



Delivering personalised care and support planning:

The journey to person-centred care

Supplementary information for commissioners

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Equality and diversity are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have given due regard to the need to:

- Reduce health inequalities in access and outcomes of healthcare services and to integrate services where this might reduce health inequalities
- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity and foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.

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Part 4 Considerations for Commissioners

4.1. Introduction

Commissioners have a key role to play in supporting the delivery of person-centred care; commissioning is after all, the foundation of the ‘House of Care’. It is therefore important for commissioners to consider how they can support the implementation of personalised care and support planning.

This section sets out:

- The commissioners’ role in making personalised care and support planning happen
- The Business Case
- Approaches commissioners might take to embed personalised care and support planning across a population

4.2. Personalised care and support planning – what is the commissioner’s role?

In order to be most effective, personalised care and support planning requires a “whole system” approach. Commissioners therefore have an important role to play in bringing the system together to make care and support planning a reality.

Commissioners should consider how they:

- ensure that commissioning reflects the needs of individuals, and commission appropriate person-centred services that promote and embed personalised care and support planning;
- promote partnership and collaboration in local health populations to implement a whole system approach;
- commission a range of support for self-management services to supplement traditional services and to ensure a more than medicine approach. This could include structured education programmes, community activities and peer support networks;
- ensure that support is in place to provide people with timely, appropriate and accessible information to enable them to make an informed contribution to discussions regarding their condition, care and support;
- promote the development of clinical environments that encourage shared decision making approaches and ensure support systems are in place to support patients who are less able to embrace this approach;
- promote the development of the workforce to have the skills and competencies to work in this way; and
- ensure a robust local measurement system is in place to inform and support improvement.

4.3. Commissioning personalised care and support planning

4.3.1. What is the pathway for a patient?

Personalised care and support planning puts people in control of their care and support. A personalised care planning approach is part of the delivery framework for a person centred approach to improving care for patients. Commissioners should consider what an effective pathway looks like for a patient with long-term conditions and how personalised care and support planning can be built into that pathway. Once commissioners, patients, carers, and providers are clear on the agreed pathway, commissioners can begin to build this into their commissioning plans and work with the system to deliver it. Pathways may look very different for different patient groups, for example for someone newly diagnosed, individuals with multi-morbidities, proactive care, and crisis care.

4.3.2. Following the commissioning cycle

Creating the right conditions and infrastructure for personalised care and support planning has a number of steps that relate to the commissioning cycle:

Analyse

- Which patients would benefit most from personalised care and support planning? This could be cut in a number of ways including, risk of unplanned admission, morbidities or combination of morbidities and identifying people with lower levels of skills, confidence and knowledge. [See handbook on [Using case finding and risk stratification](#)]
- What does the patient population have to say about the quality of person-centred care and care and support planning?
- Which services already offer personalised care and support planning? Which services could benefit from the introduction of care and support planning?
- The care and support planning process itself can be a useful source of information for understanding how services can be improved. For example, commissioners may want to look for trends in the objectives and action plans contained within care plans.

Plan

- What does a person-centred pathway look like?
- How will personalised care and support planning be incorporated into service specifications?
- What do local pathways look like and do providers have the skills to follow the principles of personalised care and support planning as set out in this document?
- What difference could personalised care and support planning make to the experience and outcomes of patients and carers?
- How can personalised care and support planning be incorporated into 3-5 year plans so that the number of people who have a care plan continues to grow?

Do

- Build care and support planning and person-centred outcomes into service specifications.
- Build a menu of “more than medicine” services to support people with long-term conditions (see section 4.5).

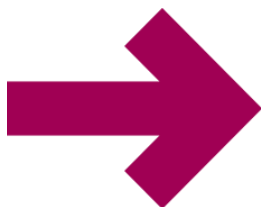
- Use innovative payment and contracting methods which promote person-centred care/care and support planning (see section 4.9).
- Ensure there is space for ongoing training, development and reflection, both for commissioners and providers.

Review

- Monitor implementation, and measure the impact of care and support planning.
- Support continuous improvement by supporting providers to measure and understand that they could improve how they provide personalised care and support planning.

A number of resources have been produced to assist commissioners with promoting person-centred care/personalised care and support planning:

- **Think Local Act Personal (TLAP)** - Tools for supporting integrated care for people with health and social care needs (2015)¹
- **Transforming participation in health and care**² – NHS England
- **People-powered health**³ - Nesta
- **Delivering better services for people with long-term conditions**⁴ – Kings Fund
- **LTC House of Care toolkit**⁵ – NHS England / NHS Improving Quality
- **Year of Care** programme⁶
- Royal College of General Practitioners - '**Stepping Forward**' commissioning principles for collaborative care and support planning (2015)⁷



Case study: Commissioning person-centred pathways⁸

Health and care organisations in Stockport sought to re-think their approach to the care of people with long term persistent mental health conditions. They wanted to move away from the traditional GP-led approach based around pharmacology to one where individuals were guided to new activities to give them a sense of purpose and increase their involvement in their local communities.

Stockport CCG and council worked together with Pennine Care NHS Foundation Trust and a consortium of local charities and voluntary agencies, to support the users of mental health services to create their own individual care pathways. The pathways are underpinned by a wide range of services from networked providers including peer groups, debt and housing advice and clinical support. To achieve this, they needed to move away from risk averse commissioning, to more collaborative approaches, such as alliance contracting.

Through the Prevention and Personalisation Service (PPS), pathway planners guide service users through the three stages of the pathway planning process and helping them to develop a personalised care and support plan. Together they look at:

- 1) Initial emotional support** – talking through why the service user is there, how they feel about themselves and their life, including their mental health but also wider quality of life issues.
- 2) Identifying aspirations** – supporting service users to identify their goals, which could be health outcomes, or related to other aspects of their lives.

