Personalised Care Mapping

Following the publication of the NHS Long term plan, the Universal Personal Care implementation model and other key documents, HLP were asked to undertake a rapid analysis of current and planned activity to understand where the gaps and opportunities are for improving personalised care in London

The following tabs offer a snapshot of current and planned activity at a national and regional level using information available in Feb-March 2019. This analysis is intended to support STPs in planning for the delivery of the Long Term Plan.
For further information on this spread sheet, please contact Helen Daly from HLP - helen.daly4@nhs.net

Long Term Plan - Personalised Care														
Interventions							**London**			**National**		**STP level**		
Category	**Intervention**	**Level of personalised care**	**Target**	**Theme:** Digital: 13 Integrated personalisation: 3 Pathway design: 2 Commissioning: 1 Social prescribing: 1	**Clinical area**	**Programme**	**Current activity**	**Planned activity**	**Trajectory**	**Current activity**	**Planned activity**	**Current activity**	**Planned activity**	**Where in LTP**
Personalised care & shared decision making	Social prescribing	Universal	Over 1,000 trained social prescribing link workers will be in place by the end of 2020/21 rising further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes by then.	Social Prescribing	Proactive Care	Proactive Care	HLP is working to embed and spread social prescribing in the health and care system across the London STP footprints. 24 of 32 London CCGs have a social prescribing offer in place. HLP supported the organisation of a GLA event in January to engage VCSE organisations in the draft Social Prescribing vision for London document. The final vision document will be published in April 19. Mapping is on-going of the current SP provision across CCG's in London using NHSE national survey results and local intelligence - provisional data due in coming weeks.	HLP have drafted Social prescribing: our vision for London 2018-2028 which includes proposed work plan and evaluation templates for CCGs and STPs to use going forward to support the social prescribing. In 2019/20 link workers will take referrals from the primary care network's members, expanding from 2020/21 to take referrals from a wide range of local agencies. Primary care networks that already have social prescribing link workers in place, or who have access to social prescribing services, may take referrals from other agencies prior to 2020/21. NHS England will provide funding directly to primary care networks for a new, additional social prescribing link worker to be embedded within every primary care network multi-disciplinary team, through the Network Contract Direct Enhanced Service (DES). This will be available from July 2019, at 100% reimbursement of the actual on-going salary costs, up to a maximum amount (£34,113) GP Contract Reform, section 1.26. The percentage will neither taper nor increase during the next five years, giving networks maximum confidence to recruit to the full.	2020/2021 2023/24		In 2019/20 link workers will take referrals from the primary care network's members, expanding from 2020/21 to take referrals from a wide range of local agencies. Primary care networks that already have social prescribing link workers in place, or who have access to social prescribing services, may take referrals from other agencies prior to 2020/21. NHS England will provide funding directly to primary care networks for a new, additional social prescribing link worker to be embedded within every primary care network multi-disciplinary team, through the Network Contract Direct Enhanced Service (DES). This will be available from July 2019, at 100% reimbursement of the actual on-going salary costs, up to a maximum amount (£34,113) GP Contract Reform, section 1.26. The percentage will neither taper nor increase during the next five years, giving networks maximum confidence to recruit to the full.			Chapter 1 - 1.40
Commissioning control	Personal health budgets	Specialist	Up to 200,000 people will benefit from a PHB by 2023/24.	Integrated personalised care	Personal Care Budgets	NHS E London - Operations/ Khadir	In Q3 of 2018/19 there were 2,878 PHBs delivered in London. An increase of 612 PHBs during Q3 or 27% more PHBs. There were 61 more children's PHBs for a total of 316 or 24% increase. There were 551 more adult PHBs for a total of 2,562 or 27% increase.	In response to the planned cohort expansion for PHBS, targeted delivery support will be provided to CCGs regarding each group (PWB, MH/s117, Joint, ECHP, LD, Carers). Expectation is that all CCGs will have cohort expansion plans beyond CHC. From Apr 2019, new CHC domiciliary care packages will be delivered as PHBs, with existing packages to transition by Mar 2020. Support will be provided to CCGs planning to use "notional" PHB letters to ensure 5 key features in place. Personalised Care team to provide: • ½-day to full day workshop to understand current position, identify gaps, develop action plans with site follow-up on those action plans • Bespoke 1:1 support as requested • 1-day master class hosted by STPs • Webinars & podcasts to share best practice and guidance • E-learning tool • 1:1 mentoring through the mentorship programme Support offers has been developed based on CCGs PHB performance.	2023/24	In Q3 18/19 40,344 PHBs delivered across England	The NHS Mandate: 50,000-100,000 people to have a personal health budget or integrated personal budget by 2021. Activity on-going to complete the transition from the wheelchair voucher scheme to personal wheelchair budgets. All people receiving home-based NHS CHC will have this provided as a PHB by 2019/20. DHSC to amend regulation to implement new rights to have a PHB for people with on-going health needs. Innovate in developing the PHB model, including by exploring the potential of multi-year PHBs, one-off proactive 'grants', and portability of support. A total of 200,000 people will be supported by PHBs by 2023/34.			Chapter 1 - 1.41
