

Finance, Commissioning and Contracting Handbook for Personalised Care

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NHS England and NHS Improvement



Finance, Commissioning and Contracting Handbook

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Using the Handbook

This is the Finance, Commissioning and Contracting Handbook for the NHS England Comprehensive Model for Personalised Care. It aims to provide finance, commissioning and contracting staff with the information required to implement personalised care locally. It will enable staff to understand what the expansion of the programme means for their areas of work; what specialist support is available to facilitate the expansion; and what the impact may be on current processes and local contracting arrangements.

The handbook is part of a suite of documents developed through the personalised care programme to support the implementation of personalised care. While it can be read in isolation, further understanding of the programme can be developed through combining this handbook with other publications available from the NHS England personalised care website¹. The handbook shares the appropriate link to the website area where more specific guidance available.

Handbook structure

The Handbook provides:

- A brief overview of the strategic context of personalised care
- A description of each of the six elements of the Comprehensive Model for Personalised Care
- Key advice and guidance for those staff who have responsibilities for finance, commissioning or contracting including tools for implementation
- Advice and guidance on financial models and budget setting
- Recommendations for good practice
- Guidance on information governance, data collection, data sharing and digital solutions
- Advice for working in partnership across an Integrated Care System, Sustainability and Transformation Partnership or Primary Care Network.

Further tools to assist commissioners and providers can be located on the Finance, Commissioning & Contracting page of the FutureNHS Collaboration Platform (<https://future.nhs.uk/connect.ti/system/home>).

The tools are under development and so commissioners are encouraged to keep checking the site to see further tools when published.

¹ <https://www.england.nhs.uk/personalisedcare/>

Chapter 1: Introduction to Personalised Care and the Strategic Context

Chapter one of the NHS Long Term Plan² makes personalised care business as usual across the health and care system. The purpose of this handbook is to provide finance, commissioning and contracting staff with the information required to implement the personalised care aspect of the NHS Long Term Plan. This handbook will help staff to understand what “business as usual” in personalised care means for their areas of work and will enable access to the specialist support required to facilitate its delivery. It will also offer support on implementing the commissioning cycle, amending local policy and working within the context of developing NHS integrated care systems, sustainability & transformation partnerships and primary care networks.

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

Universal Personalised Care³ (UPC) was published following the NHS Long Term Plan and is the delivery plan for personalised care. UPC introduces the Comprehensive Model for Personalised Care. It has been co-produced with people with lived experience and a wide range of stakeholders and brings together six evidence-based and inter-linked components, each of which is defined by a standard, replicable delivery model.

The six key components are:

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

² <https://www.longtermplan.nhs.uk/>

³ <https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf>

This model builds on the success the NHS has had in implementing personalised care in a variety of settings and locations across the country. The experience thus far, has proven that benefits are:

- Improvement to patient outcomes and satisfaction when people are in control of their care and budget
- Improved systems, equity and quality of care
- Significant improvement in the use of resources contributing to local savings programmes.
- Ultimately, when people are in control of their own health and care, including associated budgets and can direct their own resources, the NHS spending reduces.

The UPC document sets out how the NHS will systematically implement the Comprehensive Model for Personalised Care to reach 2.5 million people by 2023/24 and then aiming to double that again within a decade (by 2028/29).

To achieve the benefits of personalised care and meet the key features that people with lived experience expect, the Comprehensive Model needs to be delivered in full. For example, social prescribing is less effective when it is delivered without a complementary approach to shared decision making. The full implementation of the Comprehensive Model protects against undermining both the principles and effects of the model. Furthermore, the Comprehensive Model will also be most effective when embedded in the mainstream health and care system with universal coverage for everyone who could benefit should be business as usual for everyone.

An integrated approach will support the implementation of the Comprehensive Model for Personalised Care. The NHS will work with CCGs, Primary Care Networks (PCNs), Integrated Care Systems (ICSs), Sustainability and Transformation Partnerships (STPs), the Voluntary, Community and Social Enterprise sector (VCSE), Local Government and Public Health to develop systems that put the person at the centre of services and which removes some of the challenges that would have traditionally limited the application of personalised care. The primary care network contract has been developed for 2019-20 and the integrated care provider contract is in development to support this way of working. As the need for robust contracting arrangements is recognised, the NHS Standard Contract for 2019-20 will support the implementation of personalised care. A schedule will be introduced to support commissioners in planning for personalised care with their providers.

This Finance and Commissioning Handbook aims to support delivery of the NHS Long Term Plan and the Universal Personalised Care: Implementing the Comprehensive Model commitments. We do not underestimate the challenge in delivering this scale of ambition even over a 5- to 10-year time horizon, but there are already excellent examples across the country of this happening at a scale and pace. The Handbook will take the learning from these successes and provide practical tools, recommendations and information to support the commissioning of personalised care.

Chapter 2: Comprehensive Model for Personalised Care: Commissioning the Six Components

CHAPTER SUMMARY

1. SUMMARY OF EACH OF THE SIX PERSONALISED CARE COMPONENTS FOR THE COMMISSIONER PERSPECTIVE
2. RECOMMENDATIONS FOR IDENTIFYING THE COHORT
3. RECOMMENDATIONS FOR COMMISSIONING, CONTRACTING, SPECIFICATIONS AND METRICS

2.1 Commissioning the Comprehensive Model for Personalised Care

The following chapter provides detail regarding finance, commissioning and contracting on the six key components of the Comprehensive Model plus an additional section on co-production. Further information on each of the components, including the standard, replicable model for each, and the key commitments can be found within the Universal Personalised Care: Implementing the Comprehensive Model document⁴.

A summary of the contractual steps to implement each of the components is detailed in each section. This includes:

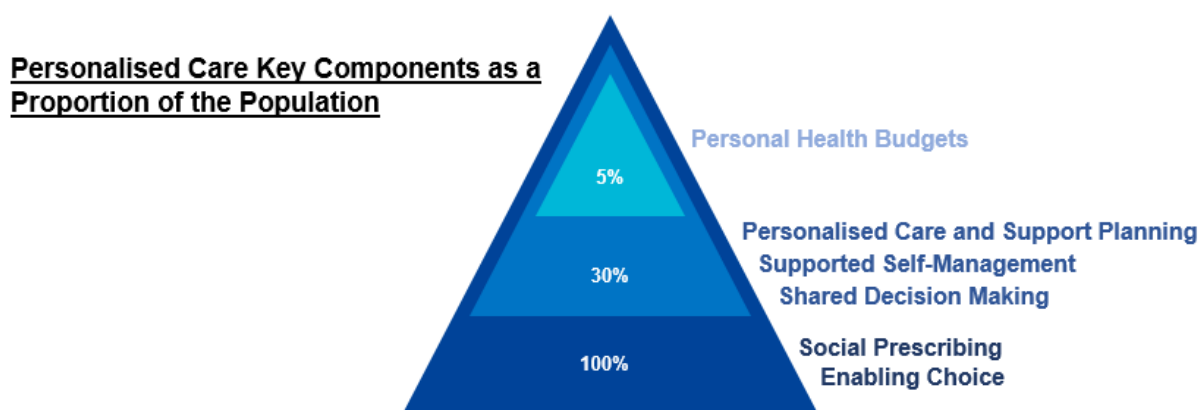
- Identifying cohorts
- Contracting and working with partners
- Suggested Service Specification wording - for local adaptation
- Suggested metrics – for local adaptation
- Financial considerations
- Information governance and digital considerations.

