, setting out the quantified difference we plan to make to people's outcomes and experiences, workforce experience and wellbeing, and to the system, including net value. This will aggregate the impact of each of the six components of the Comprehensive Model to develop a clear measure for the impact of personalised care.

- All of the metrics and quality measures for the six components of personalised care (see action 19) will be brought together to derive an aggregated National Impact Statement for personalised care. This Statement will set out the quantified difference personalised care is making to the experience, outcomes and wellbeing of people and professionals, as well as to the system.
- To develop and publish the National Impact Statement, we will work in partnership with local government, the voluntary and community sector, professional representative bodies, and academics, and in co-production with people with lived experience.

Delivering the six components

Action 4: Develop workforce skills by embedding shared decision making and personalised care and support planning in pre- and post-registration professional training. This includes through all GP training through the Royal College of General Practitioners (RCGP) from 2019/20 (subject to General Medical Council approval), and from 2020/21 for other professionals, including nurses and allied health professionals.

- Personalised care is central to the shared view of quality in general practice[81] and the future of effective primary care.[82] The personalised care components will be included in GP education and training from 2019/20, building on the existing inclusion of collaborative care and support planning in the GP curriculum and training programme.[83] This will equip up to 5,600 local and regional GP trainers in England with the knowledge, skills and confidence to train their colleagues in personalised care approaches.
- RCGP will expand their current network of personalised care champions and will create a group of at least a further 50 personalised care clinical leaders from across the primary care workforce to embed personalised care in the NHS's priority areas and in all RCGP projects.
- NHS England is also working with the Academy of Medical Royal Colleges to develop a range of e-learning materials that exemplify personalised care approaches, to be launched in 2018/19 and benefit all people experiencing 'high-value shared decision making conversations' (see action 6).
- NHS England will also work with the Nursing and Midwifery Council (NMC), Council of Deans for Health, Royal College of Nursing (RCN) and the Queen's Nursing Institute, the Royal College of Occupational Therapists, the Chartered Society of Physiotherapy, the Royal College of Speech and Language Therapists, and the British Association of Social Workers, as well as other key workforce representative bodies, to raise awareness and understanding of personalised care, identify good practice that is already taking place relevant to each professional group and identify how personalised care approaches can be built into professional practice, including pre- and post- registration education.

Action 5: From 2019/20, roll-out a new interactive face-to-face training programme to develop professional skills and behaviours to deliver shared decision making and personalised care and support planning as fundamental ways of working across health and care staff. At least 75,000 clinicians will be trained by 2023/24.

- In 2018/19, NHS England will implement a half-day personalised care essentials e-learning programme for health and care professionals, and a complementary half-day face-to-face group learning programme.
- We will then rapidly expand our offer, to deliver a new interactive face-to-face programme to develop shared decision making, personalised care and support planning and health coaching skills. This will be for approximately 300,000 staff at all levels of the system, particularly focussing on primary care practice teams, and also those staff involved in advance care planning at the end of life. Roll-out will start in 2019/20, with at least 75,000 clinicians being trained by 2023/24. It will develop the attitude, skills, and infrastructure to effect the necessary culture change, and be co-delivered with people with lived experience. It will also reflect the work being done by Public Health England, NHS England and Health Education England on Making Every Contact Count.[84]
- In 2018/19 NHS England and key stakeholders will test a methodology to support local areas to embed these new skills into business as usual, for example through redesigning pathways. From 2019/20 we will work with local areas to

effectively implement this framework, and from 2020/21 onwards deliver national roll-out, including through local education and training boards.

- By 2020/21, we will implement a framework of approved training providers for shared decision making, personalised care and support planning and health coaching, operating to robust quality standards co-produced with people with lived experience and with other partners. This framework will also enable a train-the-trainer approach.
- Building on this, we will launch a fully-certified personalised care training programme by the end of 2020/21.
- In 2021/22 we will launch a personalised care leadership programme to provide future decision makers with the knowledge and tools required to embed personalised care at system, place and neighbourhood levels.
- We will also reflect personalised care in NHS England / NHS Improvement's workforce strategy by 2020/21.

Action 6: Expand the Shared decision making programme in 2019/20, developing decision support tools and e-learning resources to embed shared decision making in 30 specific clinical situations. Personalised care will also be at the heart of work on 'rethinking medicine'.