Personalised care model (spans other categories)	Personalised care programme	Universal/ Targeted/ Specialist	We will roll out the NHS Personalised Care model across the country, reaching 2.5 million people by 2023/24 and then aiming to double that again within a decade.	Integrated personalised care	Personal Care Budgets	Personalised Care - National	London has 2 CCG (level 2) demonstrator sites - Islington and Tower Hamlets. These sites are implementing some aspects of personalised care. As part of this framework, both sites carry out a self assessment quarterly As of Q3 18/19 there were 2878 PHBs delivered in London. As of Q3 18/19 42009 PAM licences have been dispensed in London. 25 CCGs have engaged with social prescribing. In terms of the legal right to choice, 97% of the London CCGs have completed their self-assessments 28% are over 90% compliant with the 9 standards (19% compliant with all 9 standards, 9% compliant with 8 standards) 28% are over 80% compliant with the 9 standards		2023/24	Universal personalised care: Implementing the Comprehensive Model confirms how this will be done this by 2023/24. This includes an action plan for rolling out personalised care across England and follows a decade of evidence-based research working with people and community groups.	The comprehensive model document sets out how the NHS Long Term Plan commitments for personalised care will be delivered. Implementation will be guided by delivery partnerships with local government, the voluntary and community sector and people with lived experience. The LTP has committed to the following improve personalised care: 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. 200,000 people will have a personal health budget 750,000 people have a personalised care and support plan Develop the skills and behaviours of 75,000 clinicians and professionals through practical support to use personalised care approaches in their day-to-day practice. Train up to 500 people with lived experience to become system leaders. Personalised Care continues to expand across England with over 290,000 people now set to benefit by April 2019 through 21 personalised care demonstrator sites across the country, including 66 CCGs and 11 Integrated Care Systems (ICS)/Sustainability and Transformation Partnership (STPs). Each site will implement personalised care at scale on a local level, which builds on the successful pilots undertaken over the last three years pilots through the successful Integrated Personal Commissioning and the New Models of Care pilot programmes. The GMS contracts reflects Personalised Care as a national service specification.	Islington - NCL is a personalised care demonstrator site which focuses on PHBs. Tower Hamlets - NEL is a personalised care demonstrator site with a focus on social prescribing. STPs have utilised the following PAM licences: NEL - 3393 NCL - 1313 NWL - 20225 SEL - 1164 SWL - 0 The following STPs have engaged with social prescribing: NEL - 7/ 7 CCGs NCL - 4/ 5 CCGs NWL - 6 / 8 CCGS SEL - 3 / 6 CCGs SWL - 5 /6 CCGs	NCL are currently considering joining the demonstrator site collaborative.	Chapter 1 - 1.39
Choice over access	NHS 111 - Direct bookings & referrals	Universal	From 2019, NHS 111 will start direct booking into GP practices across the country, as well as refer on to community pharmacies who support urgent care and promote patient self-care and self-management	Digital - integration	Digital	Digital	NHS 111 direct booking is part of the pan London Digital First pilot. NWL STP have initiated this service.	Digital first pilots confirmed in: • Brent (NWL) • NCL (60 practices across NCL) • Waltham Forest (NEL) • Lambeth (SEL) • Wandsworth & Merton (SWL)	2019			NWL currently offers direct booking to GP practices via NHS 111.		Chapter 1 - 1.10
Personalised care model (spans other categories)	Personalised care programme	Universal	The NHS will be more differentiated in its support offer to individuals. This is necessary if the NHS is to make further progress on prevention, on inequalities reduction, and on responsiveness to the diverse people who use and fund our health service. Individual preferences on type and location of care differ quite widely – as for example with end of life choices, or on use of 'multichannel' digital services.	Integrated personalised care			Islington CCG and Tower Hamlets CCG are personalised care demonstrator sites - which are implementing some aspects of personalised care.	Islington CCG and Tower Hamlets CCG have plans in place with a signed MOU with NHSE. SWL have commenced the self assessment framework with support from HLP and NHSE.	2028					Chapter 1 - 1.4
Access to records	NHS app	Targeted	In 2020/21, people will have access to their care plan and communications from their care professionals via the NHS App; the care plan will move to the individual's LHCR across the country over the next five years.	Digital - integration	LHCRE	Digital	The app will appear on Google Play and Apple app stores at the end of December and will then be gradually rolled out to GP surgeries across London	The NHS app will be fully rolled out by 01 July 2019. Phase 1 (February up to March) will cover c.30% of CCGs in London Phase 2 (April to June) will cover the remaining c.70% of London CCGs Delivery of LHCR will be owned locally going forward with strong STP leadership required. Meet with Shona/ Patrick NHSD	Jul-19	The app will appear on Google Play and Apple app stores at the end of December and will then be gradually rolled out to GP surgeries across the country	The NHS app will be fully rolled out by 01 July 2019.			Chapter 5

