Healthy London Partnership

# Universal Personalised Care

The vision and approach of universal personalised care for London following the publication of the NHS Long Term Plan

Supported by and delivering for:

Public Health England

NHS

LONDON COUNCILS

SUPPORTED BY MAYOR OF LONDON

**London's NHS organisations include all of London's CCGs, NHS England and Health Education England**

## Contents

Healthy London Partnership

# Introduction

Healthy London Partnership

This resource pack sets out the context for the personalised care agenda in London, which is an underpinning theme of the Long Term Plan (LTP).

- It is integral that personalised care is considered business as usual across all health and social care provision in order to deliver the Long Term Plan and ensure Londoners have more control over their health. Joined up working is required nationally, regionally and locally to deliver on this ambition.

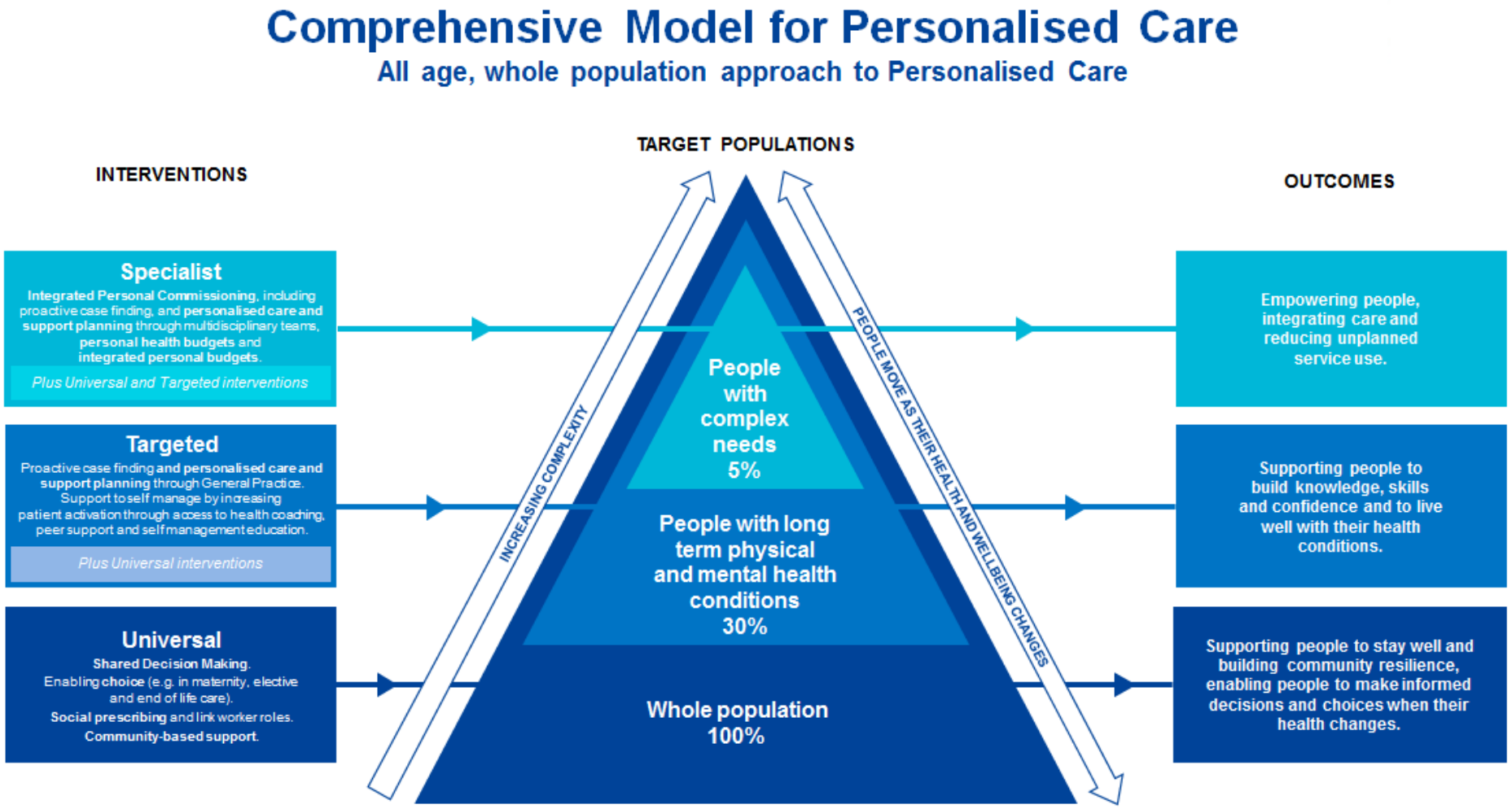
- Personalised care takes a whole-system approach, integrating services including health, social care, public health and wider services around the person. Personal health budget delivery (PHBs) already uses an integrated approach, joining up health and social care to support complex individual needs. A systematic approach to the delivery of personalised care is an opportunity to further STPs' existing ICS transformation plans and bring additional benefit for the whole of London.

- The evidence shows how personalised care can contribute to reducing health inequalities. Personalised care takes account of people's different backgrounds and preferences, with people from lower socioeconomic groups benefiting the most.

- STPs can and should capatilise on the opportunities of the Long Term Plan and the Mayors Health Inequalities Strategy for personalised care to underpin the health and social care in London for to drive improvement across the system.