- In 2018/19, we will identify 30 specific clinical situations where there are the largest opportunities to either a) reduce the uptake of low-value treatments/procedures or b) improve adherence to evidence-based therapies, through systematic implementation of shared decision making.
- From April 2019 onwards, for each clinical situation we will:
    - Work with the National Institute for Clinical Excellence (NICE) to develop a standardised in-consultation decision support tool
    - Work with Health Education England (HEE) and the Academy of Medical Royal Colleges to ensure that e-learning resources are available to staff to ensure that they host a high-quality shared decision making conversation
- By March 2020 we will have completed the job in the following initial clinical priority areas:
    - At the time of diagnosis for people with atrial fibrillation, hypertension and high cholesterol
    - With first contact musculoskeletal practitioners for people with hip, knee, shoulder and back pain
    - For interventions (including chemotherapy) in the last year of life that offer limited benefit
    - In care homes in order to optimise medication for people of all ages
    - For the best management of chronic obstructive pulmonary disease (COPD) in order to increase access to pulmonary rehabilitation.
- In addition, personalised care will be at the heart of work on 'rethinking medicine'.[85] This is a parallel approach to the Scottish 'Realistic Medicine' work,[86] and places personalised care at the heart of all clinical practice, primarily

in order to reduce over-diagnosis, over-treatment, harm and waste, particularly for those in the last year of their life, those living with frailty and those living with multiple long-term conditions.

Action 7: Embed effective mechanisms to enable people to exercise choice and control in elective care.

- The NHS Long Term Plan is clear that the ability of people to choose where they have their treatment remains a powerful tool for delivering improved waiting times and experiences of care.
- To enable this, work will continue to support the Elective Care Transformation Programme with the national roll out of the e-RS capacity alerts project. This will draw on learning from the London pilots.
- Work with local areas to ensure self-assessments are completed by all areas in 2020/21 on compliance with the standards set out in the CCG Choice Planning and Improvement Guide,[87] and ensure that choice is embedded within systems, procedures, culture and expectations. This will ensure people are offered and able to make an informed choice for their care/treatment based on what matters to them.
- Local areas must ensure an action plan is in place to address the self-assessment areas of identified development needs. We will assist CCGs to develop these plans and ensure significant progress is made against them. Action plans are the catalyst for improvement and we will put in place a structured programme of work and review to ensure compliance with the standards is achieved in a manageable timeframe.
- Local Maternity Systems (LMS) will oversee the introduction of a personalised care and support plan for every pregnant woman in England. This means that by 2021 around 650,000 women a year will have a plan that allows them to make meaningful, informed, choices about their maternity care.
- Share the work of exemplar areas to replicate existing success and best practice. This will foster innovation across local areas.
- We will additionally consider how to expand choice for women in maternity by learning from the work undertaken through the Maternity Pioneers within the national Maternity Transformation Programme. This will include the publication of resources and materials to support women to make informed choices and for frontline staff to engage in personalised care and support planning conversations. Following evaluation of the programme in the autumn of 2018, we will deliver an action plan for provision of choice in maternity services across the 44 LMS.
- Continue to improve choice at the end of life through the promotion of the six Government commitments for end of life care and other elements of the Ambitions for Palliative and End of Life Care. The work of the National End of Life Care Board will use the Comprehensive Model as a primary lens through which to view the reforms needed to support increased choice and control at the end of life. This will result in: better identification of people who are likely to die within the next 12 months; better, proactive conversations for people to identify their wishes and preferences; and integrated services which wrap around people, facilitated by improved sharing of key information.

Action 8: Fund the recruitment and training of over 1,000 social prescribing link workers to be in place by the end of 2020/21, rising further so that by 2023/24 all staff within GP practices have access to a link worker as part of a nationwide infrastructure of primary care networks, enabling social prescribing and community-based support to benefit up to an estimated 900,000 people.