The level of planning and implementation required for each component will vary according to what current interventions, data and contracting mechanisms are already in place. It is acknowledged that the timescales for implementation will vary from short term - a few months, to longer term - a few years, depending on complexity and local arrangements.

⁴ <https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/>

2.1.1 Population Impact

The six components of the model are estimated to be applicable to varying proportions of the population with choice and social prescribing having the most universal application and personal health budgets applicable to approximately only 5% of the population. Commissioners will need to be aware of this approximation when planning for personalised care locally. The estimated proportion of the population who will benefit from each component is summarised in the diagram below.



2.1.2 Key Actions for Implementing Personalised Care

The Ten Key Finance, Commissioning and Contracting Actions that commissioners should be aiming to achieve are listed below and further information will be available in each indicated chapter.

Ten Key Finance, Commissioning and Contracting Actions		
No:	Action	Chapter
1	Plan your trajectory for 100% of contracts and specifications reflecting personalised care	2 & 4
2	Plan your trajectory of identified pathways to embed shared decision making	2.2
3	Plan your trajectory for all long term condition pathways having personalised care and support plans in place	2.3
4	Ensure 100% of contracts include legal rights to choice and flexible approaches	2.4
5	Look for opportunities to expand the social prescribing offer – support communities to grow and empower local people	2.5
6	Plan your trajectory to widen opportunities for supported self-care for long term conditions	2.6
7	Promote personal health budgets with your providers – support them looking to expand PHB opportunities	2.7
8	Consider use of local incentive schemes or pilots to support initial implementation of personalised care – build confidence in the approach	3.1

9	Have a local plan to develop local data systems and embed contract monitoring to support and evaluate personalised care locally	4.3
10	Explore opportunities for lead commissioners managing Integrated Care Provider contracts where economies of scale are useful	6.1

2.2 Shared Decision Making

Further information on shared decision making can be found on the NHS England webpage (<https://www.england.nhs.uk/shared-decision-making/>)

The 'Shared Decision Making Summary Guide' can be found on the NHS England webpage (<https://www.england.nhs.uk/publication/shared-decision-making-summary-guide/>)

2.2.1 Summary

Shared decision making (SDM) aims to ensure people are supported to a) understand the care, treatment and support options available and the risks, benefits and consequences of those options, and b) make a decision about a preferred course of action, based on evidence-based, good quality information and their personal preferences. Shared decision making about tests, treatments and support options leads to more realistic expectations, a better match between individuals' values and treatment choices, and fewer unnecessary interventions.

The process supports people to understand the diagnosis they have and the options they face (including doing nothing). In a process of deliberation, they are then supported to talk about 'what matters to me' in terms of their attitude to risk, the trade-offs they are willing to make and the outcomes that are important to them. Finally, a decision is made in partnership with their professional team.

2.2.2 Identifying Cohorts

Shared decision making is appropriate in almost every situation in community, primary and secondary care where a health and care decision must be made, and that decision is said to be "preference sensitive."

For example:

- in any case where there is more than one reasonable course of action and the decision involves trade-offs e.g. length of life v. quality of life
- where there is uncertainty or unclear evidence for one option over another
- where the options have different inherent risks or benefits or where individual values are important in optimising the decision.

This applies to most decisions in healthcare and, often, it is appropriate to use shared decision making. This is even the case in some accident and emergency settings, including chest pain and stroke. The specific clinical situations are the priority areas, but shared decision making is not limited to these areas.

NHS England have identified 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. Working with NICE and Health Education England, NHS England respectively will develop decision making tools and roll out training to workforce. The specific clinical situations are listed in **Appendix 1**.

When commissioners are looking to expand shared decision making they may want to focus on specific cohort pathways and then spread the implementation wider. This approach will allow commissioners and clinicians to fully map out decision making for a particular group of people, implement with confidence, evaluate and learn from the process. Cohorts on which to initially focus may be those which are part of a local strategic plan, or an area which requires attention regarding high admissions or waiting lists. By paying attention to individuals' informed preferences providers can support people to achieve outcomes that matter to them. Aggregating the decisions of informed individuals to a population level means CCGs can commission and provide services that informed people want and therefore allocate resources more efficiently.

Agreeing a cohort should be completed in partnership with all key stakeholders. Clinical leadership and public and patient involvement is essential to ensure decision-making is high quality, people and community centred and has the desired outcomes for the patient and the system.

2.2.3 Contracting & Working with Partners

For shared decision making to become business as usual for healthcare, there needs to be a subtle shift in culture and the time to implement this will need to be recognized in action plan timescales. The amount of time needed to embed SDM should not be underestimated as it is a journey of continuous improvement.

The NHS England Shared Decision Making Summary Guide⁵ suggests four key enablers to successfully implement SDM. These are as follows:

Enablers to Implement Shared Decision Making	
1. Commissioned services	SDM should be built into points along a care pathway when a decision needs to be made. This is particularly relevant when people face 'high value' decisions where the choice can have a significant impact (positive or negative) on their lives. At these decision points, options should include medical treatments, doing nothing and (where relevant) the option of psychosocial/community support.
2. Trained teams	Most health and care staff will need to receive training to confidently take part in SDM conversations. The skills required involve training in motivational/health coaching approaches, alongside specific training in risk communication and in

⁵ <https://www.england.nhs.uk/wp-content/uploads/2019/01/shared-decision-making-summary-guide.pdf>

working with people at low levels of health literacy. A barrier to the uptake of training is 'unconscious incompetence'- in other words many clinicians do not understand that they might benefit from training. Local clinical leaders who appreciate the value of training in SDM and can act as champions can be particularly helpful in encouraging uptake of training opportunities.

3. Prepared public

Individuals should be supported to play as active a role as they wish in decisions about their care. As outlined above, there is a number of ways in which local health systems can ensure that people are prepared to share decisions.

4. Supportive Systems and processes

Implementation of SDM should be clinically-led and all improvement efforts should be co-produced with people with lived experience. Senior organisational leaders (executive, clinical, voluntary and community sector, and lived experience) should visibly signal that SDM is an important organisational priority to drive improvement.

Care pathways should be mapped to identify decision points and consideration given to embedding health literate decision support resources at these points; these tools should be readily available to clinical teams. NICE guidelines should be the primary resource for decision support tools as NICE routinely incorporates them into its guidance.

Validated measurement and monitoring of SDM should be used to ensure that it is taking place to a high standard. Measures that can be used include:

- GP patient survey item 28⁶
- Three-item CollaboRATE⁷
- SDM Q9⁸

Commissioners should also measure the *impact* of implementing SDM on service utilisation. Implementing this feedback loop will ensure that over time, commissioners and providers design and deliver services that informed individuals want.

Shared decision making should be built into points along a care pathway when a decision needs to be made. This is particularly relevant when people face 'high value' decisions where the choice can have a significant impact (positive or negative) on their lives. At these decision points, options should include medical treatments, doing nothing and (where relevant) the option of psychosocial/community support. Commissioners need to bear in mind that the psychosocial/community support options will need to be commissioned, often but not exclusively, from the VCSE via a social prescribing route.