# What is personalised care?

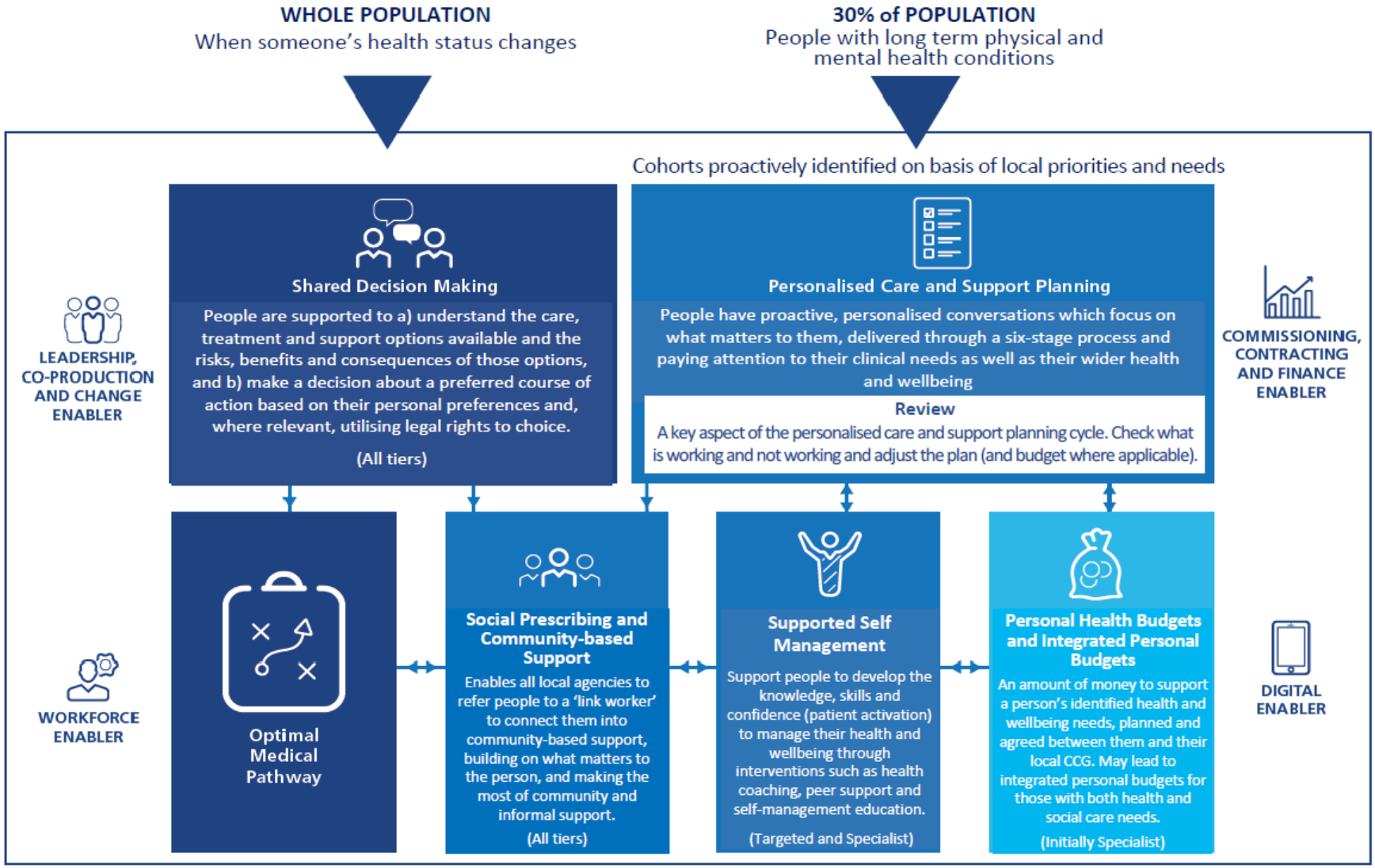
Personalised care represents a new relationship between people, professionals and the system. People access personalised care through six key components. This model demonstrates how these come together to deliver an all age, whole population approach to personalised care.




https://www.england.nhs.uk/wp-content/uploads/2019/02/comprehensive-model-of-personalised-care.pdf

# Personalised Care Operating Model

Making personalised care an everyday reality for people 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. This model shows how the six components and these enabling factors all fit together.