- The Government's loneliness strategy[88] reflected NHS England's commitment to social prescribing being the default model within primary care to connect people with their community. Social prescribing supports people to stay well for longer, by preventing or delaying the onset or worsening of long-term conditions.
- To support this, in 2018/19 we will publish a standard, replicable model and common outcomes framework, as detailed in section 2.2. This will ensure that local areas are delivering social prescribing in line with minimum standards and consistently measuring the impact on the person, on the health and care system and on voluntary and community sector organisations receiving referrals.
- In 2018/19 we will also map all social prescribing connector schemes across England to produce a national database, as well as launch an online social prescribing platform for commissioners and practitioners.
- To enable delivery of the model, we will fund primary care networks so that each GP practice has access to a link worker. This includes recruitment of 1,000 link workers by 2020/21, trained against accredited standards. Up to 900,000 people will benefit by 2023/24.
- This will be funded via a reimbursement scheme, embedded in primary care and GP contracting mechanisms.

Action 9: Work with partners in the voluntary and community sector, as well as local and central government, the wider public sector, the Big Lottery Fund, Public Health England and other arm's-length bodies to explore the best models for commissioning the local voluntary and community sector that support sustainable models of delivery and scaling of innovative provision.

- Reflecting the findings of the Voluntary, Community and Social Enterprise (VCSE) Review,[89] the work done by Public Health England on developing community-centred approaches,[90] the ongoing work of the Health and Wellbeing Alliance,[91] and a specific recommendation from the Realising the Value programme,[92] and in line with the standard model in section 2.2, we are clear that local areas should have in place a range of community-based approaches and a clear understanding of existing community assets and gaps.[93] This includes asset-based approaches such as Local Area Coordination,[94] timebanking, volunteering and peer support groups.
- To support sustainable models of delivery by voluntary and community organisations, we will explore with partners – including voluntary and community organisations, local and central government, the wider public sector, the Big Lottery Fund, Public Health England and other arm's-length bodies – the best approaches to commissioning. We will also work with the voluntary and community sector and commissioners to identify how to best to develop and

support the scaling of innovative provision (such as our work to develop and scale Shared Lives as a personalised, community-based model of healthcare[95]).

- This work will reflect NHS England's principles for voluntary and community sector engagement and partnership working.[96]
- Finally, we will also work towards embedding commitments to the voluntary and community sector in STP and ICS guidance.

Action 10: Continue to support the development of programmes and initiatives that seek to increase the knowledge, skills and confidence of people to better self-manage their long-term conditions

- Continue to promote the systematic application of self-management education, health coaching and peer support.
- Support commitments in the Long Term Plan that seek to increase capacity for supported self-management, such as offering new models of providing rehabilitation and self-management support, including digital tools, to those with mild COPD.

Action 11: Exceed our PHB Mandate goals to deliver at least 40,000 PHBs by March 2019 and at least 100,000 PHBs by 2020/21.[97] Complete the transition from the wheelchair voucher scheme to personal wheelchair budgets. Subject to the final evaluation findings, expand PMCBs to support 100,000 women per year by 2021/22.

- PHB trajectories to March 2021 are in place for all CCGs, demonstrating how we will achieve the 2018/19 and 2020/21 targets. These are being monitored as part of the CCG Improvement and Assessment Framework.
- Complete the transition from the wheelchair voucher scheme to personal wheelchair budgets. This forms part of NHS England's support to CCGs to provide wheelchair services which are personalised, effective and efficient, and will support CCG performance for children to receive equipment within the mandatory 18 weeks.
- In addition, and subject to evaluation, we aim to expand PMCBs in line with the expansion of the continuity of midwifery care programme, supporting around 100,000 women per year by 2021/22.
- As the NHS increasingly focuses on reducing the volume of medication and interventions that are proven to be less effective, the Comprehensive Model will help reinforce this approach, for example through shared decision making and social prescribing. Where clinical treatments are not routinely available on the NHS, we will also ensure they will not be routinely available through a PHB.

Action 12: Ensure all people receiving home-based NHS CHC have this provided as a PHB by default by 2019/20, benefitting around 20,000 people a year. We will explore PHBs in Fast Track NHS CHC-funded home care packages as well as children and young people's continuing care, and consider moving to a default position by 2021/22.