Primary care networks will be a key delivery mechanism for this expansion. A commitment has been made to expand the shared decision making programme in

⁶ <https://gp-patient.co.uk/Files/Questionnaire2018.pdf>

⁷ <http://www.glynelwyn.com/collaborate.html>

⁸ http://www.patient-als-partner.de/index.php?article_id=20&clang=2/

2019/20, developing decision support tools and e-learning resources to embed shared decision.

2.2.4 Service Specification

The following narrative is suggested for inclusion in Service Specifications. This should be amended locally to ensure fit for purpose.

“Shared decision making (SDM) is a process in which individuals and clinicians work together to understand and decide what tests, treatments, or support packages are most suitable bearing in mind a person’s own circumstances. It brings together the individual’s expertise about themselves and what is important to them together with the clinician’s knowledge about the benefits and risks of the options. This means that lay expertise is given the same value as clinical expertise.

Shared decision making requires skill from professionals and most importantly a willingness to involve people in decisions about their care. It also needs recognition from those same healthcare professionals that individuals, particularly those with lower levels of health literacy, may need support to take a more active partnership role with their care professional. To be successful, it relies on two sources of expertise:

- the health professional as an expert on the effectiveness, probable benefits and potential harms of treatment options; and
- the individual as an expert on themselves, their social circumstances, attitudes to illness and risk, values and preferences and increasingly knowledge of the latest evidence

In any decision where there is more than one option, the values and preferences of the person, such as their attitude to risk, may be as important as the clinical evidence in choosing which option to follow. Shared decision making enables individuals to align their preferences to treatment options that are clinically valid. It does not mean that people can choose clinical treatments that have no evidence base.

Shared decision making will be implemented within this service for the “ENTER COHORT TYPE” cohort. The provider will have a clear written protocol in place for SDM and its use in a care pathway. The provider will ensure applicable staff are trained in the skills of SDM such as health coaching, motivational interviewing and improving SDM awareness. Staff can provide valuable insight into where there are opportunities or barriers. All staff can help ensure shared decision making happens by making it part of the culture. A named clinical champion will be identified and given appropriate time to support the implementation of the new way of interacting with service users.”

2.2.5 Metrics and Evaluation Methods

As per the key enablers listed in the table above, providers can validate patient experience using the following tools:

- GP patient survey item 28⁹
- Three-item CollaboRATE¹⁰
- SDM Q9¹¹.

Commissioners should seek agreement on the evaluation techniques used and ensure there are appropriate processes in place to share the findings.

2.2.6 Digital and IG Considerations

Shared decision making in principal does not alter the environment in which the consultation takes place. The major change is being how the content of the consultation is used for decision making. Therefore, incumbent information governance procedures should not be affected.

2.3 Personalised Care and Support Planning

Further information on personalised care and support planning can be found on the NHS England webpage (<https://www.england.nhs.uk/publication/personalised-care-and-support-planning/>).

2.3.1 Summary

Personalised care and support planning mean people have proactive, personalised conversations which focus on what matters to them, paying attention to their clinical needs as well as their wider health. The overall aim is to identify what is most important to the person for them to achieve a good life and ensure that the support they receive is designed and coordinated around their desired outcomes.

Valuing people as active participants and experts in the planning and management of their own health and well-being ensures that the outcomes and solutions developed have meaning to the person in the context of their whole life, leading to improved chances of successfully supporting them.

Integrating health and social care at the point of assessment and planning means the person will not have to repeatedly share their story time and time again, as they will have one assessment and planning experience that results in a single integrated personalised care and support plan.

2.3.2 Identifying Cohorts

Personalised care and support planning is at the heart of personal health budgets and integrated personalised care and results in a personalised care and support plan (or an education, health and care (EHC) plan for children and young people). Where

⁹ <https://gp-patient.co.uk/Files/Questionnaire2018.pdf>

¹⁰ <http://www.glynelwyn.com/collaborate.html>

¹¹ http://www.patient-als-partner.de/index.php?article_id=20&clang=2/

there is a process for offering personal health budgets or integrated personal budgets then a personalised care and support plan should be a key element of this. A budget cannot be given without this comprehensive scoping and planning process that puts what matters to people at the heart of a plan of care and support. All current personal health budget services, and those planned, would benefit from having a specified pathway that includes the personalised care and support plan.

More widely, personalised care and support planning can be beneficial to anyone with ongoing care needs or long-term conditions. A personalised care and support plan process should be considered for any cohort with a long-term condition or which has complexity of care. It is recommended that as any of these services are reviewed or re-designed, a personalised care and support plan process is embedded as standard.

2.3.3 Contracting & Working with Partners

Personalised care and support plans should be built into care pathways for long-term or complex conditions. This is particularly relevant when people have choice of management options and where long-term care options can have a significant impact (positive or negative) on their lives.

If the personalised care and support plan is to become normal practice for healthcare, there needs to be a subtle shift in culture and the time to implement this may need to be recognized. A local CQUIN scheme may support this process of change as workforce will require training in the delivery and promotion of personalised care and support plans.

2.3.4 Service Specification

The following generic narrative for personalised care and support plans is suggested for inclusion in Service Specifications. This should be amended locally to ensure fit for purpose and to meet requirements of any specific cohort.

“Personalised care and support planning encourages care professionals and people with long-term conditions and their carers to work together to clarify and understand what is important to that individual. They agree goals, identify support needs, develop and implement action plans, and monitor progress. This is a planned and continuous process, not a one-off event.

Personalised care and support planning is a process in which the person with a long-term condition is an active and equal partner. The process should normally be recorded in a personalised care and support plan: but this plan is only of value if the process has taken place effectively. This process recognises the person’s skills and strengths, as well as their experiences and the things that matter the most to them. It addresses issues and identifies outcomes and actions to resolve these.

Personalised care and support planning should be offered to people receiving “ENTER SERVICE TYPE” services. It is an essential tool to integrate the person’s experience of all the services they access so they have one joined-up plan that covers their health and wellbeing needs. The pathway process will be documented by the provider and appropriate training will be implemented for all relevant staff.

A personalised care and support plan template should be embedded for routine use by all staff. The 5 areas below are the key criteria for counting personalised care and support plans. All 5 of these criteria need to be in place for a local personalised care and support plans to be counted.

1. People are central in developing and agreeing their personalised care and support plan including deciding who is involved in the process
2. People have proactive, personalised conversations which focus on what matters to them, paying attention to their needs and wider health and wellbeing
3. People agree the health and wellbeing outcomes they want to achieve, in partnership with the relevant professionals
4. Each person has a sharable, personalised care and support plan which records what matters to them, their outcomes and how they will be achieved
5. People are able to formally and informally review their personalised care and support plan.”

2.3.5 Metrics and Evaluation Methods

Local metrics can be agreed with providers to support successful implementation.

The following is a suggestion which can be amended locally to ensure fit for purpose:

- % of eligible people within a defined cohort who agree a personalised care and support plan – (X% Target)
- % of people with a personalised care and support plan were involved as much as they wanted to be in creating that plan (X% Target)
- % of people with a personalised care and support plan find it useful (X% Target)

- % of staff involved in personalised care and support planning have had access to accredited personalised care training, which includes personalised care and support planning (X% Target)
- Annual quality check of a sample of personalised care and support plans by service users, service clinicians and commissioners. The aim is to ensure the personalised care and support plan is effective and agree any improvements in an action plan.