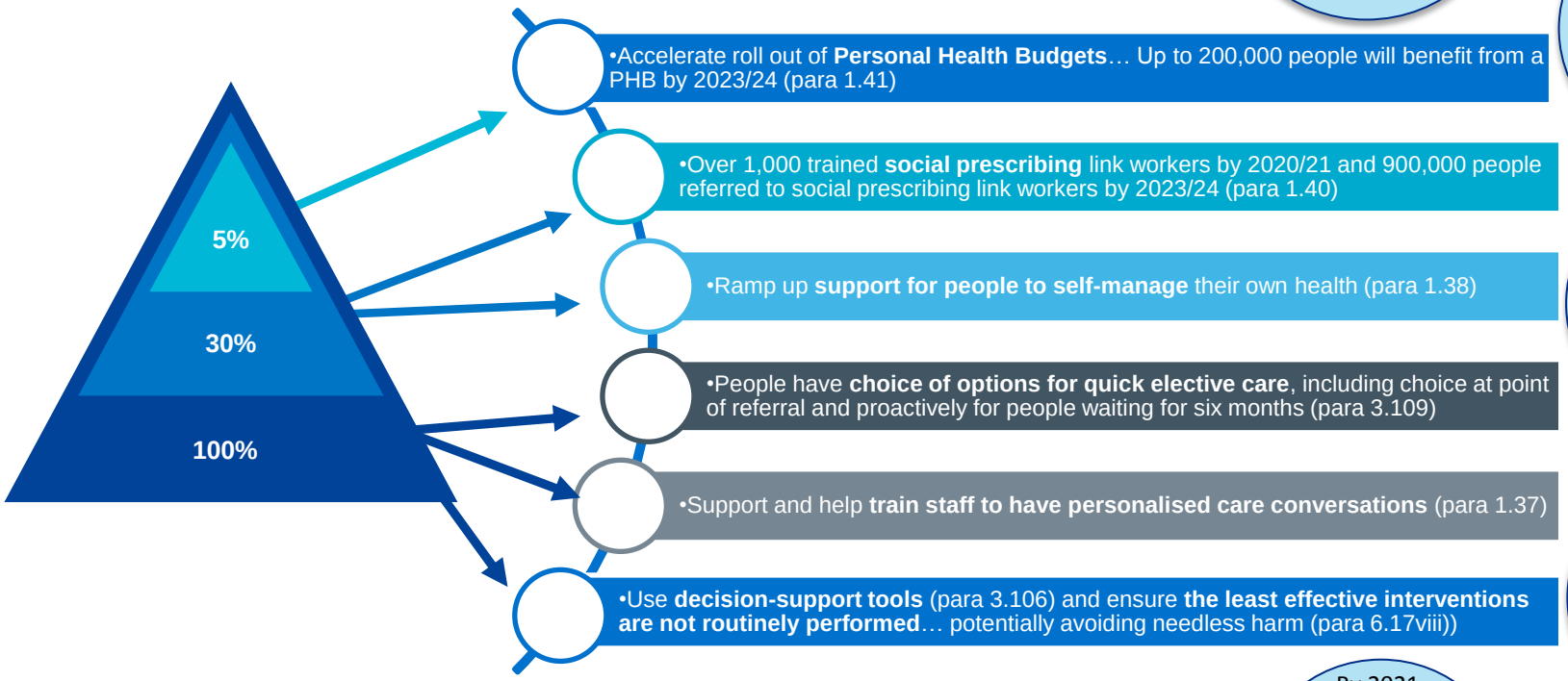

https://www.england.nhs.uk/personalisedcare/upc/comprehensive-model/

# Personalised Care commitments in LTP

Personalised Care is an underpinning theme of the LTP. The info-graphic illustrates the range of commitments across the LTP and where they fit in the comprehensive model. In order to achieve universal personalised care, it needs to be embedded into every clinical pathway. The LTP has set targets for many transformation programmes - examples of which are given below.

By 2023/24, all women will have access digital **maternity** notes

**Mental Health** Support Teams in schools and colleges will be rolled out to between 20% and 25% of the country by the end of 2023.




By 2020, patients with a **long-term condition** will access their health record through the Summary Care Record via the NHS App.

By 2020/21, all pregnant women with type 1 **diabetes** will be offered continuous glucose monitoring

By 2021, people with **cancer** will have access to personalised care

https://www.england.nhs.uk/long-term-plan/

# Current London personalised care activity

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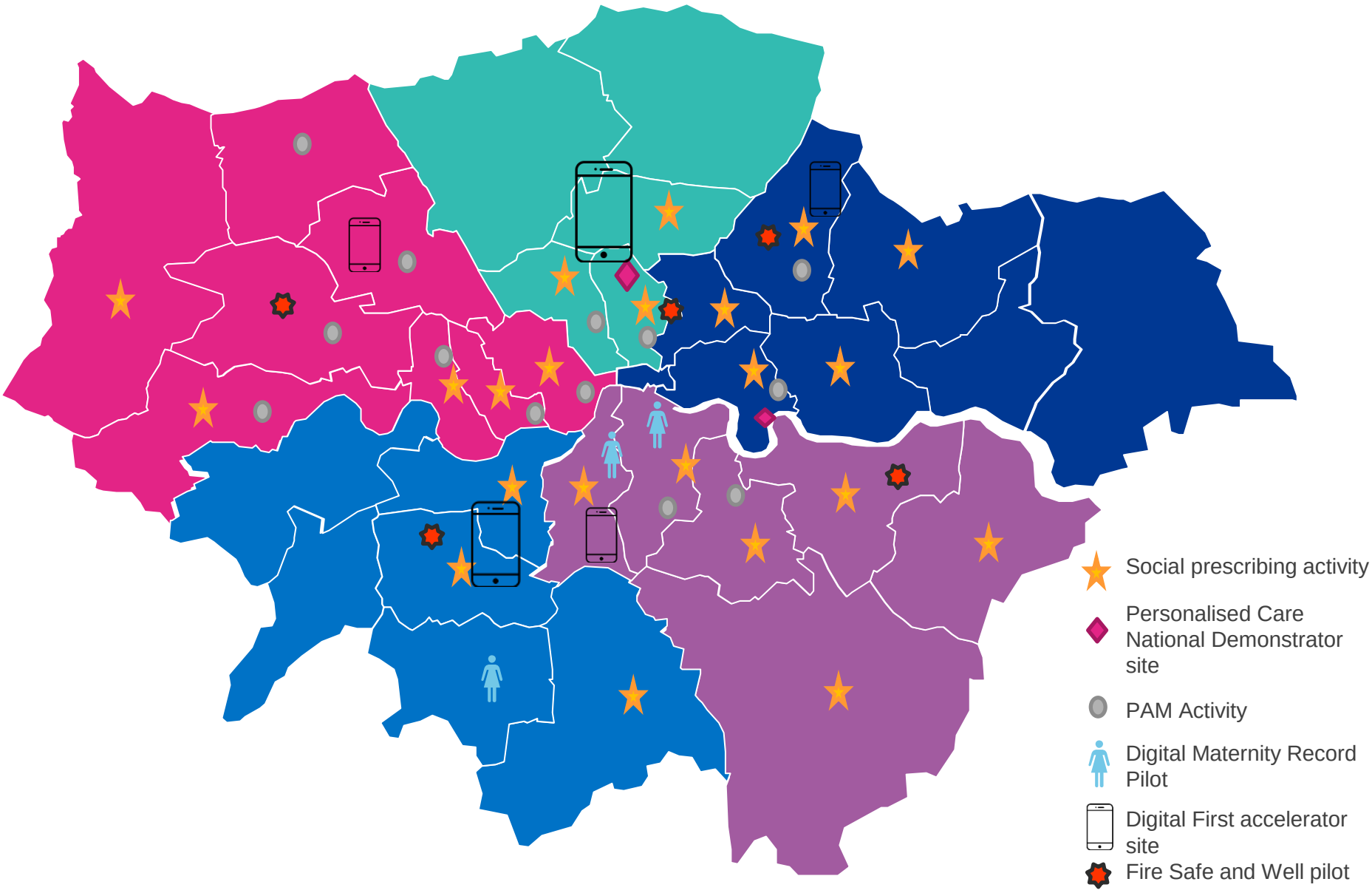