Category	Intervention	Level of personalised care	Target	Theme: Digital: 13 Integrated personalisation: 3 Pathway design: 2 Commissioning: 1 Social prescribing: 1	Clinical area	Programme	Current activity	Planned activity	Trajectory	Current activity	Planned activity	Current activity	Planned activity	Where in LTP
Choice over access	Digital first primary care offer	Universal	By 2023/24 every patient in England will be able to access a digital first primary care offer.	Digital - primary care	Primary Care	Primary Care/ Digital - James Hempsted	STP AOs have agreed the use of £1.4m regional monies to support Digital First, the digital 'front door' to NHS services (using the future NHS App) which integrates different clinical organisations and their IT solutions to support the adoption of these technologies by clinicians and patients in both primary and urgent care. The investment has been match-funded by NHS England (national).	Confirm accelerator sites for NEL, SWL, SEL. Design, implementation and testing across accelerator sites by March 2019.	2023/24	National discovery programme (Nov '18 – Jan '19) complete working with three online consultation vendors (Livi, eConsult and Qdoctor) to test NHS App integration.	NHS England will continue to ensure and resource IT infrastructure for general practice via the GP IT Operating Model40. The next version will be developed with GPC England and the Joint General Practitioners Information Technology Committee (JGPITC) by March 2019. A new centrally-funded programme will create a framework for digital suppliers to offer their platforms on standard NHS terms. The framework will be available for use in 2021. Programme details will be developed in 2019.	NWL (Brent CCG) and NCL (60 practices) have identified accelerator sites.	Confirm accelerator sites for NEL, SWL, SEL. Design, implementation and testing across accelerator sites by March 2019.	Chapter 5
Choice over access	NHS login	Universal	Over the next five years, every patient will be able to access a GP digitally, and where appropriate, opt for a 'virtual' outpatient appointment	Digital - primary care	Primary Care	Primary Care/ Digital - James Hempsted	STP AOs have agreed the use of £1.4m regional monies to support Digital First, the digital 'front door' to NHS services (using the future NHS App) which integrates different clinical organisations and their IT solutions to support the adoption of these technologies by clinicians and patients in both primary and urgent care. The investment has been match-funded by NHS England (national).	Confirm accelerator sites for NEL, SWL, SEL. Design, implementation and testing across accelerator sites by March 2019.	Pilot - March 2019	National discovery programme (Nov '18 – Jan '19) complete working with three online consultation vendors (Livi, eConsult and Qdoctor) to test NHS App integration.		NWL (Brent CCG) and NCL (60 practices) have identified accelerator sites.	Confirm accelerator sites for NEL, SWL, SEL. Design, implementation and testing across accelerator sites by March 2019.	Chapter 5 - 5.21
Access to records	Long term conditions - NHS App	Targeted	By 2020, every patient with a long-term condition will have access to their health record through the Summary Care Record accessed via the NHS App.	Digital - integration	Digital	Digital	The app will appear on Google Play and Apple app stores at the end of December and will then be gradually rolled out to GP surgeries across the country.	The NHS app will be fully rolled out by 01 July 2019. Phase 1 (February up to March) will cover c.30% of CCGs in London Phase 2 (April to June) will cover the remaining c.70% of London CCGs Delivery of LHCR will be owned locally going forward with strong STP leadership required. Meet with Shona/ Patrick NHSD	2020	The app will appear on Google Play and Apple app stores at the end of December and will then be gradually rolled out to GP surgeries across the country.	The NHS app will be fully rolled out by 01 July 2019. Meet with Shona/ Patrick NHSD			Chapter 5 - 5.14
Access to records, reminders and alerts	Long term conditions - NHS App	Universal	By 2023, the Summary Care Record functionality will be moved to the PHR held within the LHCR systems, which will be able to send reminders and alerts directly to the patient.	Digital - integration	LHCRE	Digital			2023					Chapter 5 - 5.14
Personalised care model (spans other categories)	EOL - Personalised Care	Targeted	With patients, families, local authorities and our voluntary sector partners at both a national and local level, including specialist hospices, the NHS will personalise care, to improve end of life care. By rolling out training to help staff identify and support relevant patients, we will introduce proactive and personalised care planning for everyone identified as being in their last year of life. A consequence of better quality care will be a reduction in avoidable emergency admissions and more people being able to die in a place they have chosen.				As part of the One London LHCRE it was initially agreed that EoL shared care planning using CMC should form a demonstrator.	It has been agreed to rapidly review our proposed demonstrators as a result of the 2020 review	2028	Tim Staughan is working with the LHCRE in Yorkshire and Humber on a shared care plan at the end of life				Chapter 1 - 1.42
Commissioning control	Personal health budgets	Targeted	We will also expand the PHB offer in mental health services, for people with a learning disability, people receiving social care support and those receiving specialist end of life care.	Integrated personalised care	Personal Care Budgets	NHS E London - Operations/ Khadir	In Q3 of 2018/19 there were 2878 PHBs delivered in London. Of these: 23 PHBs delivered to children with LD/ autism 86 PHSs delivered to children (other) 106 PHBs delivered to children (EHCP) 193 PHBs delivered for children (continuing care) 244 PHBs delivered to adults with mental health diagnosis 401 PHBs delivered to adults (joint) 532 PHBs delivered to adults with learning difficulties 715 PHBs delivered to adults (other) 1330 PHBs delivered to adults (CHC)	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. The mandatory CCG data collection will be changed to gett more detail from CCGs on specific cohorts to understand what CCGs are currently offering.	2019/20		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. The mandatory CCG data collection will be changed to gett more detail from CCGs on specific cohorts to understand what CCGs are currently offering.			Chapter 1 - 1.41
Choice over access	Digital primary care	Universal	Over the next five years every patient in England will have a new right to choose telephone or online consultations – usually from their own practice or, if they prefer, from one of the new digital GP providers. In	Digital - primary care	Primary Care	Primary Care/ Digital - James Hempsted	STP AOs have agreed the use of £1.4m regional monies to support Digital First, the digital 'front door' to NHS services (using the future NHS App) which integrates different clinical organisations and their IT solutions to support the adoption of these technologies by clinicians and patients in both primary and urgent care. The investment has been match-funded by NHS England (national).	Confirm accelerator sites for NEL, SWL, SEL. Design, implementation and testing across accelerator sites by March 2019.	2023/24	National discovery programme (Nov '18 – Jan '19) complete working with three online consultation vendors (Livi, eConsult and Qdoctor) to test NHS App integration.		NWL (Brent CCG) and NCL (60 practices) have identified accelerator sites.	Confirm accelerator sites for NEL, SWL, SEL. Design, implementation and testing across accelerator sites by March 2019.	Chapter 4 - 1.44
Access to records	Maternity - digital care records	Universal	In 2019/20, 100,000 women will be able to access their maternity record digitally with coverage extended to the whole country by 2023/24.	Digital - maternity	Maternity	NHSE Maternity	London has 3 maternity digital care record accelerator sites: Kings Epsom & St. Helier GSTT Collectively these trusts have a reach of approx 20,000 women, which will access their digital maternity care record by October 2019. Currently Kings and Epsom & St. Helier have the top utilisation rates for the country, with over 80% of women booked choosing to access records digitally. GSTT utilisation rates are approx 44%. Support is in place to train midwives	Benefits reporting will be in place across London sites by summer 2019 to understand the impact on the systems and women's experience. Learning's from accelerator sites will be used to extend coverage to all pregnant women by 2023/24.	Pilot - October 2019 Full coverage - 2023/24	In 2018 20 pilot sites were initiated in England, working with women, maternity services and supportive system suppliers to provide a convenient means for pregnant women to access their electronic record.	The ambition is to provide 100,000 women with access to their electronic record by October 2019. The aim of the pilot is to prove whether or not ePHRs provide the benefits people believe to be there if they are embedded properly. Learning's from accelerator sites will be used to extend coverage to all pregnant women by 2023/24.	SEL have 2 pilot sites engaged as digital maternity accelerators - Kings & GSTT. SWL have 1 pilot site - Epsom & St. Helier		Chapter 5 - 5.12