2.3.6 Digital and IG Considerations

Personalised care and support plans templates will naturally require input from different services and organisations. Therefore, the development of a template will be conducted in partnership with key stakeholders.

As well as consent, considerations must be given as to how the information sharing will take place between organisations, with clear controller / processor relationships established, underpinned by signed data sharing agreements. Logistics involved in the creation of personalised care and support plans will differ for each neighborhood as will the solutions to enable safe information sharing.

2.4 Enabling Choice Including Legal Rights to Choice

Further information on choice can be found on the NHS England webpage (<https://www.england.nhs.uk/patient-choice/>)

2.4.1 Summary

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

The Comprehensive Model for Personalised Care will ensure patients will continue to have choice at point of referral and an option to change provider if waiting beyond specified waiting times (at present 18 weeks for routine appointments and 2 weeks for suspected cancer appointments). The money will follow the patient with their choice of provider to fund their care. This applies to both elective care and mental health services. Further guidance specifically on mental health services and choice can be found in the NHS England document 'Choice in Mental Health Care' (<https://www.england.nhs.uk/wp-content/uploads/2018/02/choice-in-mental-health-care-v2.pdf>).

The Universal Personalised Care publication has also set out expansion of choice for maternity and end of life services. For maternity services, learning from the work within the national Maternity Transformation Programme has led to the publication of resources and materials to support women to make informed choices and for frontline staff to engage in personalised care and support planning conversations. For end of life services, the Comprehensive Model for Personalised Care seeks to promote the six Government commitments for end of life care and other elements of the Ambitions for Palliative and End of Life Care. This will result in: better

identification of people who are likely to die within the next 12 months; better, proactive conversations for people to identify their wishes and preferences; and integrated services which wrap around people, facilitated by improved sharing of key information.

2.4.2 CCG Responsibilities

NHS England has published a choice planning guide, ‘Securing Meaningful Choice for Patients: CCG Planning and Improvement Guide’¹² for commissioners. Within this guide, CCGs are asked to complete a self-assessment against the nine minimum standards for choice. These nine minimum standards for CCGs are:

1. Information on patients’ legal rights to choice is publicised and promoted.
2. The NHS services website (<https://www.nhs.uk/>) contains accurate and up-to-date information about providers’ services and compliance with the provider profile policy set.
3. There is engagement with providers where referral, activity and choice trends are discussed, and actions agreed/monitored.
4. There are regular reviews to understand how choice is benefitting patients and to consider extending choice beyond the established legal rights, where patients would benefit.
5. CCGs ensure that, for any services where patients have legal rights to choice, any provider of these services that meets the relevant criteria is made available for patients to choose from.
6. CCGs ensure that patients are offered a choice of provider and team for a first appointment upon referral to an elective service.
7. The Standard NHS Contract requires the full use of the NHS electronic referral system (e-RS) for all consultant-led first outpatient appointments. From 1 October 2018, providers will only be paid for activity resulting from referrals made through e-RS. This will support local health communities to plan for the paper switch off for elective referrals.
[The specific service conditions from the 19/20 standards contract are as follows;

6.2.5 the Commissioners must use all reasonable endeavours to ensure that all Referrals by GPs are made through the NHS e-Referral Service; and

6.2.6 each Commissioner must take the necessary action, as described in NHS e-Referral Guidance, to ensure that all GP Referred Services are available to their local Referrers within the NHS e-Referral Service.]

8. All contracted providers accept all their clinically appropriate referrals.
9. Where notified that a patient will not be treated within maximum waiting times, commissioners must ensure that the patient is offered an appointment with a suitable alternative provider(s).

As choice is a key component of the Comprehensive Model, CCGs need to be aware of their responsibilities and use the self-assessment tools and support offered to ensure they are meeting the requirements and their population is receiving the

¹² <https://www.england.nhs.uk/wp-content/uploads/2017/01/choice-planning-guidance.pdf>

benefits of choice. The NHS England Choice team will be working with CCGs in 2019/20 to further support them with implementing the minimum standards. In readiness for the expansion of this programme CCGs are recommended to ensure as a minimum the following:

- There is a named CCG executive for choice
- There is a local CCG choice policy in place which should aim to cover all of the nine minimum standards for CCGs
- The CCG website has clear advice to the public on their legal rights to choice
- Monitoring and assurance systems and process are in place with Providers to ensure that they are meeting their choice obligations
- Providers are aware of their obligations in regards to choice
- The CCG has a local choice promotion plan in place.

2.4.3 Contracting & Working with Partners

As choice for patients is expanded, commissioners will be required to work closely with incumbent providers and new providers. It is recommended that all provider contracts clearly set out the expectation that choice for patients will be supported by commissioners, referrers and the providers themselves. A Service Development & Improvement Plan can set out what the key deliverables will be along with timescales for achievement.

A local CCG choice policy will assist commissioners with ensuring that consistent approaches to choice are in place with all their providers. It can set out key expectations for organisations within the healthcare system and how they will be supported to enable choice locally. As a minimum this should be a choice policy statement, as detailed in the 'Securing Meaningful Choice for Patients: CCG Planning and Improvement Guide'. The statement is specified as:

1.1 We have a patient choice policy statement, which sets out clear information for patients on:

- **our choice ambitions as a CCG**
- **the scope and parameters of choice in our locality, and how patients can use choice**
- **contact details and references for further information and support.**

2.4.4 Digital and IG Considerations

Whether information is in electronic or paper form, patients have a right and the NHS has a duty to keep confidential information safe. Further resources to support the use of choice using Electronic Referral Systems (eRS) can be found on the NHS Digital webpage (<https://digital.nhs.uk/services/nhs-e-referral-service>).

2.5 Social Prescribing and Community Based Support

Further information on social prescribing can be found on the NHS England webpage (<https://www.england.nhs.uk/personalisedcare/social-prescribing/>)

The 'Social Prescribing Summary Guide' can be found on the NHS England webpage (<https://www.england.nhs.uk/wp-content/uploads/2019/01/social-prescribing-community-based-support-summary-guide.pdf>)

2.5.1 Summary

Link workers give people time, focusing on 'what matters to me' as identified through shared decision making or personalized care and support planning. They take a holistic and culturally appropriate approach to people's health and wellbeing, co-producing simple personalised care and support plans to address their health and well-being needs. They also connect people to community groups and agencies for practical and emotional support. Furthermore, a key aim of the social prescriber role is to address health inequalities locally, through working with people in most deprived areas.

The NHS Long Term Plan aims to fully encompass social prescribing into the Universal Personalised Care Model and as such over 1,000 trained 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 will be referred to social prescribing schemes by then. The funding for these link workers will be made available directly to primary care networks. These additional link workers are not intended to replace existing social prescribing services but to complement them. Commissioners need to be aware of the scheme and support their primary care partners as they contribute to increasing capacity that may already be within the system.

2.5.2 Identifying Cohorts

Social prescribing works for a wide range of people, including people:

- with one or more long-term conditions
- who need support with their mental health
- who are lonely or isolated
- who have complex social needs which affect their wellbeing.

When social prescribing works well, people can be easily referred to link workers from a wide range of local agencies, including general practice, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations. Self-referral is also encouraged.

It is recommended that for most services, social prescribing should be considered as an option within a pathway. Patients may have identified needs that can have a negative impact on their care and treatment plans. Where this is recognized then the social prescribing option should be utilized. Criteria may be required to ensure the system capacity is not affected short term but good practice models show that open

referrals, with no restrictions, allow a social prescribing system to contribute the highest level of benefit.