## Once for London highlights

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- **One London** - Local Health and Care Record Exemplar (LHCHE) is a key enabler for improving and coordinating individual care. The programme will create an information sharing environment that ensures that care is tailored to the needs of each individual, empowers people to look after themselves better and make informed choices about their own health and care.
- The **NHS app** will be rolled out in July 2019 – providing a digital front door to NHS services
- London's **Digital First** vision for unscheduled care will streamline patient flows across primary and urgent care services for unscheduled care needs, reducing inappropriate demand into general practice or ED/LAS where patients can access the right clinical skillset first time
- The **London Vision for Social Prescribing** will be published in May 2019, with the aim make London a healthier, fairer city where people have an equal opportunity to live their life in good health
- The **electronic maternity health record** is currently being piloted in Kings, Epsom & St. Helier and GSTT, enabling women to take greater control of their health and care through accessing a range of information, digitally. Learning from these sites will be used to extend coverage to all pregnant women in London by 2023/24.

# Learning's from the London analysis

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- Personalised care is a **priority across health and social care**, with the expectation that Londoners need to access their health services in increasingly flexible ways, to ensure they can manage their health care in a way that suits their needs and fits within increasingly busy and complex lives.
- There is an expectation of STPs to incorporate personalised care into **LTP implementation** plans to better serve their population needs. Personalised care needs to be **embedded by CCGs** across all pathways and transformation delivery groups.
- Huge amounts of activity is taking place to ensure people have choice and control over the way their care is planned and delivered, this ranges from social prescribing, to improving the uptake of personal health budgets.
- Currently, **London is behind the curve** and progressing slower than other regions to deliver personalised care as part of the universal offer and across pathways. At the end of Q3 18/19, 2,878 PHBs have been delivered in London. Nationally, 40,344 people have a personal health budget in this time period.
- Developments to personalised care are **not consistent across London**, widening disparity across the capital.
  - 24 of 32 London CCGs have a social prescribing offer in place
  - London is currently under 70% compliant for the 9 Choice Standards
  - Of the 42,000 PAM licences allocated up to Q3 2018/19, 32,000 of these were in NWL
- There is a need to **align and build on existing personalised approaches** that have been adopted by both social care and health in local authorities, the GLA, CCGs, STPs other local agencies, the voluntary and community sector and people with lived experience all working together.
- Personalised care spans across the social determinants of health, offering a robust opportunity to **take action on health inequalities.** People in lower socioeconomic groups 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. (PHBs)

## Gaps - Aligning activities

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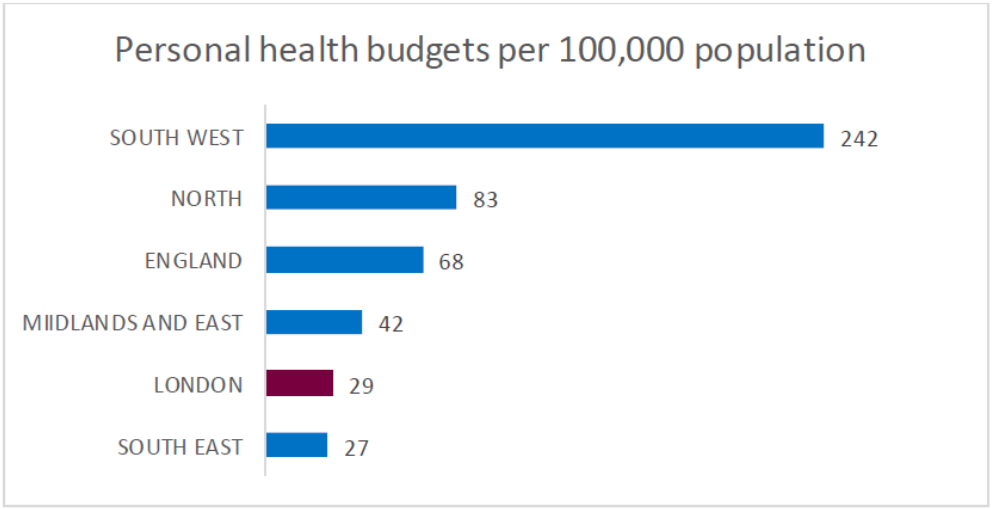
- The roadmap brings together the main commitments set out by NHS England to implement Personalised Care across health and care to **reach 400,000 Londoners** by 2023/24 and then aiming to double that again within a decade.
- Over **100 commitments** have been drawn out from the Long Term Plan, Universal Personalised Care Model and GP Contract Reform which impact on personalised care. Responsibility for the roll out of these commitments lies at a national, regional and local level, requiring an **integrated approach** to ensure maximum impact for the capital.
- Currently there is less presence of personalised care in London due a reduced number of demonstrator sites compared to other parts of the country and **no level 1 demonstrator** (STP or ICS led) in the region.
- In London much of the work has been **developed organically** within boroughs or across a small number of boroughs. In order to scale and spread this work and bring London on par with the rest of the country, systematic leadership is required to ensure personalised care is business as usual.
- STP areas have expressed the need to **establish care models that are more integrated**. Embedding personalised care as part of the development of ICSs is a way to move beyond the structural and cultural distinctions within and between national and regional bodies and commissioning and provider sectors at the sub-regional scale.