Category	Intervention	Level of personalised care	Target	Theme: Digital: 13 Integrated personalisation: 3 Pathway design: 2 Commissioning: 1 Social prescribing: 1	Clinical area	Programme	Current activity	Planned activity	Trajectory	Current activity	Planned activity	Current activity	Planned activity	Where in LTP
Access to records and personalised care	Patient personal care records	Universal	Patients' Personal Health Records will hold a care plan that incorporates information added by the patient themselves, or their authorised carer	Digital - integration	LHCRE	Digital								Chapter 5 - 5.15
Personalised care	Cancer - Personalised care	Targeted	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.	Pathway design	Cancer	HLP/ NHSE - TC		From April 2020 approximately two-thirds of patients who finish treatment for breast cancer to be on a supported self-management follow-up pathway From diagnosis, all breast cancer patients (including secondary cancer) to have access to personalised support All Alliance Trusts to have in place protocols for stratifying the follow up of prostate patients and systems for remote monitoring for these patients From diagnosis, all prostate cancer patients (including secondary cancer) to have access to personalised support All Alliance Trusts to have in place protocols for stratifying the follow up of colorectal patients and systems for remote monitoring for these patients From diagnosis, all colorectal cancer patients (including secondary cancer) to have access to personalised support	2021					Chapter 3 - 3.64
Commissioning control	Selective moving of 0-25 services	Targeted	By 2028 we aim to move towards service models for young people that offer person-centred and age appropriate care for mental and physical health needs, rather than an arbitrary transition to adult services based on age not need.	Pathway design	CYP	HLP - CYP team			2028					Chapter 3 - 3.47
Access to records	Maternity - digital care records	Targeted	Offer 100,000 eligible women in 20 accelerator sites across England maternity digital care records	Digital - maternity	Maternity	NHSE Maternity	London has 3 maternity digital care record accelerator sites: Kings Epsom & St. Helier GSTT Collectively these trusts have a reach of approx 20,000 women, which will access their digital maternity care record by October 2019. Currently Kings and Epsom & St. Helier have the top utilisation rates for the country, with over 80% of women booked choosing to access records digitally. GSTT utilisation rates are approx 44%. Support is in place to train midwives	Benefits reporting will be in place across London sites by summer 2019 to understand the impact on the systems and women's experience. Learning's from accelerator sites will be used to extend coverage to all pregnant women by 2023/24.	Pilot - October 2019	In 2018 20 pilot sites were initiated in England, working with women, maternity services and supportive system suppliers to provide a convenient means for pregnant women to access their electronic record.	The ambition is to provide 100,000 women with access to their electronic record by October 2019. The aim of the pilot is to prove whether or not ePHRs provide the benefits people believe to be there if they are embedded properly. Learning's from accelerator sites will be used to extend coverage to all pregnant women by 2023/24.	SEL have 2 pilot sites engaged as digital maternity accelerators - Kings & GSTT. SWL have 1 pilot site - Epsom & St. Helier		Chapter 3 - 3.15
Access to records	Maternity - digital care records	Universal	By 2023/24, all women will be able to access their maternity notes and information through their smart phones or other devices.	Digital - maternity	Maternity	NHSE Maternity	London has 3 maternity digital care record accelerator sites: Kings Epsom & St. Helier GSTT Collectively these trusts have a reach of approx 20,000 women, which will access their digital maternity care record by October 2019. Currently Kings and Epsom & St. Helier have the top utilisation rates for the country, with over 80% of women booked choosing to access records digitally. GSTT utilisation rates are approx 44%. Support is in place to train midwives	Benefits reporting will be in place across London sites by summer 2019 to understand the impact on the systems and women's experience. Learning's from accelerator sites will be used to extend coverage to all pregnant women by 2023/24.		In 2018 20 pilot sites were initiated in England, working with women, maternity services and supportive system suppliers to provide a convenient means for pregnant women to access their electronic record.	The ambition is to provide 100,000 women with access to their electronic record by October 2019. The aim of the pilot is to prove whether or not ePHRs provide the benefits people believe to be there if they are embedded properly. Learning's from accelerator sites will be used to extend coverage to all pregnant women by 2023/24.	SEL have 2 pilot sites engaged as digital maternity accelerators - Kings & GSTT. SWL have 1 pilot site - Epsom & St. Helier		Chapter 3 - 3.15
Access to records, reminders and alerts	Apps to support conditions	Universal	By 2020, we aim to endorse a number of technologies that deliver digitally-enabled models of therapy for depression and anxiety disorders for use in IAPT services across the NHS.	Digital - mental health	Mental Health	Mental Health	HLP led programme mobilisation in place since July 2018. 60% of IAPT services currently have on online platform. Financial case for London digital IAPT single point of access has been drafted. Market testing has taken place. NEL commissioned Silver Cloud pilot in Jan 19.	Confirm financial case with London STPs Develop API capacity across all digital IAPT services to ensure single user experience across all channels. Randomised Control Trial of e-Triage to commence in 2018/19.	2020					Chapter 5 - 5.13
Commissioning control	Better care for Diabetes - glucose monitoring	Targeted	The NHS will ensure that, in line with clinical guidelines, patients with type 1 diabetes benefit from life changing flash glucose monitors from April 2019, ending the variation patients in some parts of the country are facing.	Commissioning	Diabetes	NHSE L - Diabetes	Currently the London Clinical Network has guidance in place on Flash Glucose Monitoring. This guidance is more restrictive around reimbursement compared to the LTP ambition.	The London Clinical Network has provided feedback on the draft national guidance on flash glucose monitoring/CCG reimbursement. In response to the LTP ambition, ensuring all type 1 patients will benefit from a flash monitor, the guidance will be updated in line with the mandate by 01 April, when the changes come into place nationally. This is a priority for the London Diabetes programme/ clinical network	Apr-19	Currently there is regional variation on guidance on flash glucose monitoring/CCG reimbursement.	From 01 April, it will be nationally mandated that patients with type 1 diabetes benefit from life changing flash glucose monitors, in line with clinical guidelines. National guidance has been drafted and circulated for feedback across clinical networks/ regions.	CCGs are responsible for the reimbursement of flash glucose monitors.	All CCGs will need to align commissioning to the national mandate by 01 April	Chapter 3 - 3.80
Commissioning control	Better care for Diabetes - glucose monitoring	Targeted	By 2020/21, all pregnant women with type 1 diabetes will be offered continuous glucose monitoring, helping to improve neonatal outcomes.	Commissioning	Diabetes	NHSE L - Diabetes	To reduce the variation across London, the Clinical Network published CGM commissioning recommendations in October 2018. This currently does not specify pregnant women.	In response to the LTP ambition, ensuring all pregnant women with type 1 patients will be offered CGM, the guidance will be updated in line with the mandate in 2019/20 ahead of when the changes come into place nationally.	2020/21	Currently there is regional variation on guidance on CGM. London Clinical Network developed "Recommended Commissioning Arrangements" for use across London to mitigate the variation across STPs/ CCGs.	All CCGs will need to align commissioning to the national mandate by2020/21.	CCGs are responsible for the commissioning of CGM for pregnant women.	All CCGs will need to align commissioning to the national mandate by2020/21.	
Access to records	Shared health management tools	Universal	Primary care networks will from 2020/21 assess their local population by risk of unwarranted health outcomes and, working with local community services, make support available to people where it is most needed	Population health	Primary Care	Digital	Plans for primary care networks are currently in development - no update available from the London primary care workforce team.	A PCN contract will be introduced from 1 July 2019 as a Directed Enhanced Service (DES). It will ensure general practice plays a leading role in every PCN and mean much closer working between networks and their Integrated Care System. This will be supported by a PCN Development Programme which will be centrally funded and locally delivered.	2020/21		A PCN contract will be introduced from 1 July 2019 as a Directed Enhanced Service (DES). It will ensure general practice plays a leading role in every PCN and mean much closer working between networks and their Integrated Care System. This will be supported by a PCN Development Programme which will be centrally funded and locally delivered.		Refreshing NHS Plans for 2018-19 set out the ambition for CCGs to actively encourage every practice to be part of a local primary care network so that these cover the whole country as far as possible by the end of 2018/19. Primary care networks will be based on GP registered lists, typically serving natural communities of around 30,000 to 50,000. They should be small enough to provide the personal care valued by both patients and GPs, but large enough to have impact and economies of scale through better collaboration between practices and others in the local health and social care system.	Chapter 1 - 1.17