- Reflecting the evidence on the impact of PHBs in NHS CHC-funded home care packages,[98] from 1st April 2019 PHBs will be the default model for all home-based CHC services. This will benefit around 20,000 people each year when fully rolled out, with an expectation of PHBs to rise from the current figure of 7,300 in 2017/2018 to around 11,000 in 2018/19, to reach full rollout in 2019/20.
- In 2018/19, we will continue to develop PHBs for Fast Track NHS CHC-funded home care packages, which has already been implemented successfully in some areas such as Warrington and NEW Devon. In light of evidence gathered we will explore moving to a default PHB position in 2021/22. We will also explore this for children and young people's continuing care.
- Investigate the feasibility of delivering PHBs in residential care.

Action 13: Following publication of the consultation response, work with DHSC to implement new rights to have a PHB for people with ongoing health needs. In 2019/20 we will explore new rights to have personal health budgets in five further areas: end of life care, equipment, dementia, carers and neuromuscular diseases.

- Since 2014 there has been a right to have a personal health budget for around 60,000 people in receipt of NHS CHC and children and young people's continuing care, which has successfully supported the roll-out of PHBs for these groups.
- In April 2018, DHSC and NHS England launched a joint consultation[99] to extend this right to have a PHB to new groups. Based on the results of this consultation, NHS England will now work with DHSC to begin introducing new rights for all groups consulted on, starting from 19/20 for certain groups.
- In 2019/20 planning guidance, CCGs will be required to extend PHBs to these groups. The CCG Improvement and Assessment Framework will also incorporate these new rights.
- In the interim period, and prior to any possible legislative change, NHS England will work with DHSC to strengthen the messages in the Handbook to the Constitution about personalised care, and the benefits a personalised approach can bring.
- At such a point when any new rights are established, NHS England will explore with DHSC how best to include them in the NHS Constitution when it is next updated.

Action 14: Innovate in developing the PHB model, including by exploring the potential of multi-year PHBs, one-off proactive 'grants', and portability of support.

- There are further areas where PHBs are being explored but where either rollout is at an early stage or testing is still underway. The top five areas where consultation responses supported PHBs are: end of life care, equipment, dementia, carers and neuromuscular diseases.
- In 2019/20 we will continue to test, gather best practice and build the evidence for PHBs in these new areas in order to move towards these additional groups having the right to a PHB in future.

- We will also investigate how the operation of personal health budgets can be expanded to include:
    - Multi-year PHBs, to provide certainty and future planning for people over a longer period of time, particularly for young people in transition
    - One-off personal health ‘grants’ to pro-actively invest in adaptations that keep people safe and well
    - Portability of PHBs between different local areas
    - Transport, which we know to be a driver of social isolation and non-attendance at appointments.
- Identify actions on how the Comprehensive Model works for carers, working with relevant representative organisations. This reflects the potential identified by DHSC’s “Action Plan for Carers”[100] for personalised care to positively impact carers.

Action 15: A total of 200,000 people will be supported by PHBs by 2023/24.

- As we continue to extend the Comprehensive Model to more people, the cumulative impact of actions 11-14 set out above is that we expect 200,000 people will be supported by a PHB by 2023/24.
- Put in place PHB trajectories beyond March 2021 for local areas to achieve this. These will be monitored as part of the CCG Improvement and Assessment Framework and through the personalised care dashboard (see action 19).

Underpinning actions

Action 16: NHS Personalised Care will be a national centre of excellence for personalised care to (1) support local delivery, (2) provide national infrastructure services, (3) set policy and quality standards, and (4) learn and evaluate what works.

- The administrative delivery of PHBs can be highly variable.[101] To support local delivery we will consider the options for establishing and training a personalised care assessor workforce of nearly 1,000 people by 2025 for local areas to use to carry out PHB assessments and personalised care and support planning.
- The School for Social Care Research established by the National Institute for Health Research[102] and the various What Works Centres[103] have contributed valuable and practical research to social care and a number of other public service issues. In medical research more generally, there are growing calls for approaches that harness people and community participation and rebalance efforts from a dominant biomedical focus to one which addresses the social, behavioural and wider determinants of health.[104]
- Recognising these approaches, NHS Personalised Care will support research and evidence in a What Works Centre for at least four years from 2020. This will draw together the existing evidence base on personalised care so that it is more accessible and practical for professionals, and understand the ongoing impact of personalised care, including on people, practice, professionals and the system. This research will also incorporate the efficacy of the standard, replicable models of the Comprehensive Model.