2.5.3 Contracting & Working with Partners

VSCE organisations and community groups are key contributors to social prescribing. They can provide link workers, community activities and support. Development and support to VCSE services is required from local commissioners to increase the menu of community activities and enable robust social prescribing connector schemes with link workers embedded in primary care. Larger, established VCSE organisations are often able to manage the link worker services on behalf of an area. They are important to maintain an infrastructure of trained staff and directories of services. However, commissioners should also ensure smaller and more diverse community services are supported as they will support equality for people and help reduce health inequalities.

Contracting arrangements can vary significantly. There is a clear requirement for partners to work together to ensure social prescribing and its infrastructure is supported by joint working arrangements. Namely between CCGs, primary care networks, local authorities, VCSE and public health.

2.5.4 Link Workers and Primary Care Networks – Requirements for CCGs

Investment and Evolution: A Five-Year Framework for GP Contract Reform to implement the NHS Long Term Plan¹³ (January 2019) establishes Social Prescribing Link Workers (SPLW) as one of five additional reimbursable¹⁴ roles that are intended to become “an integral part of the core general practice model throughout England” by 2023/24. NHS England has committed to reimburse the SPLW role at 100%, without tapering, over a five-year period, to enable at least 900,000 people to be referred to social prescribing by 2023/24.

In response to this, CCG commissioners should work with other partners, including Primary Care Networks, other statutory agencies, Local Government, existing social prescribing schemes, and the VCSE, to ensure that sustainable funding is in place to ensure a broad range of community-based activities are in place for people to be referred to by the SPLW. The five-year commitment to fund SPLWs creates the opportunity for innovative funding models to be developed on a sustainable and strategic basis. These might include locally-held shared investment funds to support shared local priorities, social action bonds, allocating a proportion of the community services budget to VCSE organisations, small-grant making, and micro-commissioning. It should be remembered that VCSE groups and organisations come in a wide range of shapes and sizes, and so a range of funding mechanisms will be required.

At system level, STPs /ICSs should ensure that their five-year plans in response to the NHS Long Term Plan contain explicit proposals to deliver the above.

¹³ <https://www.england.nhs.uk/publication/gp-contract-five-year-framework/>

¹⁴ The reimbursement is only for salary and employer on-costs.

2.5.5 Financial Considerations

It may be helpful for organisations to seek written agreement of their working funding arrangements for social prescribing which may or may not be through a contract. The written document may include as a minimum an outline of the funding values, how money will be allocated to VCSE providers, and the responsibility within each organisation linked to funding levels.

2.5.6 Service Specification

a) Link Workers in Primary Care Networks

The social prescribing link worker requirements for primary care networks is set out in section 4.5 of the [Network Contract Directed Enhanced Service](#) (DES). Paragraph 4.5.16 provides the key role requirements for social prescribing link workers and section 5 sets out the reimbursement information arrangements.

b) Referral into Social Prescribing Services

The wording suggested below can be inserted into all service specifications where a social prescribing service is available for referral. Commissioners will need to share with the providers a clear referral pathway and relevant information to enable referral into the service where needed. In addition to this it is important to be clear on what makes a good referral or list any acceptance criteria where appropriate.

“Social prescribing is a way for local agencies to refer people to a link worker. As members of the primary care network team of health professionals, link workers give people time, focusing on ‘what matters to me’ and take a holistic and culturally appropriate approach to address people’s health and wellbeing. They provide personalised support to individuals, their families and carers to take control of their health and wellbeing, live independently and improve their health access and outcomes and also connect people to community groups and statutory services for practical and emotional support.

The provider will put into place a process for identifying and referring people who may benefit from the social prescribing. For the purposes of this service this may include people who:

- “LIST THOSE PEOPLE IN SERVICE WHO MAY BENEFIT”

The provider will identify people for social prescribing following assessment of needs and will ensure the individual is aware of the referral and the benefits it may have.

The provider will liaise with social prescribing connector services to ensure they have appropriate access to link workers for the service cohorts needs, for example accessibility.”

2.5.7 Metrics and Evaluation Methods

It may be appropriate with some services, especially where there is likely to be a large cohort who can benefit, to include some monitoring of referral to social prescribing services. The following is a recommendation which can be amended for local use:

- Number of referrals made to social prescribing service – target to increase against a set baseline
- X% of people take up their social prescription after referral.

2.5.8 Digital and IG Considerations

Social prescribing is a way of connecting people to community groups and agencies for practical and emotional support. Informed decision-making takes place prior to referral and this must ensure the patient is fully informed of what social prescribing involves to enable them to make the choice of whether it is right for them.

Community assets, for example community groups, will be at varying stages of maturity and therefore it is advised to adopt a risk based and prudent approach to information sharing. As a result, information governance should not act as barrier to entry for new groups. For social prescribing to work well, commissioners are advised to cultivate a community asset base which can flex according to local demands. To achieve this, assets need to be supported to adhere to bureaucratic controls to enable them to create innovative community initiatives.

2.6 Supported Self-Management

Further information on Self-Management can be found on the NHS England webpage (<https://www.england.nhs.uk/ourwork/patient-participation/self-care/>).

2.6.1 Summary

Supported self-management is the approach to supporting people to have choice and control over the way their care is planned and delivered, based on ‘what matters’ to them and their individual strengths, needs and preferences. Supported self-management starts by proactively identifying the knowledge, skills and confidence (patient activation) that people have to manage their own health and care. This can be complete using tools such as the Patient Activation Measure® (PAM®), long term condition patient reported impact measure (PRIM) or self-efficacy scales for people with long term conditions.

It is part of the shift in relationship between health and care professionals and people represented by personalised care. This means a person not being seen as a patient with symptoms or different conditions that need treating, but rather as a whole person with skills, strengths and attributes, as well as needs that need to be met. It means health and care professionals tailor their approaches to working with people, based on the person’s individual assets, needs and preferences, as well as taking account of any inequalities and accessibility barriers, and so working in a personalised way based on ‘what matters’ to the person.

Supported self-management means ensuring approaches are systematically put in place to help build knowledge, skills and confidence. These approaches include:

- Health coaching – helping people gain the knowledge, skills, tools and confidence to become active participants in their care so that they can reach their self-identified health goals
- Self-management education and learning – any form of formal education, informal learning or training for people with long-term conditions focused on helping them to develop the knowledge, skills and confidence they need to manage their own health care effectively
- Peer support – a range of approaches through which people with similar long-term conditions or health experiences support each other to better understand the conditions and aid recovery or self-management. Peer support may be formal or informal: it can be delivered by trained peer support staff and volunteers, or through more informal, ad hoc support among peers with lived experience.

‘Patient activation’ describes the knowledge, skills and confidence a person has in managing their own health and care. Evidence shows that when people are supported to become more activated, they benefit from better health outcomes, improved experiences of care and fewer unplanned care admissions. Patient activation is of particular importance to people living with long-term conditions who rely, more than most, on NHS services. By understanding people’s activation levels, the NHS can support those people with long-term conditions in ways appropriate to their individual needs. The PAM[®] is a tool that enables healthcare professionals to understand a patient’s activation level, or their level of knowledge, skills and confidence to manage their long-term condition.