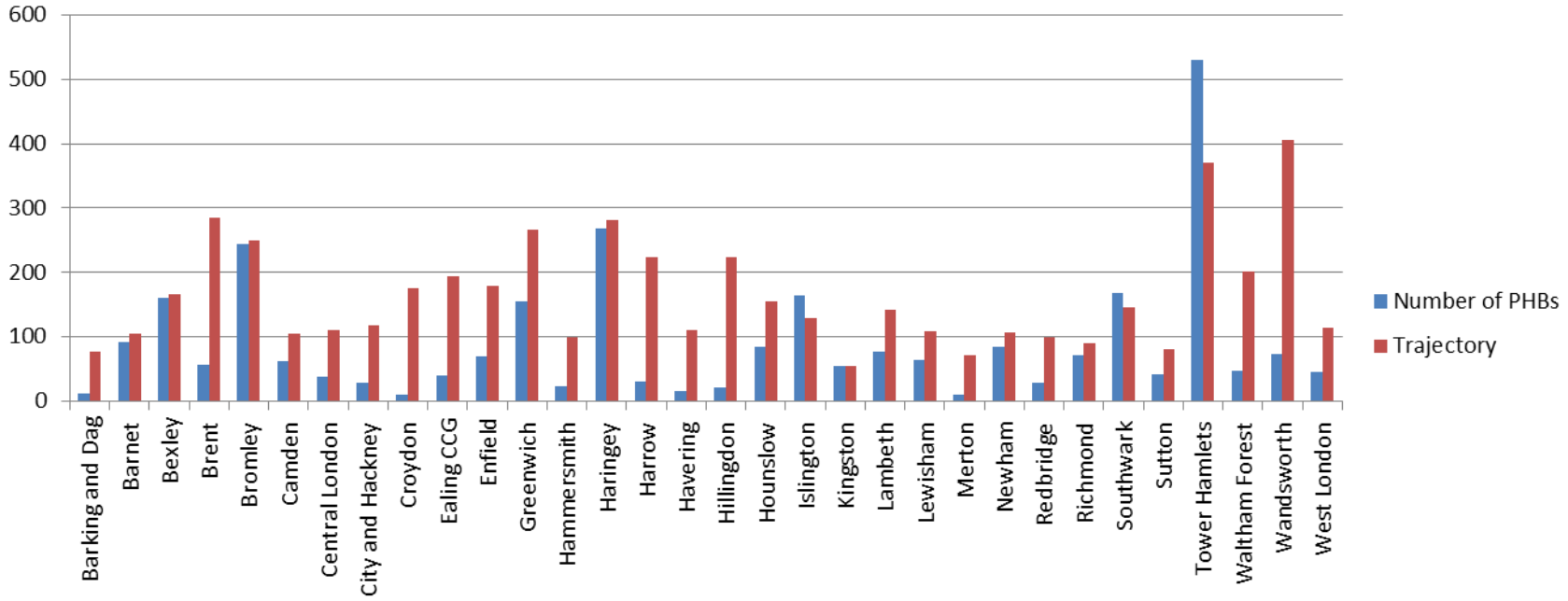
# London – PHB baseline data

Healthy London Partnership

NHS England




## Q3 PHB performance against planned trajectory



# London – Personalised Care baseline data

Healthy London Partnership

NHS England

| STP | PHBs per 100,000 | Number of PHBs | Proportion of London PHBs | PAM licences | Social prescribing |
|---|---|---|---|---|---|
| North East | 33 | 746 | 25.9% | 3393 | 7/ 7 CCGs |
| North Central | 61 | 657 | 22.8% | 1313 | 4/ 5 CCGs |
| North West | 15 | 341 | 11.8% | 20225 | 6 / 8 CCGS |
| South East | 48 | 871 | 30.3% | 1164 | 3 / 6 CCGs |
| South West | 18 | 263 | 9.2% | 0 | 5 /6 CCGs |