3) Overcoming barriers – working through issues that are preventing service users from achieving their aspirations, or are keeping them in secondary care.

In addition, a drop in centre was established by the PPS, run in conjunction with local mental health charities and a faith group, where people could receive additional advice and support. This included support to re-engage in the local community, for example putting service users with specific skills in touch with local businesses or charities who can use those skills. The drop in service is run by service users in recovery themselves.

Preliminary results show that the scheme has improved the quality of life for people with mental health problems; increased the numbers discharged from specialist care; and is saving the NHS costs. The initiative has helped to reduce the use of secondary services. Within 18 months of the scheme starting, over 100 patients were discharged from specialist care who would not otherwise have been.

Nick Dixon, the Mental Health Commissioning Manager at Stockport Council described the importance of the scheme: “this is where the solution to our problems is going to come from. It doesn’t lie with the NHS or social care – we haven’t got the resources even if it did - it lies in the communities in which people live.”

4.4. The business case for an overall approach to person-centred, co-ordinated care

Whilst personalised care and support planning can act as an enabler to delivering better health outcomes across local populations, it should not be thought of as a single service, entity or piece of paper that can be commissioned. Instead it should be seen as part of routine care for people with long-term conditions. The introduction of personalised care and support planning is part of a journey towards delivering person-centred coordinated care that requires time, targeted introduction, training and changes in the way that individuals, carers, and health and care practitioners work together.

Personalised care and support planning can also lead to better informed needs assessments by collecting and aggregating data from care plans to determine ‘unmet’ needs. This can help commissioners deliver the services that people actually want and ensure a positive impact on individual’s and population’s overall health and well-being.

The benefits to commissioners include:

- Being able to commission services that people want to experience and clinicians want to provide – reduces tensions between commissioners and providers and improves job satisfaction and the experience of care
- Offers a measurable assessment of an individual’s needs or goals to guide commissioning of appropriate services
- Facilitating better monitoring of health and care, such as annual review
- This approach having a positive impact on other ‘must dos’ in health policy for example, reducing acute admissions, improving the patient experience
- Having measurable outcomes
- Increasing effective self-management

Whilst the primary function of building the House of Care (see [Part 1](#)) is to provide the person-centred coordinated care that people want, it is possible that improving quality can also bring cost savings. There are many case studies showing cost savings for integrated care from both the UK and internationally; these are collected together in the [House of Care toolkit](#), [Integrated Care And Support Exchange \(ICASE\)](#) and the [Local Government Association Integrated Care Evidence Review](#) which contains reviews of reports by the King's Fund, RAND etc. as well as value cases for specific localities.

Well known exemplars have shown substantial achievements and cost saving. For example in [North West London](#), population risk stratification combined with multidisciplinary team working, case conferences and personalised care planning have led to reductions in emergency admissions of 15% and a fall in A&E attendances of 30% in targeted populations.



The **Rotherham Social Prescribing scheme**, delivered by Voluntary Action Rotherham for Rotherham CCG, represents a model whereby voluntary and community services work alongside GP practices to help provide a quality service for patients. GP practices referred patients to Voluntary and Community Sector (VCS) Advisors who then carried out needs assessments and referred people to relevant VCS services that could help them. An evaluation of the pilot⁹ showed (for patients for whom 12 months post-referral data was available):

- Inpatient admissions reduced by 21 per cent
- Accident and Emergency attendances reduced by 20 per cent
- Outpatient appointments reduced by 21 per cent within the 12 month cohort
- 83% of patients experienced positive change in at least one wellbeing outcome area (results were most significant for patients with low baseline scores)

At a system level (aside from numerous international examples such as Kaiser Permanente and the Veteran's Administration in the U.S.)¹⁰, evidence for the House of Care's potential financial savings comes from two main sources. The first is the Nesta [People Powered Health project](#)¹¹ which advocates three 'House of Care-style' changes:

- Changing consultations (e.g. self-management support and social prescribing);
- Commissioning new services (such as peer-support groups and coaching/mentoring); and
- Co-designing pathways with service users (e.g. integrated care and personal health budgets).

With an average cost of £100-£450 per patient, these interventions could deliver savings of 7 per cent for clinical commissioning groups (over £21 million per average CCG) or a total of £4.4 billion per annum across England. These savings are accrued in the form of reductions in A&E attendance, planned and unplanned hospital admissions, and outpatient attendance.

The second source on system savings is the repository of information from Monitor and McKinsey entitled 'Improvement Opportunities in the NHS: Quantification and Evidence'¹².

Amongst a raft of savings from productive, allocative, and technical efficiencies, the analysis shows significant savings through 'House of Care-style' changes. For example, a reduction in hospitalisations through integrated care (risk stratification, multidisciplinary teams etc.) could save £2billion per annum. Support for patient empowerment and self-care could save up to £0.4billion per annum. Shifting activity to most appropriate settings (e.g. some outpatient and A&E activity moved to primary care) could save up to £1.6billion per annum. Organisational and clinical processes in the 'roof' of the House of Care, such as reducing interventions/procedures of low clinical effectiveness (e.g. using shared decision-making and preventing consequent adverse drug effects) could save an additional £1.8billion. If the £5.8bn per annum from 'House of Care-style' interventions could be achieved that this report suggests, then each CCG could save over £27million per annum.

Whilst all these savings are unlikely to be exclusive, and represent upside estimates, the House of Care supports improved quality which can be achieved at lower cost. Building the House of Care approach might enable us to make significant inroads into the £30bn NHS funding shortfall anticipated by 2021¹³ even if only a proportion of the upside estimates of the House's value are delivered.