NHS England has been working with partners to understand how patient activation can lead to more personalised care. As part of this, 1.8m PAM[®] licenses were purchased in 2016, which are now being utilised across over 100 sites. Currently sites are using PAM[®] to understand the activation level of their local population and tailor their services according to individuals’ needs, which can help them lead better lives at a lower cost to the system. Further information on how the PAM[®] tool is used can be found in the ‘Quick Guide to Implementation’¹⁵ published by NHS England.

2.6.2 Identifying Cohorts

Supported self-management approaches can work well with people with long-term conditions who will benefit from understanding and managing their condition. Case studies, available from the PAM[®] Learning Set¹⁶, have shown positive outcomes for mental health, long-term conditions with three or more co-morbidities, diabetes and weight management programmes.

As with any planned service development, commissioners should look for opportunities to introduce a supported self-management model within cohorts that

¹⁵ <https://www.england.nhs.uk/wp-content/uploads/2018/04/patient-activation-measure-quick-guide.pdf>

¹⁶ <https://www.england.nhs.uk/ourwork/patient-participation/self-care/patient-activation/pamlearning/>

have strategic prioritisation or have other cause to look at offering different approaches such as high delivery costs or quality issues. Understanding people's activation levels can support commissioners to put in place approaches to meet their population's needs more appropriately. This can include targeting and allocating resources to provide more in-depth support to those people with low knowledge, skills and confidence to self-manage. As areas implement tried and tested self-management approaches they can then roll out the learning to other cohorts.

2.6.3 Contracting & Working with Partners

An agreed Service Development & Improvement Plan can set out how partners will work to introduce new models of supporting self-care intervention along with timescales for achievement.

NHS England are seeking to implement PAM[®] licences throughout the country during 2019-20. If areas are interested in implementing PAM[®] sooner, then they can submit an expression of interest using the following email address: ENGLAND.patientactivation@nhs.net.

2.6.4 Service Specification

The wording for a service specification will need to be agreed locally to meet the requirements of the self-management intervention in place. Commissioners may want to consider service specification wording for any of the following:

- Use of the Patient Activation Measure (PAM[®]) tool where licences are in use including:
 - patient criteria and exception criteria
 - who will implement the tool and undertake the required training
 - defined timeframes for PAM[®] reassessments
 - what the intervention will be to improve patient activation (particularly for PAM[®] levels one and two)
 - how this will be monitored and evaluated
- Health Coaching interventions – either delivery of or referral to
- Patient Education programmes – either delivery of or referral to
- Peer Support programmes – either facilitating delivery or referral to

Where a provider is required to deliver an intervention then full details of this will be required within the specification. Where a provider is required to refer into programmes delivered by other providers then ensure they have full details on who and how to refer.

2.6.5 Metrics and Evaluation Methods

Local quality measures and information reporting can be agreed with providers. The following are suggestions which can be amended locally to ensure fit for purpose:

- Number of PAM[®] licences utilised within the defined cohort as a proportion against agreed trajectory (aiming to achieve a minimum of X% of agreed target)
- AND/OR

- Increase in knowledge, skills and confidence of people, within the defined cohort, for at least X% of people with measured patient activation levels of one or two by 15 points
AND/OR
- Number of attendees for health coaching within the defined cohort as a proportion against agreed trajectory (aiming to achieve a minimum of X% of agreed target)
AND/OR
- Number of attendees/ utilisations for patient education within the defined cohort as a proportion against agreed trajectory (aiming to achieve a minimum of X% of agreed target)

It is important to note when setting targets that not everyone is suitable to complete the PAM[®] survey. The PAM[®] survey is not suitable for all cohorts including people with severe and enduring mental health issues, dementia and learning disabilities and it is designed to be completed only by those with a reading age of above 12.

2.7 Personal Health Budgets and Integrated Personal Budgets

Further information on personal health budgets can be found on the NHS England webpage (<https://www.england.nhs.uk/personal-health-budgets/>).

2.7.1 Summary

A personal health budget is an amount of money to support the identified health and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the health care team/local clinical commissioning group (CCG). It isn't new money, but a different way of spending health funding to meet the needs of an individual.

Personal health budgets are one way to give people with long term health conditions and disabilities more choice and control over the money spent on meeting their health and wellbeing needs. A personal health budget may be used for a range of things to meet agreed health and wellbeing outcomes. This can include therapies, personal care and equipment. There are some restrictions in how the budget can be spent. Further details on these restrictions can be found within the personal health budgets frequently asked questions document on the NHS England personalised care website (<https://www.england.nhs.uk/personal-health-budgets/what-are-personal-health-budgets-phbs/frequently-asked-questions-about-phbs/>).

The NHS Long Term Plan has a commitment to accelerate the roll out of personal health budgets and up to 200,000 people will benefit from a personal health budget or integrated personal budget by 2023/24.

2.7.2 Identifying Cohorts

Since October 2014, people in receipt of NHS Continuing Healthcare (CHC) or Continuing Care for Children and Young People, have had the 'right to have' a personal health budget in law.

During 2018, NHS England consulted on extending this legal right to have to the following groups:

- People with on-going social care needs, who also make regular and on-going use of relevant NHS services (as an integrated budget, discussed later)
- People eligible for Section 117 aftercare services, and people of all ages with on-going mental health needs who make regular and on-going use of community-based NHS mental health services
- People leaving the armed forces, who are eligible for on-going NHS services
- People with a learning disability, autism or both, who are eligible for on-going NHS care
- People who access wheelchair services whose posture and mobility needs impact their wider health and social care needs. For further information on wheelchair budgets see the NHS England Wheelchair Budgets webpage (<https://www.england.nhs.uk/personal-health-budgets/personal-wheelchair-budgets/>).

The outcome of the consultation has been confirmed and the first new areas which will have a legal right to a personal health budget are for people eligible for an NHS wheelchair and for people who access after care services under section 117 of the Mental Health Act. However, benefit is linked to need rather than a particular condition, so a personal health budget may also be appropriate for many other people with health needs. For example, someone who is accessing acute services frequently, illustrating that their current provision is not working effectively for them.

For further information on how to develop a personal health budget offer for any of the cohorts from the consultation then visit the NHS England website (<https://www.england.nhs.uk/personal-health-budgets/>). The consultation outcome can be read in full on the gov.uk webpage (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/780330/Extending_legal_rights_to_health_budgets_consultation_response.pdf).

2.7.3 Contracting & Working with Partners

Clear contracting structures need to be in place to support personal health budgets with larger providers due to the complexity of funding and governance. However, current use of personal health budgets is largely limited to arrangements where there are no structured contracts in place, such as for Continuing Healthcare.

Where no single contract exists, clarity is required for the process of issuing and managing a personal health budget. There needs to be clearly defined roles for

organisations to be clear on who and how a patient will be selected, referred, assessed, supported to manage a budget, reviewed and evaluated.

Therefore, it is recommended that each element of a personal health budget pathway is assessed in regard to the contractual agreements or frameworks in place. Those elements include:

- Who will identify the patients suitable for PHB?
- Who will make the referral?
- Who will receive the referral and assess initial acceptability?
- Who will discuss the personal health budget process and agree an indicative budget along with a personalised care and support plan with the patient?
- How will integrated budgets be managed?
- How will the plan and budget be approved?
- Who will review the plan and budget?