Long Term Plan - Personalised Care															
ENABLERS								London		Trajectory	National		STP level		
Category	**Intervention**	**Personalisation score out of 10**	**Level of personalised care**	**Enablers**	**Theme** Digital: 6 Workforce: 6 Self management: 5 Medicine: 1 Risk stratification: 1 Patient choice: 1	**Clinical area**	**Programme**	**Current activity**	**Planned activity**		**Current activity**	**Planned activity**	**Current activity**	**Planned activity**	**Where in LTP**
Advances to medicine	Precision medicine	3	Targeted	Advances in precision medicine also mean treatment itself will become increasingly tailored to individuals, and patients will be offered more personalised therapeutic options	Advances in medicine	Research	Digital								Chapter 1 - 1.36
Enabler: Access to records, reminders and alerts	Home based/ wearable monitoring	5	Targeted	Currently available technology can enable earlier discharge from hospital and transform people's lives if it is connected to their Personal Health Record (PHRs) and integrated into the NHS' services.	Digital - integration	Digital	UEC?								Chapter 1 - 1.18
Access to records, reminders and alerts	NHS App	4	Universal	The NHS App will work seamlessly with other services at national and local levels and, where appropriate, be integrated into patient pathways.	Digital - integration	Digital	NHS Digital - Empower the Person	The app will appear on Google Play and Apple app stores at the end of December and will then be gradually rolled out to GP surgeries across the country.	The NHS app will be fully rolled out by 01 July 2019. Phase 1 (February up to March) will cover c.30% of CCGs in London Phase 2 (April to June) will cover the remaining c.70% of London CCGs Delivery of LHCR will be owned locally going forward with strong STP leadership required.	Jul-19					Chapter 5 - 5.11
Access to records, reminders and alerts	Maternity - digital care records	4	Targeted	Maternity Pioneers have commissioned and rolled out apps to help women to make choices about their care and access services and information in a more convenient and efficient way.	Digital - maternity	Maternity	NHSE Maternity								Chapter 3 - 3.15
Access to records, reminders and alerts	e Redbook	5	Targeted	A digital version of the 'red book' will help parents record and use information about their child, including immunisation records and growth. This will be made available in a mobile format that follows the family and removes the need for a paper record. It will also help children start life with a digital Personal Health Record (PHR) that they can build on throughout their lives.	Digital - maternity	Maternity/ CYP	NHSE L - Maternity/ CYP	NHSE have commissioned SiteKick to develop eRedbook							Chapter 5 - 5.12
Enabler: Access to records, reminders and alerts	Digitally enabled primary and outpatient care	4	Universal	Support the development of apps and online resources to support good mental health and enable recovery.	Digital - mental health	Mental Health	NHS Digital - Empower the Person	The NHS App Library provides a trusted collection of apps to help people with their health and social care needs. The growing library has over 800,000 visits and holds over 80 apps which have been clinically reviewed, validating their efficacy and safety. this is providing patients with a growing number of digital health products from dementia to mental health, COPD and others.		On-going					Chapter 4 - 1.43
Pathway redesign	Capacity alerts - Elective care	5	Universal	The NHS will continue to provide patients with a wide choice of options for quick elective care, including making use of available Independent Sector capacity. This will be supported by continued roll out of Capacity Alerts as a tool for CCGs to use to support GPs and patients to make informed decisions about where to have their treatment.	Digital - pathway design	Elective Care	Elective Care	HLP/ NHSE London extended capacity alerts offer in 18/19. Successful roll out with 5 sites and NCL identified Royal Free as the next potential to roll out	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.	On-going	The Capacity Alerts Standard Operating Procedure has been published, integrating policy guidance on how to implement capacity alerts with a number of tested tools. A number of test sites have rolled out capacity alerts following implementation of eRS.				Chapter 3 - 3.109
Pathway redesign	Short waits for routine operations	4	Targeted	Patients will continue to have choice at point of referral and anyone who has been waiting for six months will be specifically contacted and given the option of faster treatment at an alternative provider, with the NHS money following the patient to fund their care.	Patient choice	Elective Care	Elective Care	The NHS e-Referral Service (e-RS) combines electronic booking with a choice of place, date and time for first hospital or clinic appointments. Patients can choose their initial hospital or clinic appointment, book it in the GP surgery at the point of referral, or later at home on the phone or online. All 23 London acute hospital trusts and GP practices have made the move to sending and receiving all first outpatient referrals through the NHS e-Referral Service (e-RS)							Chapter 1 - 1.35
Access to records	Electronic Frailty Index	4	Targeted	Extending independence as we age requires a targeted and personalised approach, enabled by digital health records and shared health management tools. Primary care networks will from 2020/21 assess their local population by risk of unwarranted health outcomes and, working with local community services, make support available to people where it is most needed. Based on their individual needs and choices, people identified as having the greatest risks and needs will be offered targeted support for both their physical and mental health needs, which will include musculoskeletal conditions, cardiovascular disease, dementia and frailty.	Risk stratification	Long-term conditions	Long term conditions			2020/21	GPs are already using the Electronic Frailty Index to routinely identify people living with severe frailty. Based on individual needs and choices, under the Anticipatory Care Service, people identified as having the greatest risks and needs will be offered targeted support for both their physical and mental health needs, which include musculoskeletal conditions, cardiovascular disease, dementia and frailty. Typically, this involves a structured programme of proactive care and support in which patients with multi-morbidities will have greater support– including longer GP consultations where appropriate - from the wider multidisciplinary team.				Chapter 1 - 1.17
Enabler: Access to records, reminders and alerts	Improved technology	5	Universal	Patients, clinicians and the carers working with them will have technology designed to help them. They will have a digital service for managing their interactions with the NHS, a view of their record, care plan, expectations, appointments and medications, to enable care to be designed and delivered in the place that is most appropriate for them.	Self management	Digital	NHS Digital - Empower the Person				The NHS website provides high-quality advice and information with around 40million visits a month. There is a library of health apps which are NHS assured as secure and safe to use. NHS 111 Online is live across 100% of CCGs, enabling their populations to access the same urgent medical help and advice as the NHS 111 telephone service, online. NHS WiFi provides free online access to over 50million people, and our widening digital participation programme seeks to ensure that nobody is left behind by increased digitisation.	A private beta test of the NHS App, will provide a core suite of services that allows people to manage their interactions with their NHS services more effectively, started in areas in England in September 2018, and will be rolled out publicly from early 2019. The NHS App is underpinned by a single NHS login to enable secure connection to NHS digital services, enabling people to authenticate themselves online, rather than still having to go to their GP in person to do so.			Chapter 5 - 5.20