- Work with academic institutions to ensure that the evidence base is rigorous, objective and peer reviewed.
- The approach to national infrastructure services is set out in action 17 and to setting policy and quality standards in actions 18, 19 and 20.

Action 17: Establish a consistent digital platform for payment, management and monitoring of PHBs, and for personalised care and support planning, aligning this with digital and data standards and the work of the Empower the Person digital transformation work of NHS England.

- Explore how NHS Personalised Care can ensure consistent infrastructure is in place (see action 16), including digital infrastructure that is linked to the Empower the Person digital roadmap.[105]
- Commission a feasibility study in 2019/20 to explore what this digital infrastructure could look like, and set out options for its delivery.
- Areas the feasibility study is likely to cover include:
    - Working with IT providers to provide best practice for the development and implementation of high quality digital systems for payment, management and monitoring of PHBs. This will include support for people when they need it with tasks in the day-to-day management of personal assistants
    - Extending shared care records, platforms and standards to encompass personalised care and support planning processes. From 2020/21 work to ensure coherent standards are in place for people and professionals for common recording, management and editing of personalised care and support plans
    - Ensuring that solutions implemented provide business intelligence – with data creating a real-time feedback loop on the optimum approaches to personalised care for people
    - Embedding digital tools and services into the personalised care components, to enable people to take an increased role in managing their health and care at scale.

Action 18: Train up to 500 people with lived experience to become system leaders by 2023/24. Empower people with lived experience to access personalised care by providing good quality information and explore supporting people with a legal right to a PHB to have access to advocacy.

- NHS England is committed to the quality of personalised care, which requires the active and equal engagement of people. We will:
    - Continue a central resource for strategic co-production and commit to co-producing all of NHS Personalised Care’s work based on people’s lived experience
    - Continue to develop and support people with lived experience who can take an active role in co-production. Through the established Peer Leadership Academy we will in 2018/19 develop 20 new peer leaders, including young people, who are equipped with the essential knowledge, skills and confidence to play an active role. The Academy will be continued and significantly

  - extended from 2019/20 onwards to reflect national coverage of personalised care, developing up to 500 new peer leaders by 2023/24
  - We will complement the face-to-face Academy with an online Peer Leadership Essentials training course that provides necessary good quality information.
- We recognise that exercising choice and control sometimes brings additional responsibilities. We will continue to explore support options to ensure that people feel equipped to take on their chosen level of responsibility. There will be a particular focus on people employing personal assistants. This extends the approach taken by Skills for Care in its employing personal assistants toolkit,[106] and the specific work already completed on personal assistants and delegated healthcare tasks.[107]
- Explore access to advocacy for people with a legal right to a PHB, in order to help them successfully exercise their rights. We will explore a statutory basis for this advocacy.

Action 19: Develop a personalised care dashboard, with key metrics on uptake embedded in routine NHS Digital data collections, and local and national planning and performance frameworks. We will introduce indicators of quality and show progress against our goals.

- We currently collect PHB numbers in the NHS Digital core data collection, and have data on choices in maternity services and utilisation of the NHS e-RS to enable choice at first routine elective referral.
- From 2018/19, we will work with areas to consider, develop and test the most appropriate personalised care activity metrics to expand this core data collection, including: shared decision making and social prescribing in general practice; personalised care and support plans; personal wheelchair budgets; and PMCBs. From 2018/19 we will also consider how best to draw down relevant activity measures from other data collections, such as SEND data, end of life data, and number of PAM licences.
- We will aim to embed these additional personalised care activity measures, from 2019/20 on a voluntary basis and then from 2020/21 as part of the NHS Digital formal data collection.
- Continue to build on and refine the quality standards set out in section 2.2. We will also aim to set an appropriate, proportionate timescale for (a) the personalised care and support planning process, and (b) the approval and set-up of a PHB that reflects people’s preferences and circumstances. We will look to legislate for this if possible.
- Embed these quality standards through a personalised care dashboard. This will be developed and tested in 2018/19 and 2019/20, for full rollout in 2020/21. This will provide a standard way of measuring local delivery against all the core personalised care quantity and quality metrics, as well as reflect the impact of personalised care on public health indicators and health inequalities. It will provide the information that will be drawn together into the National Impact Statement for Personalised Care (see action 3).
- This dashboard will take account of, and possibly ultimately be reflected in, other relevant frameworks or dashboards, including any further work done by NHS

England (for example, by the Population Health Management and Empower the Person programmes), NHS Digital and Public Health England, work done by the Social Care Institute for Excellence for DHSC on an integration scorecard,[108] or any other cross-sector approaches as proposed by the VCSE Review[109] and others.