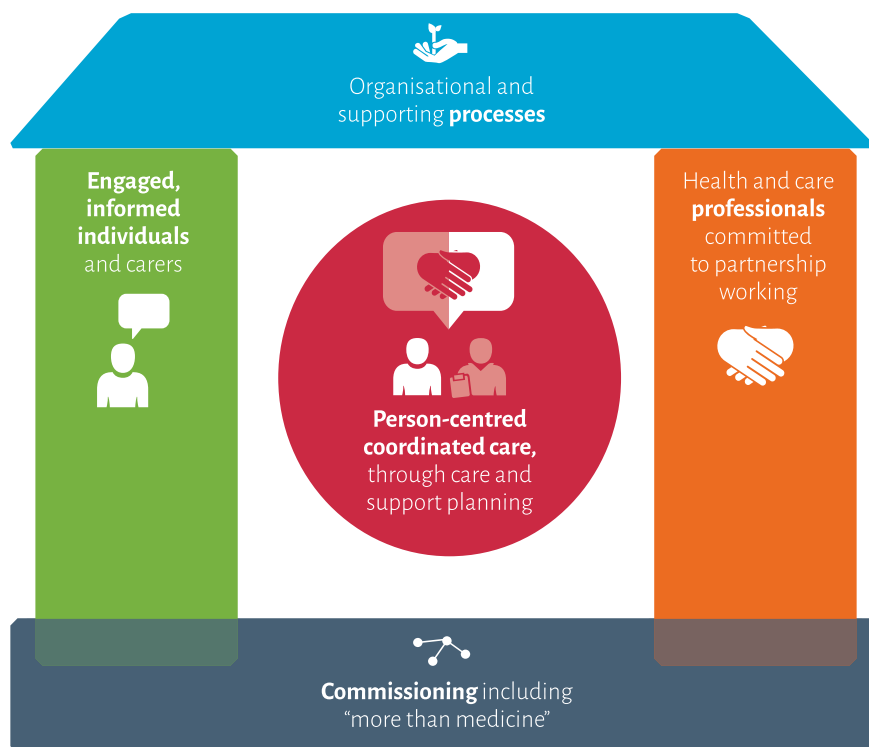
Evidence relating specifically to the impact of personalised care and support planning on the use of healthcare services is still fairly limited, however there are some examples. The Kings Fund (2010)¹⁴ cited a review of 15 studies which measured the impact of adult asthma self management education on health care utilisation and costs. The review found that eight studies demonstrated reduced hospital or emergency department use, while seven failed to demonstrate a reduction. Of the eight studies that did demonstrate a reduction, six included use of a self-management action plan, compared with three of the seven studies that did not demonstrate a reduction. This suggests that action plans are a useful component.

There is also evidence of reduced hospital re-admissions where hospital inpatients are given individualised discharge plans rather than routine discharge care. A systematic review of randomised controlled trials¹⁵ showed that re-admissions to hospital were significantly reduced by around 15% for patients allocated to structured, individualised discharge planning.

The personal health budget pilot showed that people who were given more control over their care on a day to day basis were less likely to need acute unplanned care¹⁶ as they could tailor the support and services they required (as agreed in their care and support plan) in order to prevent a crisis situation or having to wait for a health care professional to visit. Pilot sites also reported they were less likely to receive emergency phone calls from individuals with complex needs who had a personal health budget as such situations had been discussed and plans put in place during the care planning stage of the personal health budgets process.

Of course, the challenge of demonstrating the impact of personalised care and support planning will rely on the measures which are used to assess outcomes this is discussed in section 4.8 below.

4.5. Whole system approach based on the House of Care



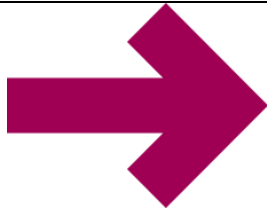
There are many factors to consider when planning for the whole system change required for care and support planning and each population is unique. However, the House of Care provides a framework to consider the broader aspects that will be required to embed personalised care and support planning. For more on the House of Care, please see [Part 1](#).

Organisational and supporting processes

Personalised care and support planning relies on a number of organisational and supporting processes. Commissioners should consider if the correct infrastructure is in place to support the care and support planning process. For example, can providers identify the people who would most benefit from personalised care and support planning? Can care plan templates be embedded using patient records? Can patient preferences be gathered and fed into population commissioning?

Health care professionals committed to partnership working

Health care professionals will need to have the skills and confidence to collaborate with individuals on personalised care and support plans. Not only will individual professionals need support, but also organisations as a whole may need support to work out how care and support planning can be embedded. This could include whole-team training on person-centred approaches. Training whole teams together has been found to be helpful in embedding care and support planning¹⁷.



Training and support programmes

There are a number of training packages available to assist commissioners and care professionals in gaining the skills required for person-centred care. For example:

- [Health Foundation, Co-Creating Health](#)
- [NHS England personal health budgets support programme](#)
- [Helen Sanderson Associates](#)
- [Year of Care](#)
- [Diabetes UK Year of Care](#)

Healthcare professionals also need to work in partnership with professionals from other parts of the health and care system in order to deliver more co-ordinated, person-centred care. This will rely on having the right systems in place for sharing information, but also relies on having the right skills and attitudes to work in collaboration, and working in new ways as part of multidisciplinary teams. [See handbook on [MDT development](#)]

Engaged and informed individuals

Commissioners should consider the services and information available across the population to support people to build their skills confidence and knowledge. Numerous factors contribute to individuals' skills, confidence and knowledge and therefore commissioners should consider how voluntary and community services, schools, Local Authorities and other public services could contribute to supporting people in both preparing for personalised care and support planning and in gaining support to more confidently manage their health and wellbeing. Commissioners also need to recognise the vital role of carers and the support they may need in their caring role and to manage their own health and wellbeing.