Long Term Plan - Personalised Care

ENABLERS								**London**		**Trajectory**	**National**		**STP level**		
Category	**Intervention**	**Personalisation score out of 10**	**Level of personalised care**	**Enablers**	**Theme** Digital: 6 Workforce: 6 Self management: 5 Medicine: 1 Risk stratification: 1 Patient choice: 1	**Clinical area**	**Programme**	**Current activity**	**Planned activity**		**Current activity**	**Planned activity**	**Current activity**	**Planned activity**	**Where in LTP**
Access to records, reminders and alerts	Digitally enabled primary and outpatient care	5	Universal	Digital technology will provide convenient ways for patients to access advice	Self management	Digital	NHS Digital - Empower the Person	HLP proactive care team have provided oversight of a project commissioned by NHSE to train social prescribing champions in Merton and Wandsworth using a digital platform for helping people navigate local services and activities.							Chapter 4 - 1.43
Access to records, reminders and alerts	Access to virtual services	5	Universal	Patients will be able to access virtual services alongside face-to-face services via a computer or smart phone. We will continue to invest in the nhs.uk platform so that everyone can find helpful advice and information regarding their conditions	Self management	Digital	Digital	STP AOs have agreed the use of £1.4m regional monies to support Digital First, which has been match-funded by NHS England (national) MOUs established between National / TH CCG / Lead CCG within STPs to govern funding transactions. National discovery programme (Nov '18 – Jan '19) complete working with three online consultation vendors (Livi, eConsult and Qdoctor) to test NHS App integration. NWL (Brent CCG) and NCL (60 practices) have identified accelerator sites. Planning phase complete.	Confirm accelerator sites for NEL, SWL, SEL. Design, implementation and testing across accelerator sites by March 2019.	2023/24					Chapter 4 - 1.43
Access to records, reminders and alerts	Mainstream digitally enabled care	4	Universal	When ill, people will be increasingly cared for in their own home, with the option for their physiology to be effortlessly monitored by wearable devices. People will be helped to stay well, to recognise important symptoms early, and to manage their own health, guided by digital tools.	Self management	Life course	NHS Digital - Empower the Person								Chapter 5
Enabler: Access to records, reminders and alerts	Better care for Diabetes - education and self management	5	Targeted	We will support people who are newly diagnosed to manage their own health by further expanding provision of structured education and digital self-management support tools, including expanding access to HeLP Diabetes an online self-management tool for those with type 2 diabetes.	Self management - Diabetes	Diabetes	NHSE L - Diabetes	Structured education is part of the London Region Diabetes "Treatment and Care" programme with a structured education offer in all STPs. In 18/19 £1.457m was invested in structured education in London, with the objective to deliver structured education to and additional 10% of newly diagnosed people with diabetes.	As a structured education offer currently in place in London, planned activity is to on to support delivery and assure progress.	2018/19	HeLP is still a nationally led programme. Regions are currently waiting on national direction on roll out as evaluation is on-going.		The following STPs received funding for structured education following bids for Treatment and Care allocative funding: NEL:£0.034m SEL: £0.843m NWL: £0.58m Funding for structured education usually becomes self funded by the STP once the programme is in place.		Chapter 3 - 3.79
Advances to medicine	Better care for CVD - personalised planning	4	Targeted	When admitted to hospital, we will improve rapid access to heart failure nurses so that more patients with heart failure, who are not on a cardiology ward, will receive specialist care and advice. Better, personalised planning for patients will reduce nights spent in hospital and reduce drug spend.	Workforce	CVD	NHS E - CVD	Phil/ Trudy? - Personalised care element							Chapter 3 - 3.70
Pathway redesign	Emergency Mental Health Support	5	Specialist	In the next ten years we will ensure that anyone experiencing mental health crisis can call NHS 111 and have 24/7 access to the mental health support they need in the community and we will set clear standards for access to urgent and emergency specialist mental health care.	Workforce - mental health	Mental Health	HLP - Crisis Mental Health	The pan-London section 136 pathway was developed by service users and partners in 2016 to improve the care of Londoner's detained under s136 of the Mental Health Act. Since launched by the Mayor of London in late 2016, significant work has taken place across London to implement this new model of care, doing so by continuing the collaborative multi-agency approach as well as aligning with legislation changes of the Mental Health Act. South London and Maudsley Mental Health Trust (SLaM) are the pioneers in London having piloted the London model at their all-age centralised centre of excellence at the Maudsley Hospital which offers a 24/7 dedicated service. SLaM's new site has been evaluated and after 18months of operation significant benefits have been seen across the adult and children's service including quicker handovers from the police and ambulance to Trust staff, reduced inpatient admissions (18% reduction) and Emergency Department attendances for those in crisis as well as better staff and service user experiences.	Proposed pan-London Health Based Place of Safety site configurations were developed based on this model following an extensive options appraisal process. The options appraisal focussed on the optimal number of sites for London (based on 24/7 staffed service), London's preferred sites based on criteria such as prevalence and proximity to urgent care and inpatient beds as well as the preferred configuration of sites for an equitable pan-London model of care. More recently, each STP has developed local implementation plans in line with the London model and proposed configurations and are progressing these with a view to implement the new model by 2020. Pan-London support will continue to help local systems implement the new model by 2020 including workforce modelling, engagement support including material for local authorities and Health Overview Scrutiny Committees, pan-London evaluation of the new model with consistent success measures and reviewing commissioning & payment processes.	2020					Chapter 3 - 3.97
Pathway redesign	Emergency Mental Health Support - crisis	5	Targeted	The NHS will ensure that a 24/7 community-based mental health crisis response for adults and older adults is available across England by 2020/21. Services will be resourced to offer intensive home treatment as an alternative to an acute inpatient admission.	Workforce - mental health	Mental Health	HLP - Crisis Mental Health - Emily/ Patrice			2020					Chapter 3 - 3.96
Skilled workforce	Mental health support of children and young people - schools	5	Universal	Over the next five years the NHS will fund new Mental Health Support Teams working in schools and colleges, building on the support already available, which will be rolled out to between one-fifth and a quarter of the country by the end of 2023.	Workforce - mental health	CYP mental health	HLP/ NHS E mental health		Following the publication of the Government's response to the Green Paper for transforming children and young people's Mental Health, the London Region has been awarded over £7million to support 7 trailblazer pilot areas. By December 2019, there will be 15 Mental Health Support Teams operational to support schools across these pilot areas, with at least two teams in each of London's Sustainability and Transformation Partnership areas. Mental Health Support Teams will provide evidence based interventions for children and young people with mild-moderate mental health conditions and will further support London's ambitions to ensure that children and young people in need of mental health support are able to access it when they need it. Four of the pilot areas are also testing a four week waiting-time standard for access to children and young people's Mental Health services.						Chapter 3 - 3.28
Skilled workforce	Ways of working	5	Universal	Creating genuine partnerships requires professionals to work differently, as well as a systematic approach to engaging patients in decisions about their health and wellbeing. We will support and help train staff to have the conversations which help patients make the decisions that are right for them.	Workforce development			London Social Prescribing mapping survey results from Feb 2019 showed there are currently 205 members of paid social prescribing staff across London. The survey showed a total of 439.5 volunteers in London, an increase of 262.5 volunteers since 17/18.	NHS England will provide funding directly to primary care networks for a new, additional social prescribing link worker to be embedded within every primary care network multi-disciplinary team, through the Network Contract Direct Enhanced Service (DES).				The Universal Personalised Care - Implementing the Comprehensive Model sets out the workforce delivery and development plans.		Chapter 1 - 1.37
Skilled workforce	End of life - personalised care planning	4	Targeted	By rolling out training to help staff identify and support relevant patients, we will introduce proactive and personalised care planning for everyone identified as being in their last year of life.	Workforce development - end of life	End of life care									Chapter 1 - 1.42