**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

# Opportunities – Once for London

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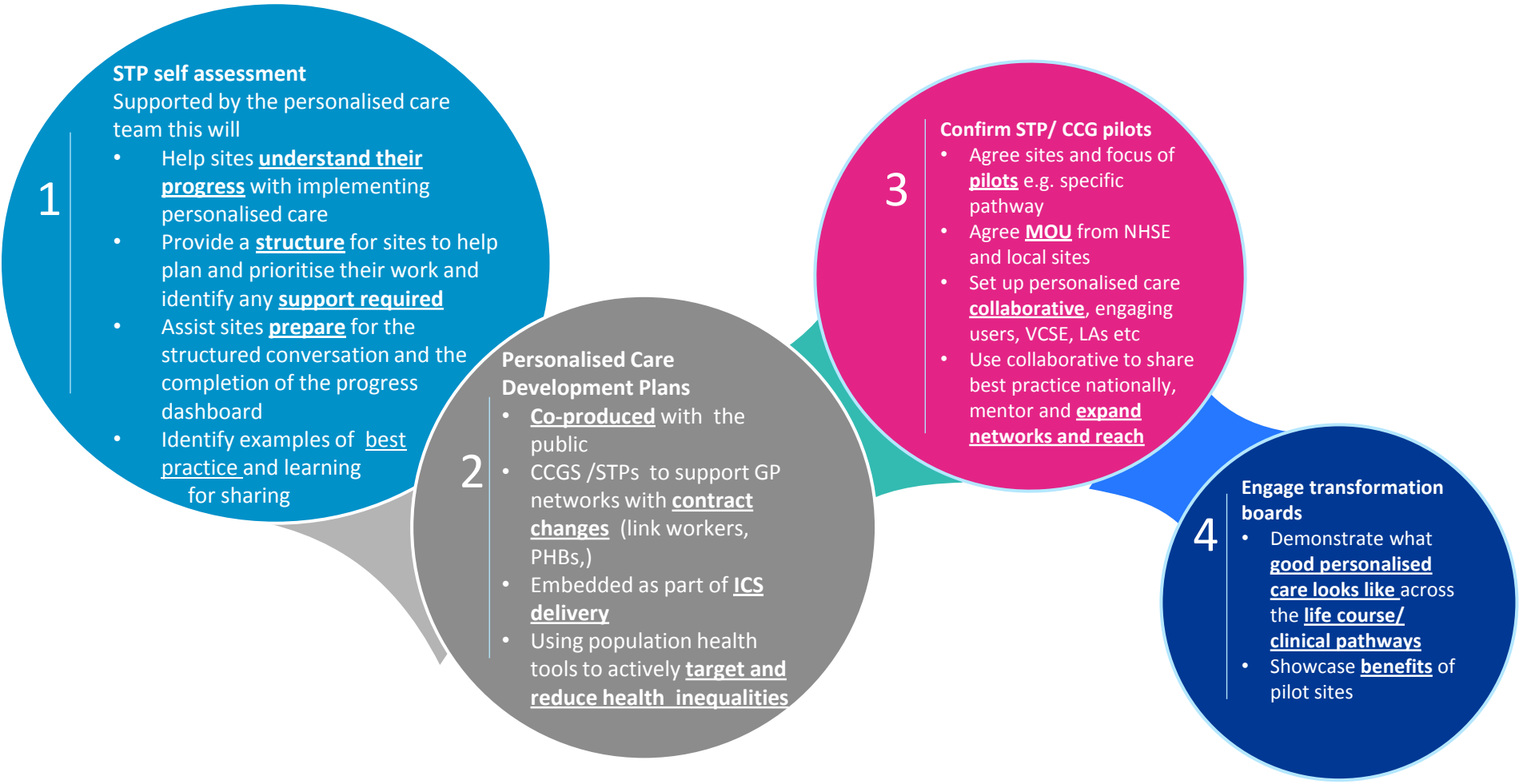
NHS England

The LTP, Universal Personalised Care Model, GP contract and Health Inequality Strategy sets an ambitious objective to make personalised care business as usual across the health and care system. The following model shows how London can ascertain a baseline for personalised care and work with communities to develop and deliver a plan to systematically reduce health inequalities, further STPs' existing ICS transformation plans and bring additional benefit for the whole of London.



## Annex A

Healthy London Partnership

- Detailed analysis spread sheet attached

# Appendix B: LTP – Personalised Care Roadmap for London

## 2019/20

GP practices will ensure at least 25% of appointments are available for online booking by July 2019

Digital First pilot

London Capacity Alerts pilot – 5 sites

Publish Social prescribing: our vision for London 2018-2028

There will be 15 Mental Health Support Teams operational to support schools across these pilot areas, with at least two teams in each London STP

Updated Flash Glucose Monitoring guidance for CCGs

Full roll out of the NHS app

Roll out of NHS 111 direct booking

Patients with a long-term condition will have access to their Summary Care Record accessed via the NHS App.

NHS England will launch a public campaign in 19/20 to raise awareness of the ability to book appointments online

Digital Maternity Care Record pilot

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

QOF reform - introduction of personalised care adjustment

Amend DHSC regulation to enable new rights to have PHBs in five further areas: end of life care, equipment, dementia, carers and neuromuscular diseases

## 2020/2021

Develop API capacity across all digital IAPT services

All pregnant women with type 1 patients will be offered CGM

Locally led

Regionally led

Nationally led

# LTP – Personalised Care Roadmap for London

| 2019/2020 | 2020/2021 | 2023/24 | →→→ |
|---|---|---|---|

Pan-London implementation of section 136/ Crisis Mental Health pathway

Individual's care plan will move to LHCR

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

All practices will be giving all patients access online to correspondence by April 2020, as the system moves to digital by default

Expand personal health budget offer - mental health, learning disabilities, social care support and specialist end of life care.

PCNs will 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

Deliver 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.