Responsive commissioning

The foundation of commissioning requires consideration of the resources needed to introduce and sustain personalised care and support planning and ensuring all the right components are in place to build the rest of the House.

Commissioners not only need to ensure that the right conditions and structures are in place to deliver personalised care and support planning, but also need to consider the wider landscape of care and support available to people to help them to meet not only their bio-medical needs, but also their wider social, physical and mental wellbeing goals. This could include peer support services, advocacy services, structured education, coaching and support for self-management programmes.

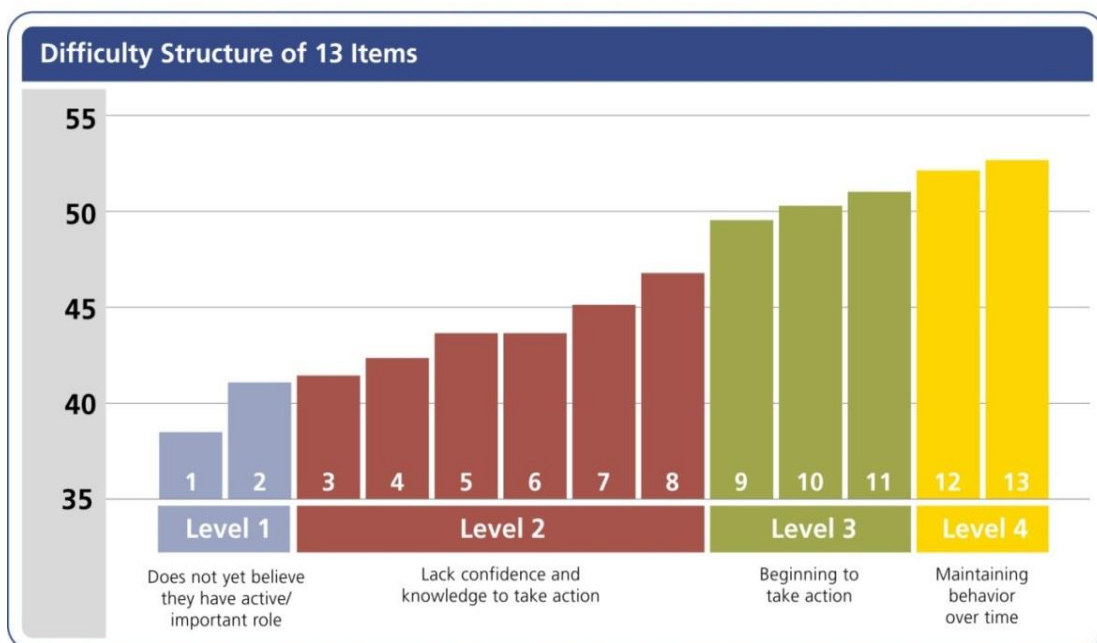
4.5.1. The Role of Individuals and “Patient Activation” (Section has been updated)

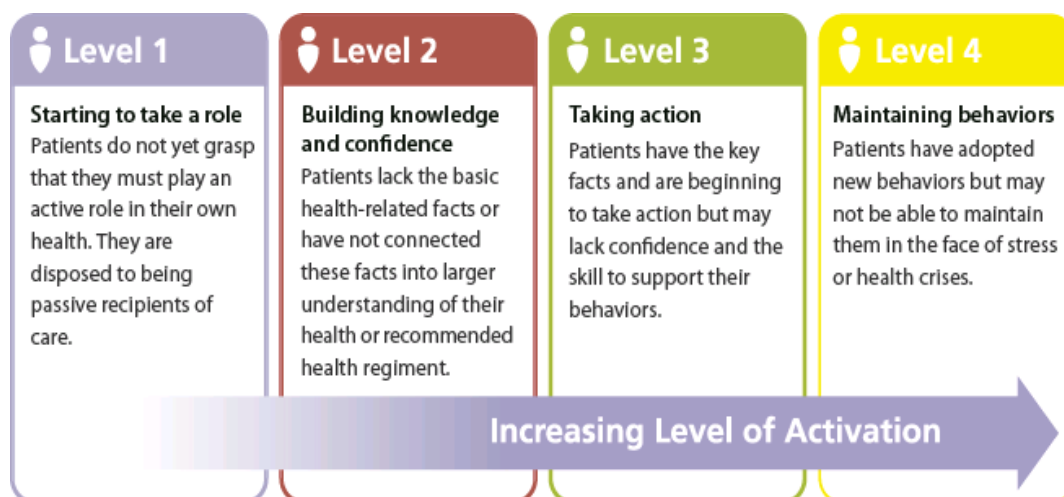
There is now a growing understanding of the role of individuals in managing their health and wellbeing as well as their long term conditions. A vital aspect of this is the extent to which people have the skills, knowledge and confidence to engage in managing their care.

In order to deliver personalised care and support that meets the needs of individuals, we need to understand the extent of their knowledge, skills and confidence to manage their condition. This is referred to as a level of 'activation'¹⁸. Both the approach to the discussion and the actions and interventions that are identified to help meet the persons' needs will differ widely, depending on their activation.

Understanding the patient's skills and confidence is helpful for the practitioner to be able to tailor the care and advice they offer. It provides them with a starting point to meet people 'where they are', determine the realistic 'next steps' for individuals to take in terms of self-management, and build it into the personalised care and support planning process.

The Patient Activation Measure (PAM) is a measurement for the ability a person has in managing their health and care. It is a validated tool and has been extensively trialled in a number of countries. The PAM score/level is based on responses to 13 questions in a survey.