Long Term Plan - Personalised Care
AMBITIONS

Category	**Level of personalisation**	**Intervention**	**Ambition**	**Theme**	**Clincal area**	**Where in LTB**
Commissioning Control	Specialist	Learning difficulties and autism - specialist care offer	Every local health system will be expected to use some of this growing community health services investment to have a seven-day specialist multidisciplinary service and crisis care.	Workforce	Learning disabilities	Chapter 3 - 3.35
Choice over access	Specialist	Learning difficulties and autism - personalised care	Increased investment in intensive, crisis and forensic community support will also enable more people to receive personalised care in the community, closer to home, and reduce preventable admissions to inpatient services.	Workforce	Learning disabilities	Chapter 3 - 3.35
Choice over access	Universal	Personalisation	More differentiated in its support offer to individuals - responsiveness to the diverse people who use and fund our health care system	Integrated personalised care	Personalisation	Chapter 1
Commissioning Control	Specialist	Shared responsibility for health	Over the next five years the NHS will ramp up support for people to manage their own health. This will start with diabetes prevention and management, asthma and respiratory conditions, maternity and parenting support, and online therapies for common mental health problems.	Integrated personalised care	Long-term conditions	Chapter 1 - 1.38
Choice over access	Universal	Short waits for routine operations	Patients will continue to have choice at point of referral and anyone who has been waiting for six months will be specifically contacted and given the option of faster treatment at an alternative provider, with the NHS money following the patient to fund their care.	Pathway design	Elective Care	Chapter 1 - 1.35
Personalisation	Universal	Personalisation	People will get more control over their own health, and more personalised care when they need it.	Integrated personalised care	Personalisation	Chapter 1
Commissioning Control	Targeted	Personal health and social care budgets	We will continue to support local approaches to blending health and social care budgets where councils and CCGs agree this makes sense, one option shown to work is individual service user budget pooling through personal health and social care budgets;	Integrated personalised care	PHBs	Chapter 4 - 1.58
Access to records, reminders and alerts	Specialist	Home based/ wearable monitoring	We will support advances in these care models over the next five years. To do so requires major work to digitise community. As well as deploying technology to support community staff, we will expand the scope of the existing Community Dataset to standardise information across the care system and integrate it with Local Health Care Records (LHCRs).	Integrated personalised care	Digital	Chapter 1 - 1.18

Universal Personalised Care - Implementing the comprehensive model

Category	Target	Clinical area	Where
Universal Personalised Care - Implementing the comprehensive model	Fully embed the six standard components of the universal care model 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 reach 5 million by 2028/29. Over 300,000 people will benefit from personalised care in these areas by the end of 2018/19	All	Action 1
Universal Personalised Care - Implementing the comprehensive model	Full delivery of the Comprehensive Model across a number of ICSs and STPs in 2018/19 and 2019/20.	All	Action 2
Universal Personalised Care - Implementing the comprehensive model	Support other personalised care demonstrator sites - Tower Hamlets & Islington. 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 will benefit from personalised care in these areas by the end of 2018/19. (Proportionate to London)	All	Action 2
Universal Personalised Care -	Include personalised care in the ICS accountability and performance framework to ensure that all ICSs reflect personalised care.	All	Action 2
Shared decision making	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.	Primary Care	Action 4
Shared decision making	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 training from 2020/21 for professionals, including nurses and allied health professionals.	Primary Care	Action 4
Personalised Care	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. 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.	Primary Care	Action 4
Personalised Care	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.	Primary Care	Action 4
Shared decision making	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'	Primary Care	Action 4
Personalised Care	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.	Nursing & Midwifery Allied Care Professionals Social Care	Action 4
Shared decision making	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	Personalised Care	Action 5
Personalised Care	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.	Personalised Care	Action 5
Personalised Care	Expand the 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.	Personalised Care	Action 5

Universal Personalised Care - Implementing the comprehensive model

Category	Target	Clinical area	Where
Personalised Care	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.	Personalised Care	Action 5
Personalised Care/ Shared decision making	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.	Personalised Care	Action 5
Personalised Care	Building on this, we will launch a fully-certified personalised care training programme by the end of 2020/21.	Personalised Care	Action 5
Personalised Care	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.	Personalised Care	Action 5
Shared decision making	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'.	Personalised Care	Action 6
Shared decision making	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.	Personalised Care	Action 6
Shared decision making	From April 2019 onwards, for each clinical situation we will: Work with the 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	Personalised Care	Action 6
Shared decision making	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.	Personalised Care	Action 6
Shared decision making	Personalised care will be at the heart of work on 'rethinking medicine' This is a parallel approach to the Scottish 'Realistic Medicine' work, 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.	Personalised Care	Action 6
Social Prescribing	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	Personalised Care	Action 8
Social Prescribing	We will publish a standard, replicable model and common outcomes framework. 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.	Personalised Care	Action 8
Social Prescribing	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.	Personalised Care	Action 8
Social Prescribing	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	Personalised Care	Action 8

Universal Personalised Care - Implementing the comprehensive model

Category	Target	Clinical area	Where
Personalised Care	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.	Personalised Care	Action 9
Personalised Care	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.	Personalised Care	Action 10
PHBs	Exceed our PHB Mandate goals to deliver at least 40,000 PHBs by March 2019 and at least 100,000 PHBs by 2020/21 (Proportionate to London)	Personalised Care	Action 11
PHBs	Complete the transition from the wheelchair voucher scheme to personal wheelchair budgets.	Personalised Care	Action 11
PHBs	Subject to the final evaluation findings, expand PMCBs to support 100,000 women per year by 2021/22. (Proportionate to London)	Personalised Care	Action 11
PHBs	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. (Proportionate to London)	Personalised Care	Action 12
PHBs	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.	Personalised Care	Action 12
PHBs	From 1st April 2019 PHBs will be the default model for all home-based CHC services	Personalised Care	Action 12
PHBs	A total of 200,000 people will be supported by PHBs by 2023/24. (Proportionate to London)	Personalised Care	Action 15
Social Prescribing	To support local delivery of Personalised Care 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. (Proportionate to London)	Personalised Care	Action 16
Personalised Care	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. (Proportionate to London)	Personalised Care	Action 18
Personalised Care	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. (Proportionate to London)	Personalised Care	Action 18
Personalised Care	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.	Cancer	

GMS Contract - A five-year framework for GP contract reform to implement The NHS Long Term Plan