When each part of the process is identified, commissioners can then assess in regard to governance and risk. The following questions may help the process:

- Is there a contract or structured agreement in place such as a grant?
- Where contracts are in place do they adequately set out the process detail in appropriate schedules i.e. service specifications, activity and information requirements, pricing structures?
- Are there adequate quality standards in place?
- Are there audit processes in place for assessing quality standards?
- Does each part of the process have any risk regarding Information Governance? Assess data security, confidentiality, consent etc
- Is there an adequate data system in place and does it support data sharing where required?
- Is there a process in place for reporting incidents, risk or concerns?
- Is there a panel or group that will oversee the personal health budget process?

2.7.4 Financial Models

The primary focus of a personal health budget setting process is to:

1. Develop a realistic indicative budget after carrying out a needs assessment but before having detailed knowledge of the person's care and support needs.
2. Set the final budget at a sufficient level to cover the full costs of the services agreed later in the personalised care and support plan.

The budget setting process is important because there is a need to:

- Adequately plan and make decisions about their care, people need to know the amount of money in their budget.
- Have a consistent approach to budget setting to ensure fairness across all budget holders.
- Understand costs at a person level and plan for the population accordingly.

The personal health budget and indicative budget should be set at no more than the cost of care that the person would have received under traditionally commissioned

services in the agreed place of care. Following detailed care and support planning the funding requested may be higher or lower than the indicative budget.

a) Underlying budget setting principles

All approaches to budget setting should be underpinned by the following principles.

- **Transparency.** The person and their family should be made fully aware of what their budget is and how it has been calculated. A person-centred approach to budget setting must be transparent to fully involve the person in the process.
- **Timeliness.** An indicative budget is known prior to the detailed personalised care and support planning process, to enable the person to plan how their needs and outcomes can be met.
- **Sufficiency.** The final budget must be sufficient to meet the assessed needs and intended outcomes of the person. In the NHS, funding must be sufficient to fully meet all identified health needs within the personalised care and support plan.

b) The Budget Setting Process

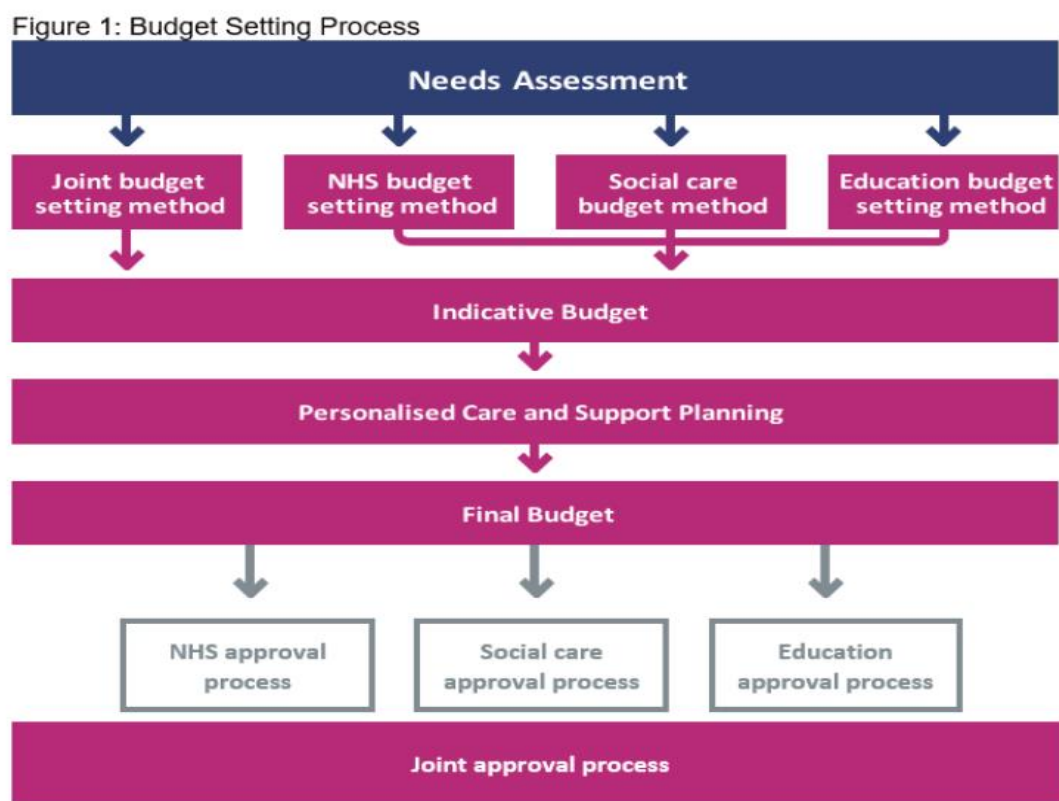
The primary focus of a budget setting process is to develop a realistic estimate of the money available to a person to meet their assessed needs and which is used to develop their personalised care and support plan. Estimating the healthcare cost for somebody who potentially uses many different services across several provider organisations can be complex. The statement of resources, described further within this chapter, enables all service and cost information to be brought together in one place, thus enabling the development of an indicative budget.

Whatever method is used to calculate an indicative budget, it should be informed by the linked data set (see Chapter 5 for more detail), which indicates historic service use and the needs assessment. It will also be informed by what services or elements of services can be included locally, how the personal health budget or integrated personal budget is going to be funded, and where that funding is coming from. This information will be set out in the system-level statement of resources, discussed below.

Ideally, where people are eligible for support from social care or through an EHC plan, a joint budget setting process should be carried out with the NHS. However, this takes time to design and implement in a local area, so it is possible for each organisation to carry out their own process in parallel, meeting the specific regulatory requirements for their organisation, but bringing them together to give the person one joint indicative budget prior to the start of personalised care and support planning. See Figure 1. This stage also allows a 'cross-check' for areas of duplication where different organisations may be providing the same service.

The final budget is calculated after the detailed personalised care and support planning has been carried out. The final budget reflects the costs of all the services and support agreed in the personalised care and support plan and the extent to which the person may be contributing to the costs of their own care for social care. The final budget may be higher or lower than the indicative budget and may need to

go through an additional approval process accordingly. The approval process outlined below covers only the financial elements, since in practice, the personalised care and support plan will also need to be signed off by the CCG.



c) What is the statement of resources?

The statement of resources is a tool that brings together all health, social care and education activity and cost information. It can be used to develop a personal health budget or an integrated personal budget. It does not replace budget-setting practices in social care or education, but rather, it enables the output of these processes to be summarised into one statement for the person. Two versions of the statement are developed as set out below; one for the system, and one for the person. Examples of these statements in use can be found on the FutureNHS Collaboration Platform (<https://future.nhs.uk/connect.ti/system/home>).

d) System-level statement of resources

The system-level statement of resources enables a health and care economy to understand all planned support that a person or cohort receives and considers fluctuations or deteriorations in condition. It sets out what services the person is anticipated to access for their planned care over the forthcoming period (generally one year). This includes items that cannot be included within a personal health budget, such as prescribing or some condition-specific treatments, or services that it does not make sense to include in a personal health budget.

The system-level statement of resources sets out what can and cannot be included within a personal health budget at the present time and whether there are plans to expand the scope of personal health budgets in the future. The statement of resources includes a timeline column that recognises that it may not currently be possible to release funding from some contracts but sets the ambition to do so. This enables the whole system to understand the long-term local intentions for the programme, allowing appropriate plans to be made when commissioning or developing services.