The patient's activation level has been shown to be linked to their likelihood of engaging with preventative and healthy behaviours. A key review of evidence on patient motivation found that interventions that tailor support to the individual's level of activation, and that build skills and confidence, are effective in increasing patient activation and their capacity to self-manage their condition more effectively¹⁹. When appropriately supported, evidence shows that the least activated patients make the most gains²⁰. People with higher levels of activation have been shown to have better health outcomes, a more positive experience of care and they also incur lower healthcare costs²¹.

Understanding people's activation levels can help commissioners to put interventions in place to meet their population's needs more appropriately. Training and education resources can be tailored according to the population's needs. It can enable targeting and allocation of resources more appropriately, so as to provide more in-depth support to those who are less activated and confident about their ability to manage their own care.

As a quantifiable measure, PAM can be used at scale to evaluate the effectiveness of services. Measuring patient activation can help commissioners in quality improvement to assess whether an intervention made a difference to an individual or population's level of knowledge, skills and confidence. This can help to support commissioning activity to make any required changes to the types of services required in the local area tailored to people's needs.

In England, we are currently testing the use of PAM in a learning set of 5 CCGs and the UK Renal Registry and looking at different ways to embed measuring of patient activation in local commissioning and delivery systems. The ongoing evaluation of the learning set will help with the learning around:

- the feasibility of measuring patient activation across the NHS;
- how activation can inform support for self-management;
- what support clinicians and commissioners need to use the measure effectively; and
- build the evidence on whether supporting activation can improve outcomes, reduce costs and reduce inequalities for patients in the NHS.

For more information, please email england.patientactivation@nhs.net

4.6. Addressing individuals' holistic needs – the 'More than Medicine' approach

It is widely recognised that the prevalence of long term conditions, and particularly multi-morbidity, is predicted to rise, and the current systems supporting people with LTCs are not financially viable, with demands on health and social care services exceeding the predicted funding available. A more flexible approach is needed to meet the personalisation agenda and the broader individual needs of people with long-term conditions, which helps to increase social capital and social connections, and explores the potential of non-traditional providers.

'More than medicine' refers to the idea that there are social as well as medical aspects of long-term conditions and that there are a number of different services which can help people to meet not only their bio-medical needs, but also their wider social, physical and mental wellbeing goals. Such services offer an alternative to traditional health and social care services, instead looking at mobilising communities and networks to support people. Commissioning should consider the range of services available to patients and carers, this could include peer support services, advocacy services, coaching, training, volunteering and community activities.

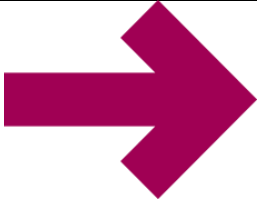
4.6.1. Examples of 'More than Medicine'

As described by Nesta, the People Powered Health approach²² supports patients and clinicians to address the behavioural and social aspects of long term conditions - helping people to exercise more, eat more healthily, build strong social networks and feel supported and in control of their lives. Examples of 'more than medicine' support options include:

- Physical activity e.g. community gardening project
- Healthy eating/cooking e.g. cookery club in a community centre
- Arts for health e.g. 'knit and natter' groups
- Befriending e.g. local volunteer led befriending scheme
- Welfare rights/benefits e.g. local Citizens Advice Bureau or advocacy centre
- Volunteering opportunities e.g. volunteering at community hub
- Telehealth, telecare, telemedicine and self-care apps that give individuals more control and an alternative route for interacting with care services.

Alternative provision is not intended to replace traditional planned medical care, but to complement it by developing an infrastructure to reliably and consistently deliver social models of support to enable people to live better. Working in this way requires different models of commissioning and relationships between commissioners and providers.

Case study: More than medicine



[Mosaic Clubhouse](#) is part of a worldwide network of clubhouses that exist to provide support and opportunities to people living with a mental health condition. They believe that being part of a community that encourages everyone to participate and re-discover their talents, dreams and skills is key to supporting individuals on their recovery journey. Mosaic is organised to support people living with a mental health condition to re-join the world of friendship, family, employment and education. Staff work side-by-side with members to complete all the tasks necessary to run the service.

Patients can self-refer or be referred by mental health teams, secondary care or GPs. They are invited to the centre to see if they feel it's a good fit for their needs. Activities offered are tailored according to what people feel will move them forward in their recovery and other aspects of their lives. Classes offered include cooking, computer skills, financial literacy, car maintenance, gardening or music lessons.

John, one of the members says:

"I think if I'd come to Mosaic at an earlier date I'd be one step further than I am. I prefer to come here than to take medication. There will always be some members who are on meds for a long time, possibly for life. But I find this is a great alternative to taking medication for me."²³

4.6.2. Roles for Commissioners and Practitioners

Practitioners involved in the care planning discussion need to be able to identify what services are available that would support the patient and carer with self-management. It can be difficult for care practitioners to be knowledgeable about all the potential opportunities available. This issue can be addressed by commissioners providing up to date directories of services (like [ALISS](#), the system used in Scotland), clarity over referral pathways, and having specific roles to connect people to the services that would address their needs, such as link workers, care plan co-ordinators, service navigator roles, peer support schemes and social prescribing.

In drawing up a 'menu' of services, commissioners will want to create a detailed understanding of the alternative sources of support that are available in their local community and who the providers are. Commissioners will want to consider if there are gaps in provision, or opportunities for new types of services to be developed. Creative commissioning, in partnership with local authorities, and the voluntary sector, can be used to develop innovative community based services which support patients.

Having a 'menu' of services is not about restricting options, it is about increasing awareness of the options that are available, and making it easier for practitioners to refer to non-traditional sources of support. However, there should still be opportunity for patients and carers to identify additional solutions and services which might fall outside this 'menu'.