Category	Target	Trajectory	Clinical area	Where
Enabler: Access to records, reminders and alerts	With new registrants having full online access to prospective data from April 2019	Apr-19	Primary Care - digital	
Choice over access	All practices will ensure at least 25% of appointments are available for online booking by July 2019	Jul-19	Primary Care - digital	
Personalised Care	Through a new Additional Roles Reimbursement Scheme, Primary Care Networks (PCNs) will be guaranteed funding for 100% of the costs of additional social prescribing link workers	2019/20	Personalised Care	
Personalised Care	QOF reform - introduction of personalised care adjustment	2019/20	Primary Care	
Choice over access	NHS England will launch a public campaign in 19/20 to raise awareness of the ability to book appointments online	2019/20	Primary Care - digital	
Enabler: Access to records, reminders and alerts	All patients will have online access to their full record, including the ability to add their own information, as the default position from April 2020	Apr-20	Digital	
Choice over access	All practices will be giving all patients access online to correspondence by April 2020, as the system moves to digital by default	Apr-20	Primary Care - digital	
Personalised Care	The NHS Long Term Plan commits to delivering personalised care to all cancer patients by 2021, ensuring that every person with cancer has the best possible care, quality of life and system resources are utilised effectively. Primary Care Networks will have a responsibility for doing their part, alongside the Cancer Alliances and other local partners, and this will be reflected in the service specification.	2021	Cancer	
Personalised Care	The NHS Long Term Plan committed to the full roll out of the NHS Comprehensive Model for Personalised Care. This model has been developed and tested over the past three years, and it will now be delivered in full by Primary Care Networks under the Network Contract DES by 2023/24.	2023/24	Personalised Care	6.22
Personalised Care	The Comprehensive Model is expected to benefit 2.5 million people by 2023/24, including over 900,000 referrals for social prescribing	2023/24	Personalised Care	
Choice over access	Subject to systems capability, where patients wish, and as part of concluding the NHS 111 call, NHS 111 could book into these appointments on their behalf where that is appropriate, rather than requiring patients to do so in a separate process;		Primary Care/ IUC - digital	
Enabler: Access to records, reminders and alerts	As a critical enabler of the Personalised Care service specification outlined in chapter 6, practices will also have the critical role in creating and updating care plans for all appropriate patients, in as near to real-time as possible, to the Summary Care Record and to Local Health and Care Records when they are available. This will enable patients, their carers and professionals involved in their care are able to see the same information.		Primary Care - digital	

Personalised Care	In England, general practice is based on traditions that are partly psycho-social as well as bio-medical. Consistent with that heritage, this service specification is intended to avoid over-medicalising care, and ensure patients are asked by the primary care team “What matters to you?”, not just “What’s the matter with you?”52. It is about engaging people fully, sharing control, and connecting them to wider societal support. The model partly reflects the wider movement led by doctors for ‘rethinking medicine		Personalised Care	6.23
Personalised Care	For both the complex care and personalised care service specifications, requirements and expectations will increase over the following three years in line with workforce expansion. As part of the national requirements, a Primary Care Network will need to contribute to their ICS plan, and the ICS will also need to set out what it is doing locally, given some of the services are best delivered within a framework of wider local coordination and support.		Personalised Care	
Social Prescribing	By 2024, clinical pharmacists, social prescribing link workers, physician associates, first contact physiotherapists and first contact community paramedics will have become an integral part of the core general practice model throughout England – not just ‘wrap around’ support that could instead be redeployed at the discretion of other organisations.			
Social Prescribing	Between 1 July 2019 until 31 March 2020, every network of at least 30,000 population will be able to claim 100% funding for one additional WTE social prescribing link worker. This will deliver by 2020 on the government’s commitment in the loneliness strategy that by 2023 all local systems will have implemented social prescribing connector schemes.			
Social Prescribing	Beyond 100,000 network size, the 2019/20 reimbursement scheme doubles to two social prescribers; with a further WTE of each, for every additional 50,000 network population size. Were a single ‘super-practice’, covering 200,000 patients, agreed as a network by its CCG in line with national rules, it would be eligible for four additional of each in 2019/20			
Social Prescribing	With agreement from the CCG, the 2019/2020 entitlement could be used to vary between numbers of clinical pharmacists and social prescribers, e.g. a typical network could hire two clinical pharmacists or two social prescribing link workers instead of one of each.			

Name	Programme	Organisation	Contact	Job Title
James Hempsted	Digital	NHSE/ HLP	jameshempsted1@nhs.net	Head of Primary Care Digital Technology – NHS E Digital Transformation Team Lead – HLP
Mark Kewley	Digital	NHSE	mark.kewley@nhs.net	Director of Strategic Development for Digital, NHSEL
Jo Fulton	LHCRE	NHSE	j.fulton@qmul.ac.uk	
Shona Ash	Empower the Person	NHS D	s.ash@nhs.net	EtP Implementation Lead
Richard Anderson	Digital	NHS D	richard.anderson81@nhs.net	Principal Relationship Manager
Leanne Summers	Empower the Person	NHS D	leanne.summers1@nhs.net	Digital Strategy Delivery Lead | Empower the Person
Pip Hodgson	Empower the Person	NHS D	phillipa-rose.hodgson@nhs.net	
Andy Martin	CYP/ Mental Health	HLP	andy.martin3@nhs.net	
Tracy Parr	CYP	HLP	tracyparr@nhs.net	Director of Transformation - CYP
Emily Treder	Crisis Mental Health	HLP	e.treder@nhs.net	
Fola Omotunde	IAPT	HLP	fola.omotunde@nhs.net	Programme Manager – London Digital IAPT
Anne Whately	Primary Care	NHSE	a.whateley@nhs.net	Director of Primary Care Commissioning and Transformation
Liz Wise	Cancer	NHSE	liz.wise1@nhs.net	Regional Director – Cancer Transformation and Improvement
Shaun Crowe	Diabetes	NHSE	Shaun.Crowe@nhs.net	Clinical Network Lead
Tarita Turtiainen	Diabetes	NHSE	tarita.turtiainen@nhs.net	
Kara Renno	Maternity	NHSE	k.rennno@nhs.net	Senior Healthcare Consultant
Matt Noonan	Elective Care	NHSE	Matt.Noonan@nhs.net	Head of Elective Care Improvement Programme
Leanne Summers	Empower the Person	NHSE	leanne.summers1@nhs.net	Digital Strategy Delivery Lead
Trudy Reynolds	Personalised Care	NHSE	Trudy.reynolds2@nhs.net	Head of Personalised Care
Steven Pruner	Personalised Care	NHSE	steven.pruner@nhs.net	Senior Manager Personalised Care
Emma Christie	London Commissioning Operations	NHSE	emma.christie2@nhs.net	Head of Assurance