- In 2019/20 we will launch a series of people's experience surveys specific to personalised care, collecting qualitative and quantitative data and so embedding a continuous feedback loop with people with lived experience to monitor the quality of personalised care and drive continued quality improvement.
- Begin to scope a new national Patient Reported Outcome Measures (PROMs) strategy from January 2019, building on and significantly expanding the current long-term condition PROM. This can be used to inform local contracting and can complement the use of the PAM.

Action 20: Use incentives such as the revised GP Quality and Outcomes Framework (QOF), and further embed personalised care into the Care Quality Commission (CQC) regulatory framework.

- As set out in the NHS Long Term Plan, the revised QOF will include a new Quality Improvement (QI) element, and will support more personalised care. Subject to regulations, the QOF update will make changes to exception reporting that should allow more flexibility for patients to opt-out of treatment options and should encourage more shared decision making. We are also pursuing changes to the palliative care indicator to encourage earlier identification of people approaching end of life, conversations to enable personalised care and support planning and improvements in quality of palliative and end of life care offered.
- Continue to embed personalised care in wider programmes as set out in the NHS Long Term Plan. This includes ensuring by 2021 that, where appropriate, every person diagnosed with cancer will have access to personalised care, including a needs assessment, a care plan and health and wellbeing information and support, all delivered in line with the Comprehensive Model for Personalised Care. Other areas supported include dementia, delayed transfers of care, urgent and emergency care, mental health, people with learning disabilities, autism or both, and in maternity. We will improve existing legal care planning requirements to align with the personalised care and support planning key features, e.g. Education, Health and Care plans and the Care Programme Approach. This will provide additional support to build on or guide work that is often already happening.
- Embed personalised care within primary care network frameworks and work with wider primary care transformation to enable shared decision making.
- Beyond NHS England, the CQC key lines of enquiry currently incorporate important components of personalised care, including how the service supports people to express their views and be actively involved in making decisions about their care, treatment and support. Building on this, in 2019/20 we will work with CQC to explore how personalised care can be fully embedded in key lines of enquiry and core service frameworks, including for hospital, community and primary care services.

- Explore how else we can work with CQC on personalised care, building on the ‘Better Care in My Hands’[110] thematic review. We will also work with CQC’s Public Engagement team to ensure that people with lived experience of personalised care are effectively supporting the CQC inspection regime.
- Working with the Healthcare Financial Management Association (HFMA), we will engage with directors of finance and directors of commissioning across England to share skills and tools to embed personalised care in contracts.

Personalised care in wider public services

Action 21: Make the case for the Comprehensive Model to become a basis and chassis for wider public services integration around people, including by working with DWP, DfE, MHCLG and DHSC.

- Personalised care already integrates health, social care and (where applicable) education funding, but people with long-term conditions and complex needs receive services and benefits provided by other parts of the public sector, for example DWP or MHCLG. We will therefore explore whether the Comprehensive Model could be expanded to include other funding streams alongside health and social care.
- From 2018/19, we will work with local government, CCGs and primary care to test incorporating supported employment provision in personalised care and support planning and PHBs. This will focus on people in areas of high unemployment and social deprivation who persistently access primary care. It will combine health coaching, social prescribing and access to voluntary and community sector organisations to achieve employment and meaningful activity as a positive outcome.
- The PHB consultation[111] has highlighted other funding streams that could be included within PHBs, such as the Disabled Facilities Grant. We will undertake further work to explore whether this and other funding streams could be incorporated into IPBs, testing new approaches if possible and scaling up approaches subject to successful testing.
- Building on the inclusion of social prescribing in the government’s loneliness strategy, we will also explore how personalised care can support wider policy initiatives.
- Work with DHSC, DWP and MHCLG and HM Treasury to identify opportunities to align funding allocations, system auditing and reporting so that local areas can more easily integrate funding streams.