4.6.3. Implementing a 'More than Medicine' Approach

Year of Care's document 'Thanks for the Petunias'²⁴ offers a practical guide to developing and commissioning non-traditional providers to support the self-management of people with long term conditions. It sets out a number of key steps in doing this, including:

- Recruiting a GP champion to promote the 'More than Medicine' approach throughout local GP practices
- Building local buy in across health economy
- Undertake a programme to create a baseline list of the non-traditional providers (NTPs) in an area who could be commissioned to provide support for patients and carers, including encouraging self-management
- Creating a simple referral mechanism from primary care to NTPs
- Building in mechanisms for assessing effectiveness of interventions provided by NTPs; and
- Annual review of 'More than Medicine' programme, success, learning points..

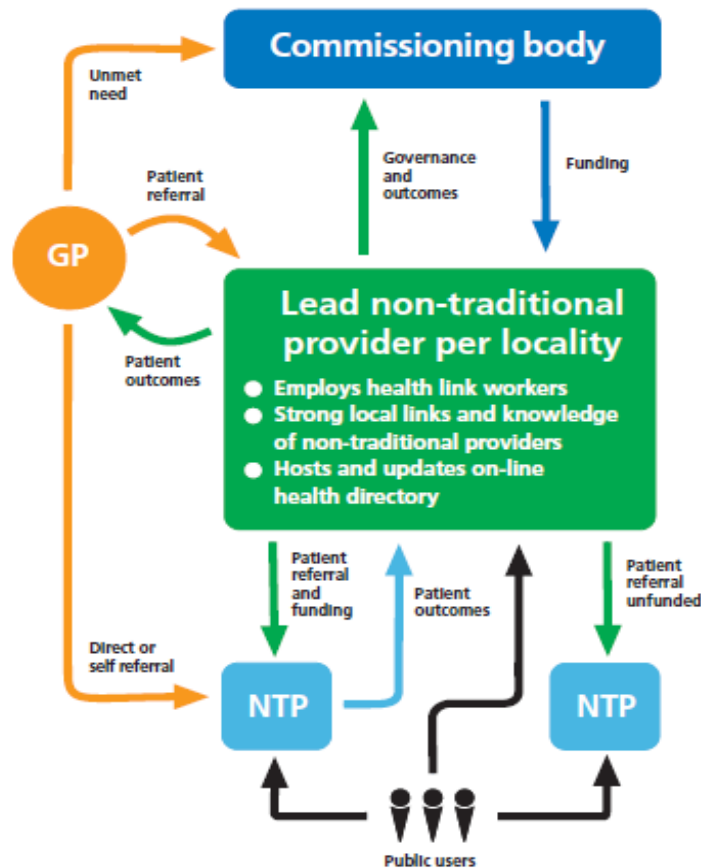
Moving towards a more personalised, sustainable approach for supporting people with long-term conditions to manage their health and wellbeing requires significant cultural and systems change across the local health economy. Commissioners across Area Teams, CCGs, CSUs, Public Health, Local Authorities, Strategic Clinical Networks and also individuals commissioning services using their personal health budget, will need to consider new partnerships (with each other and with the third sector), different models of contracting and commissioning, and different methods for measuring patient outcomes and unmet needs.

[Personal health budgets](#) are another way to enable people to buy goods and services not normally commissioned by the NHS.

[Thanks for the Petunias](#) provides an exploration of a possible organisational model that can be adapted according to local circumstance, resources and need to allow commissioners to work with non-traditional providers (such as voluntary organisations, community groups and social enterprises) to deliver:

- Better outcomes for people with LTCs (social and clinical)
- More cost effective use of NHS resources (and social care)
- Widening of the local provider base.

The model is shown below.



Note: Non-traditional providers (NTPs) - two shown for illustration as there could be 1,000 or more.

4.7. A collaborative approach

A whole system approach will only be successful if there is collaboration across the system. The approaches outlined above will require working with a number of partners across the system, including patients, carers, voluntary and community services, a range of providers and other commissioners. Organisations will need to have governance conversations about how they will work together and how they will share information. This is particularly true for people with multiple morbidities who may be receiving services from across a number health and care commissioners; these services should not be commissioned in isolation but considered as part of a person-centred care pathway.

Commissioning and contracting formalise the process of collaboration, but real collaboration across the system should come before any commissioning and contracting. 'By us, for us: the power of co-design and co-delivery'²⁵, by Nesta, gives a number of examples of commissioners taking a collaborative approach. Commissioners should consider which contract options would best support their collaborative approach. The Kings Fund have also published a report describing some of the emerging models for contracting and commissioning²⁶, such as alliance contracting and some important lessons for commissioners.

A number of initiatives are looking at how we integrate the commissioning system in order to enable better quality personalised care and person-centred care and support planning:

- [Better Care Fund](#) – In 2016/17, the Better Care Fund (BCF) will be a mandated minimum of £3.9bn to be deployed locally on health and social care through pooled budget arrangements between local authorities and CCGs. The aim is to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.
- [Integrated Personal Commissioning Pilots](#) (IPC) – Testing new commissioning and funding models including joined-up capitated funding approaches for key groups of people across social care, CCGs and specialised commissioning, and explore how individuals can have more control over how the funding is used through personalised care and support planning and personal budgets.
- NHS England has set up a phased, £1 billion transformation fund and is continuing to work with CCGs and GP practices on the development of new models for the co-commissioning and [transformation](#) of primary care.
- There are 50 [new care model](#) and vanguard sites across England, chosen to take forward the Five Year Forward View. Among these are multi-speciality community providers, new models to enhance care in care homes and vanguards which focus on integrated primary and acute care systems.

4.8. Measuring what matters

Commissioners will want to assess how well the system they commission is performing, while providers want to know where and how so that they can improve their performance over time. Commissioners and providers will need to work together to develop a suitable local measurement hierarchy of both process and outcome measures around personalised care and support planning.