People will have access to their care plan and communications from their care professionals via the NHS app

Train social prescribing link workers

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.

Increase the number of social prescribing link workers with the aim that over 145,000 people are able to be referred to social prescribing schemes

Up to 32,000 people will benefit from a PHB

Full coverage of the Digital Maternity Care Record

All patients will be able to access GP digitally

All patients will be able to access a digital first primary care offer.

Locally led

Regionally led

Nationally led

# Universal Personalised Care - Implementing the comprehensive model

| 2019/2020 | 2020/2021 | 2023/24 |
|---|---|---|

New GP registrants having full online access to prospective data from April 2019

Develop an online social prescribing platform for commissioners and practitioners.

Ensure all people receiving home-based NHS CHC have this provided as a PHB by default

Complete the transition from the wheelchair voucher scheme to personal wheelchair budgets.

Locally led

Regionally led

Nationally led

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.

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

Develop workforce skills by embedding shared decision making and personalised care and support planning in pre- and post-registration professional training

Full roll out of the NHS Comprehensive Model for Personalised Care through Primary Care Networks under the Network Contract DES, to benefit 400,000 people by 2023/24, including over 145,000 referrals for social prescribing.

A total 32,000 people will be supported by PHBs by 2023/24.

Fully embed the six standard components of the universal care model across the NHS and the wider health and care system and will reach 400,000 people

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.

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

Fully embed the six standard components of the universal care model across the NHS and the wider health and care system and will reach 400,000 people

# Universal Personalised Care - Implementing the comprehensive model

| 2019/2020 | 2020/2021 | 2023/24 | →→→ |
|---|---|---|---|

Personalised care components will be included in GP education and training from 2019/20, equipping 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'

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.

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

Locally led

Regionally led

Nationally led

# GP Contract reform – Personalised Care Roadmap for London

| 2019/2020 | 2020/2021 | 2023/24 | →→→ |
|---|---|---|---|

QOF reform - introduction of personalised care adjustment

PCNs will be guaranteed funding for 100% of the costs of additional SP link workers

With new registrants having full online access to prospective data from April 2019

All practices will ensure at least 25% of appointments are available for online booking by July 2019

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

Locally led

Regionally led

Nationally led

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.

The Comprehensive Model is expected to benefit 400,000 people by 2023/24, including over 145,000 referrals for social prescribing

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 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.

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.

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

# Annex C – Additional information

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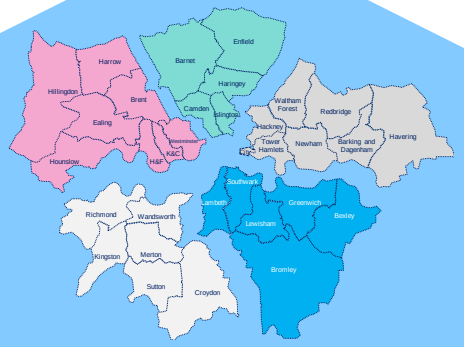
## Key highlights of personalised care delivery in London*

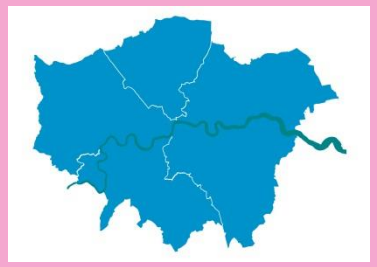
**Islington CCG and Tower Hamlets CCG are personalised care demonstrator sites**