A. Technical appendix: what has been delivered and the difference it has made

The following table summarises what has been delivered through the Comprehensive Model for Personalised Care, and the evidence so far on the difference it has made.

Component	Delivery	Evidence
PHBs and IPBs	• 32,341 PHBs, of which 23% jointly funded packages with social care, in place by September 2018. Increase of 105% in the last 18 months to September 2018 • 55,511 PMCBs delivered by September 2018 in seven Maternity Pioneers covering 36 CCGs • An estimated 45% of CCGs were in the process of transitioning to PWBs (to November 2018) • Five areas developed and tested PHBs for end of life care • Seven areas developed and tested PHBs for looked after children and young people with mental health needs	• In a recent survey of PHB holders, 86% of respondents said they had achieved what they wanted to with their PHB. 77% of people would recommend PHBs to others.[112] These findings are consistent with previous results from the POET PHB surveys of 2014 and 2015[113] • An independent evaluation found that PHBs were overall cost neutral. People with a PHB had lower indirect costs, through less use of secondary healthcare (average £1,320 per person per year). For people with the highest needs there were overall cost savings (average £3,100 per person per year)[114] • More recently, monitoring of costs for PHB holders receiving NHS CHC home care packages found an average saving of 17% compared with conventional services. This related mainly to people with a direct payment with high levels of needs[115] • An evaluation of PMCBs is under way[116]
IPC	• Over 204,000 people had joined the IPC cohort by September 2018 through the IPC demonstrator programme • Approximately 60% of IPC sites reached model maturity by March 2018,	• An evaluation of the IPC programme is under way[117] • In one site, IPC was implemented at scale alongside other interventions. Following the 100-day challenge in 2017 the site saw a reduction in emergency admissions of 12%, as well as

	successfully implementing all components of personalised care - IPC rolled-out to new cohorts, including substance misuse in three sites and neuro-disability	a 24% reduction in A&E attendances for the two practices which took part[118]
Personalised care and support planning	- 142,904 people in demonstrator sites have a personalised care and support plan, between April 2017 and September 2018	- Independent reviews have found evidence that people's well-being, satisfaction and experience improves through good personalised care and support planning,**[119]** including for people with cancer.**[120]** Personalised care and support planning has been shown to improve GP and other professionals' job satisfaction**[121]**
Supported self-management	- 101,637 PAM assessments delivered in total by September 2018, enabling self-management support interventions to be targeted towards those who will benefit most - 59,545 people referred to self-management support or health coaching in demonstrator sites, as of September 2018 - 44,093 people referred to community-based support in demonstrator sites, as of September 2018	- An independent evaluation found that people who had the highest knowledge, skills and confidence had 19% fewer GP appointments and 38% fewer A&E attendances than those with the lowest levels of activation[122] - This finding was corroborated by a Health Foundation study which tracked 9,000 people across a health and care system[123] - A literature review of over 1,000 research studies found peer support can help people feel more knowledgeable, confident and happy, and less isolated and alone.[124] There is an emerging evidence base that indicates peer support is cost-effective for different areas of healthcare[125]
Social prescribing	In 55 CCG areas in 2017/18 there were: - 68,977 referrals - 331 link workers	- Local evaluations of social prescribing have reported improvements in quality of life and emotional wellbeing,[126] as well as lower use of primary care and other NHS

		services,[127] although systematic reviews have found that the quality of evidence is variable.[128,129] There is a need for more evidence on the effectiveness of social prescribing.
Enabling choice, including legal rights to choice	• 97% of CCGs have now completed Choice Planning and Improvement self-assessment • Of these, 85% report compliance with at least 5 (of 9) choice standards	• In a survey of people who booked hospital outpatient appointments online, 75% felt that they were able to make choices that met their needs[130] • A systematic review found limited evidence that choice improved outcomes or reduced costs, although choice was associated with modest but statistically significant reductions in waiting times[131]
Shared decision making	• In 2017/18 we started embedding shared decision making into musculoskeletal elective care pathways across 13 CCGs and into respiratory elective care pathways in eight CCGs	• Systematic evidence reviews show that people consistently over-estimate treatment benefits and underestimate harms.[132,133] Shared decision making supports them to understand benefits and harms of options available and tends to reduce uptake of high risk, high cost interventions by up to 20%.[134]

B. End notes

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