The Health Foundation has produced resources to assist commissioners with measurement of person-centred care:

- [Measuring what really matters -Towards a coherent measurement system to support person-centred care](#)²⁷
- [Helping measure person-centred care](#)²⁸

In social care, the POET (Personalisation Outcome Evaluation Tool) surveys for personal budget holders and for carers of personal budget holders is a way for personal budget holders and carers to report their experiences of personal budgets. This is also now being used in some CCGs as a way of getting feedback on personal health budgets²⁹.

4.8.1. Things to consider when selecting a measurement approach³⁰

1. Develop a clear local definition of person-centred care and support planning to help shape what needs to be measured.

2. Think about why it is important for you to measure person-centred care and how the information will be used because this will shape the measurement approach chosen.
3. Think about how approaches can be combined to provide both depth and scale for example having metrics which can be applied to care planning for different cohorts of patients. This may include both qualitative and more quantitative material.
4. Consider whether it is important to ask everyone using services or only a sample to provide feedback. The most appropriate sample will depend on why the information is being collected.
5. Consider the best time to collect feedback. Sometimes it is helpful to collect feedback immediately after using services, when experiences are fresh in people's minds. At other times it may be more helpful to allow time for reflection. Using a combination of immediate and follow-up feedback could be worthwhile.
6. It is important to allocate enough time and resources to plan, implement, analyse and use measures of person-centred care. Pilot testing is sometimes overlooked or only done on a small scale but allocating enough time at the outset to plan and test methods is worthwhile, particularly if these will be used for many years to monitor change over time.
7. In order to make positive change, appropriate infrastructure is needed at an organisational level to analyse and use information about person-centred care.
8. Consider how the end result needs to be presented for various audiences as this may shape how data is collected.
9. Make sure patients, carers, managers and clinicians are all comfortable with why data is being collected and how it will be used.
10. Person-centred care measures are one component of a broader framework of measurement so all the approaches need to work well together, without excessive burden for patients or staff.
11. Measures should reflect a multi-agency approach.

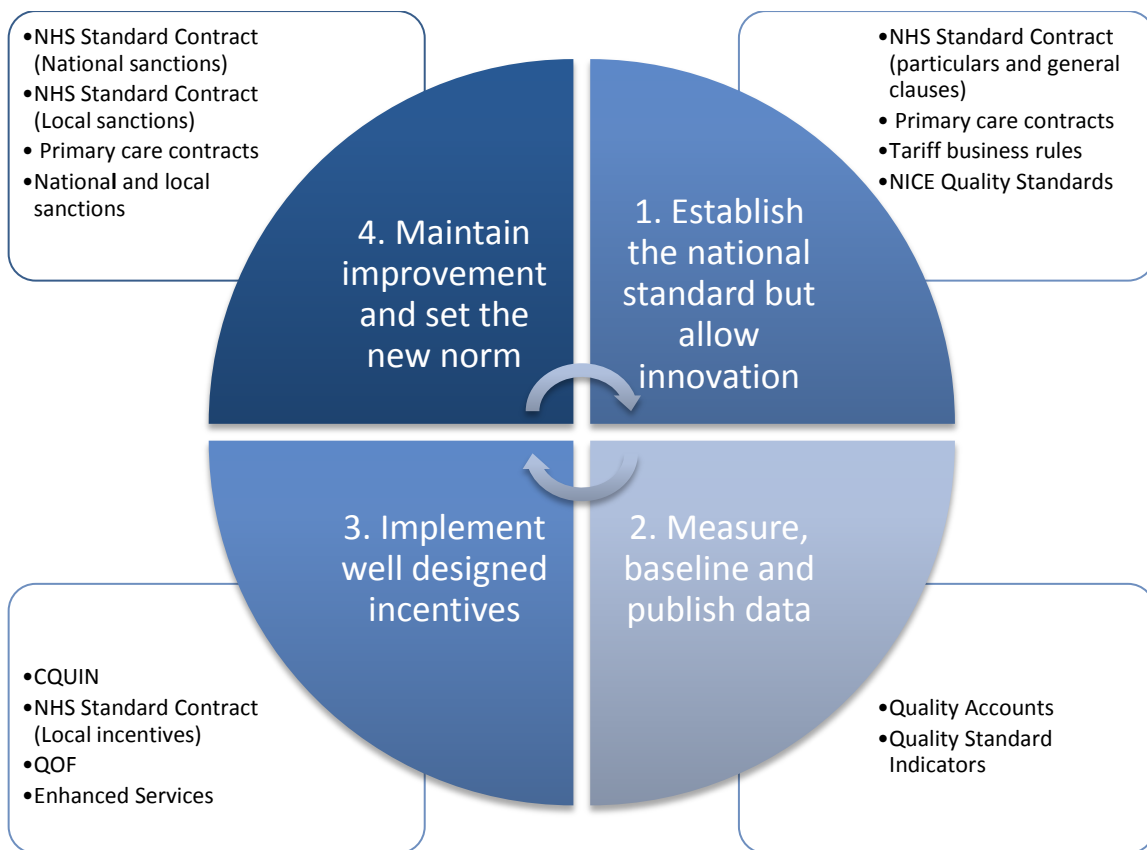
4.9. Levers and incentives

Commissioners should use the full range of levers and incentives available to them in order to promote person-centred care.

This includes:

- The service condition clauses on care and support planning in the **NHS Standard Contract**³¹
- Local **CQUINs** (Commissioning for Quality and Innovation payments)³²
- The GP contract terms and national and local **enhanced service schemes**³³

The model below illustrates how levers for assurance and contract incentives can work together in cycle to improve person-centred care.



Incentives rely on agreeing a local measurement hierarchy around personalised care and support planning. Once the process and outcomes measures are agreed they can then be used to inform the commissioned outputs and outcomes.