**24 of 32 London CCGs have a social prescribing offer in place**

**In Q3 of 2018/19 there were 2,878 PHBs delivered in London compared to 5,248 which CCGs had committed to delivering**

**LHCRE – One London**



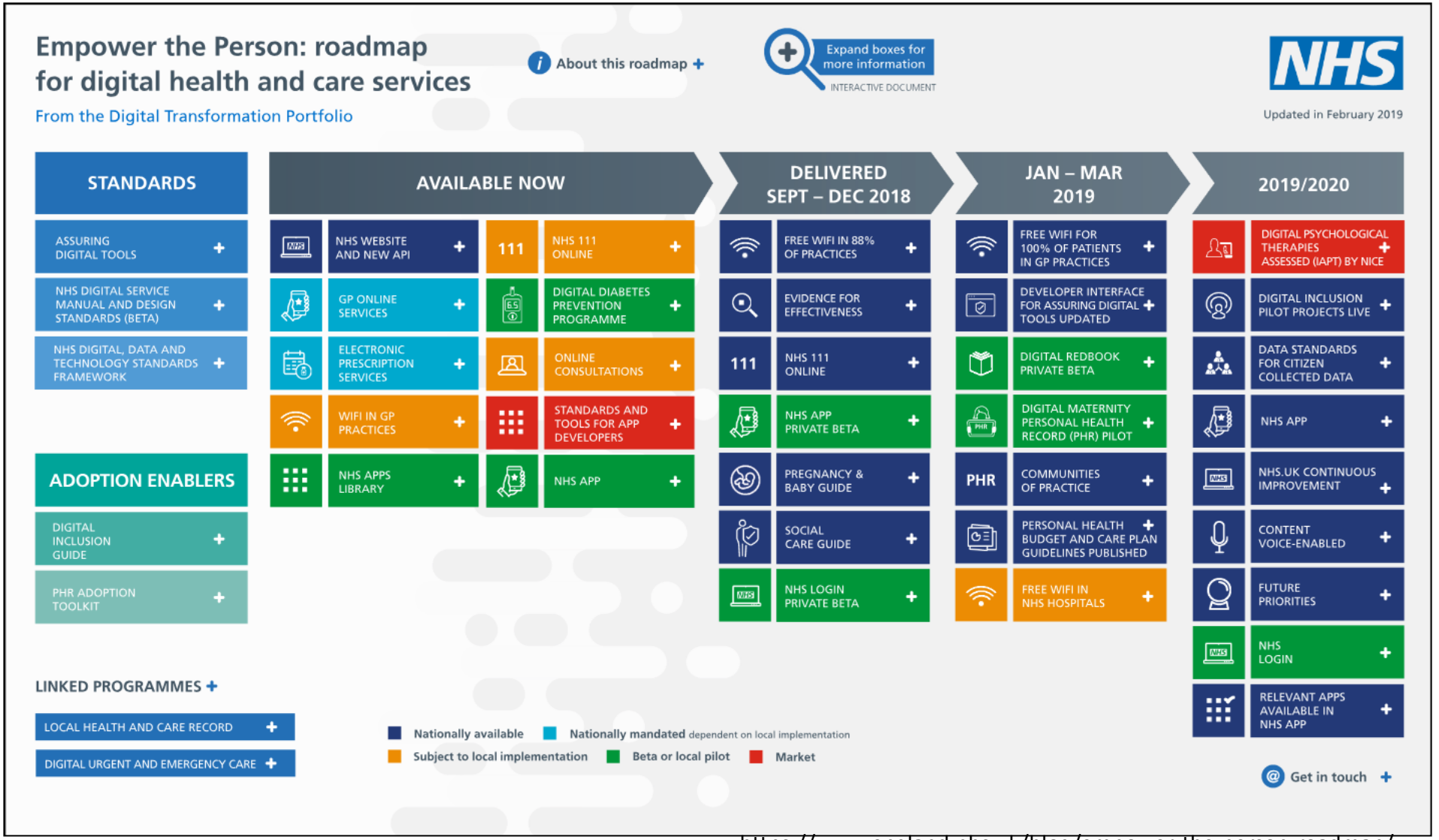

**Digital First accelerator sites across STPs**

*Full analysis of current and planned activity is available in attached document

# Empower the Person roadmap

Healthy London Partnership

The Empower the Person road map looks at the future of digital health services and role of personalised patient journeys. Digital is a key enabler for personalised care.




https://www.england.nhs.uk/blog/empower-the-person-roadmap/

# The NHS app: Enabling personalised care

Healthy London Partnership

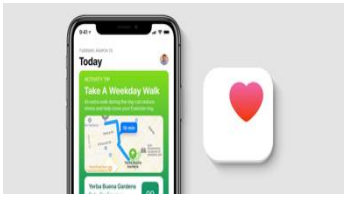
The Long Term Plan  confirmed the NHS app will be the digital front door to the NHS. It is an opportunity to empower people to take control of their own health care, whilst providing safe and secure access to trusted health information, 111 online, repeat prescriptions and GP appointments.

## Market interoperability & standards

Developing the interoperability standards required to transform the NHS App in to a platform, allowing commercial third party providers to develop and integrate healthcare applications.

## Personalised apps library

A suite of apps that are checked and approved by the NHS covering a broad range of conditions, allowing for people's medical records to be quizzed, linking external devices such as Fitbit and Apple Watches to allow patients to monitor their health and have more meaningful conversations with their clinicians.




## Fingerprint log in

Biometric fingerprint log in functionality for iOS and Android devices to allow users to log in quickly, easily and securely without the need for log in credentials.

## GP Video Consultation

Allows users to have on-the-go video consultations with qualified NHS doctors through the NHS App on their mobile device. Provides patients with easy access to medical practitioners.

## e-Referral Service

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.

# London personalised care activity – Islington

Healthy London Partnership

Islington CCG have been a level 2 demonstrator site since 2017.

PAM training, smoking cessation and spirometry training has been delivered to peer coaches

Personalised care is included within the Haringey & Islington CCG 18/19 Business Plan

Commissioned a Navigation service to offer personalised care

PHBs is the default position for all adults with wheelchairs


Brought together the Peer Coaching and Personalised Care co-production groups

Carers are involved in the care planning and support process when applicable.

CHINs/Localities undertake case identification work, targeting at-risk patients for various conditions including; frailty, SMI, Asthma.

Peer working forum organised by council

Health coaching to be incorporated into CHINS work – piloting one health coach

Choice & Control Pilot, Expert Patient Programme and Diabetes Self-management Prevention Programme use PAM

Ongoing work with LA and VCSE Sector to build capability and capacity

Choice & Control Pilot is taking place
NCL has an approved Choice Policy

Navigation service is provided by Age UK Islington

# London personalised care activity – Tower Hamlets

Healthy London Partnership

Tower Hamlets CCG have been a level 2 demonstrator site since 2017. Key activities have focused on improving the uptake of PHBs and social prescriptions.


- Default offer of PHB in CHC and CC. PHBs expanded to people with LTC, MH, LD and SEND
- Priority of the Joint Commissioning Executive
- Co-production group to focus on Personalised care
- Local arrangements are being developed to help people have as much control over resources as possible
- linked data across Tower Hamlets, including social care data
- CCG and LAs relationships developing to ensure a seamless experience of personal budgets
- Social prescribing operates across Tower Hamlets
- Personalised care has been included in all commissioning intentions
- commission a self management programme through the voluntary sector
- Data is collected to check the benefits of personalised care
- Checklist has been created to ensure principles of Personalised care planning are maintained
- A 'common framework' guidance to enable a good personalised care process