References

¹ [Think Local Act Personal \(TLAP\) Personalised Care & Support Planning Tools for people with health and social care needs \(2015\)](http://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/)

<http://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/>

² NHS England (2013) *Transforming Participation* www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf

³ Nesta (2013) *People Powered Commissioning: Embedding innovation in practice* www.nesta.org.uk/publications/people-powered-commissioning-embedding-innovation-practice

⁴ Kings Fund (2013) *Delivering better services for people with long term conditions: building the house of care* www.kingsfund.org.uk/publications/delivering-better-services-people-long-term-conditions

⁵ NHS IQ (2013) *House of Care toolkit*, www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/long-term-conditions-improvement-programme/house-of-care-toolkit.aspx

⁶ Year of Care <http://www.yearofcare.co.uk/>

⁷ [Royal College of General Practitioners](http://www.rcgp.org.uk/~/_/media/Files/CIRC/Quality-Improvement/RCGP-Stepping-Forward-2016.ashx) 'Stepping Forward' commissioning principles for collaborative care and support planning (2015)

http://www.rcgp.org.uk/~/_/media/Files/CIRC/Quality-Improvement/RCGP-Stepping-Forward-2016.ashx

⁸ NHS IQ (2014) *Mental health services case study: personalised care planning for mental health offers a better quality of life and more effective services* www.nhsiq.nhs.uk/media/2573248/ltc_case_study_personalised_care_planning_for_mental_health_stockport_mh.pdf

⁹ Sheffield Hallam University (2014) *The social and economic impact of the Rotherham Social Prescribing pilot* www.shu.ac.uk/research/cresr/ouexpertise/evaluation-rotherham-social-prescribing-pilot

¹⁰ Kings Fund (2014) *Accountable Care Organisations in the United States and England: Testing, evaluating and learning what works* www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/accountable-care-organisations-united-states-england-shortell-mar14.pdf

¹¹ Nesta (2013) *The business case for people powered health* www.nesta.org.uk/sites/default/files/the_business_case_for_people_powered_health.pdf

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- ¹² Monitor (2013) *Improvement opportunities in the NHS: Quantification and Evidence Collection* access archived document via page 4 link in: www.gov.uk/government/publications/closing-the-nhs-funding-gap-how-to-get-better-value-healthcare-for-patients
- ¹³ Monitor (2013) *Closing the NHS funding gap: how to get better value healthcare for patients* www.gov.uk/government/publications/closing-the-nhs-funding-gap-how-to-get-better-value-healthcare-for-patients
- ¹⁴ Kings Fund (2010) *Avoiding hospital admissions - What does the research evidence say?* www.kingsfund.org.uk/publications/avoiding-hospital-admissions
- ¹⁵ Shepperd S, McClaran J, Phillips CO, Lannin NA, Clemson LM, McCluskey A, Cameron ID, Barras SL (2010). 'Discharge planning from hospital to home (Cochrane Review)'. *Cochrane Database of Systematic Reviews*, Issue 1
- ¹⁶ Personal health budget evaluation (2012) *Evaluation of the personal health budget pilot programme*
- ¹⁷ Year of Care (2011) *Report of findings from the pilot programme*
- ¹⁸ Kings Fund (2014) *Supporting people to manage their health: An introduction to patient activation* www.kingsfund.org.uk/publications/supporting-people-manage-their-health
- ¹⁹ Hibbard, JH, Greene, J, (2013) "What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs", *Health Aff (Millwood)*. 2013 Feb;32(2):207-14
- ²⁰ Kings Fund (2014) *Supporting people to manage their health: An introduction to patient activation* www.kingsfund.org.uk/publications/supporting-people-manage-their-health
- ²¹ Hibbard, JH, Greene, J, (2013) "What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs", *Health Aff (Millwood)*. 2013 Feb;32(2):207-14
- ²² Nesta (2013) *More than medicine: New services for people powered health* www.nesta.org.uk/publications/more-medicine-new-services-people-powered-health
- ²³ Nesta (2013) *More than medicine: New services for people powered health* www.nesta.org.uk/publications/more-medicine-new-services-people-powered-health
- ²⁴ Year of Care (2011) *Thanks for the Petunias: A guide to developing and commissioning non-traditional providers to support the self management of people with long term conditions* www.diabetes.org.uk/upload/Professionals/Year%20of%20Care/thanks-for-the-petunias.pdf
- ²⁵ Nesta (2013) *By us, for us: The power of co-design and co-delivery* www.nesta.org.uk/publications/us-us-power-co-design-and-co-delivery
- ²⁶ Kings Fund (2014) *Commissioning and contracting for integrated care* www.kingsfund.org.uk/sites/files/kf/kings-fund-commissioning-contracting-integrated-care-nov14.pdf

-
- ²⁷ Health Foundation (2014) *Measuring what really matters*
www.health.org.uk/publications/measuring-what-really-matters/
- ²⁸ Health Foundation (2014) *Helping measure person-centred care*
www.health.org.uk/publications/helping-measure-person-centred-care/
- ²⁹ Think Local Act Personal (2013) *The POET surveys of personal health budget holders and carers*
www.personalhealthbudgets.england.nhs.uk/library/Resources/Personalhealthbudgets/2013/POETPHBReportFINAL.pdf
- ³⁰ Health Foundation (2014) *Helping measure person-centred care*
www.health.org.uk/publications/helping-measure-person-centred-care/
- ³¹ NHS England 2016/17 NHS Standard Contract <https://www.england.nhs.uk/nhs-standard-contract>
- ³² NHS England *Commissioning for quality and innovation CQUIN: guidance*
<https://www.england.nhs.uk/nhs-standard-contract>
- ³³ NHS Employers (2015/16) *GP contract changes to improve care for patients*
<http://www.nhsemployers.org/gms201516>