The use of this version of the statement of resources assures all interested parties that all aspects of planned care have been considered and gives a rationale for their inclusion or exclusion. It enables commissioners and providers to recognise those services that may be affected by personal health budgets and personalised care, and whether it is included within the budget. It can also support contract redesign, since it indicates which contracts may be most affected by the implementation of personal health budgets.

This high-level statement of resources can be developed at cohort level, giving an average cost for a person who meets the characteristics of that group. In reality, an 'average' person does not exist, so personalised care areas that are using this methodology have used it to create a banded statement of resource depending upon levels of need.

The system-level statement of resources should be based on both historic resource use and the person's needs assessment. The historic resource use will give a sense of what the person has previously accessed to inform the personalised care and support planning discussion. The needs assessment, in addition to giving a sense of what health and care needs the person has, will also inform whether the person's condition is likely to change over the coming year. This too will need to be taken into account within the system-level statement of resources.

e) Person-level statement of resources

The person-level statement of resources is derived from the system-level version. This statement includes information about all the services available to support the person but only includes costs for those elements that the person has choice and control over and can be included in the budget, hence providing an indicative budget.

It may also include additional information about the outcomes that the money is intended to support, although this will be refined during the personalised care and support planning process.

f) Completing the system-level statement of resources

The system-level statement requires the following information:

- Current provider: Which organisation is currently delivering a service for this cohort or person?
- Service: What is the service being provided?
- What the service is for: What is this treating or what outcome is it trying to meet?

- How cost is calculated: Which costing system is being used, and are costs available?
- Units per year: How many times will that service be provided in a year and what is the unit measure (e.g. hour, session, test).
- Cost per unit: Monetary value of each item of activity.
- Include [service] in personal budgets? A yes/no answer for whether that service can currently be included within a personal budget. For some services this will always be 'no', (such as prescribing) but for others it may change depending on contractual arrangements varying with providers.
- When could [the service] be included? For those services waiting for a contractual change before inclusion, when is that change anticipated?
- Financial forecast columns. These can be used to both estimate cohort costs by entering the anticipated uptake of these services, and to begin calculation of a person's indicative budget by multiplying up an individual service usage (in which case, the uptake is 1).

g) Budget mechanisms

There are different ways in which people can receive a personal health budget or integrated personal budget. People can have a personal health budget or integrated personal budget in one, or any combination of these three ways:

1. A notional budget, where the money continues to be held by the local authority or the NHS, but the person has a clear understanding of the amount of money allocated to their care and support and is supported to develop a care and support plan.
2. A third-party budget, where an organisation independent of the person, the local authority and NHS commissioners holds some or all the money on the person's behalf to fund the support identified within the agreed care and support plan.
3. A direct payment, where the budget holder holds the money in a bank account or an equivalent account and takes responsibility for arranging care and support in line with the agreed, personalised care and support plan.

Part of the aim of personalised care and personal health budgets is to give people more choice about the care that they receive. In practice, some people will want to have more choice and control than others. This includes personal health budgets, where a notional budget may involve the CCG administering the funding on the person's behalf, through to a direct payment where the person directly commissions the services they access. Experience and emerging evidence show that people's outcomes improve, and costs fall when they receive a personal health budget; however, they should not be forced to take more control than they are comfortable with.

CCGs will enable the use of personal health budgets by ensuring the following is in place:

- CCGs must be in a position to be able to offer all three types of budget. There may be some circumstances where one or more options are unsuitable – but these decisions should be taken at person level rather than for a whole cohort.

- CCGs should have adequate support in place for all budget models so that the person has sufficient information to make a decision about which option is best for them or offer help to make the most use of the budget.
- Regardless of the type of budget the person uses, the CCG should ensure that the implementation of personal health budgets is in line with the key features of personal health budgets, particularly transferring control to the person.

It may be useful to have a list of examples of what a personal health budget could be spent on (but do not restrict to these examples) and how this interacts with any social care budget and any implications about where pooled budget operate at commissioning or provider basis.

The type of arrangement put in place should support the purpose of each personal health budget and be adapted to suit each person's circumstances. Some people may be clear from the start on how they would like to receive and manage their personal health budget; others may decide as the process unfolds. Whichever approach, or combination of approaches, people go for, they should be given sufficient information, advice and support to ensure that they can take responsibility effectively. It should also be possible for people to be able to change the method as they go through the process.

h) Exclusions from direct payments

Direct payments offer the person the highest level of control. However, they will not be suitable for everyone. Access to specialist advice and peer support may, however, enable people to choose this option who may not otherwise have done so. Some people will opt not to take their personal health budget as a direct payment and others may be deemed unsuitable to receive a direct payment, due to circumstances in their life. Further details on these restrictions can be found within the personal health budgets frequently asked questions document on the NHS England personalised care website (<https://www.england.nhs.uk/personal-health-budgets/what-are-personal-health-budgets-phbs/frequently-asked-questions-about-phbs/>).

Personal health budgets, including direct payments, remain public money, and are taxpayer funded. Therefore, the CCG should be clear that transferring the money to the person as a direct payment will result in the money being spent in ways that are likely to meet the desired health and wellbeing outcomes set out in the personalised care and support plan. If this is not the case, the CCG has the right to withhold a direct payment from a person and only offer a personal health budget as a notional budget or a third-party arrangement.

2.7.5 Service Specification

The state of readiness of a provider for personal health budgets will vary dramatically and there is a need for careful planning before a personal health budget can be offered to a particular cohort. Where there is joint agreement to develop a personal health budget process then the detail of the process must be carefully recorded within a service specification.

Note that in many cases a testing period may be appropriate where a personal health budget process is new. Therefore, specifications should reflect the flexibility required to introduce change.

As the wording for each cohort and process will be very different, the following is a list of considerations for which the provider and commissioner must consider and then detail within the service specification.

- Defined cohort
- Eligibility criteria
- Mapped service pathway
- Budget setting process
- Financial systems
- Auditing processes
- Linked data sets
- Evaluation measures
- Liaison with key stakeholders including service users
- Workforce requirements
- Communication and information on offer
- Governance arrangements

2.7.6 Metrics and Evaluation Methods

Local quality measures and information reporting can be agreed with providers. Due to the variability of delivery of personal health budgets these will need to be developed in agreement with the provider on a case by case basis. The following are generic suggestions which can be amended locally to ensure fit for purpose:

- X% or more of people with a PHB/IPB would recommend one to someone else
- X% or more people with a PHB/IPB would, on average, rate their experience of having a PHB/IPB at seven or higher on a scale of 1-10.

2.7.7 Digital and IG Considerations

Personal health budgets bring together IG considerations from other aspects of the Comprehensive Model for Personalised Care. For example, every personal health budget will be underpinned by a personalised care and support plan and in some cases a PAM[®] answer sheet and score may be attached to the care record.

When planning a local personal health budget offer, data must be considered in the same way as other components of a project (finance, operations, workforce, etc.). An effective method is by using a Privacy Impact Assessment (PIA), where data considerations can be risk assessed and mitigating plans are created. PIAs are detailed in Chapter 5.

A personal health budget can bring together professionals from various government departments as well as other agencies and organisations. Data sharing between these organisations must be clear, with contracts in place if required.

As personal health budgets are a new way of working for most areas, many organisations approach this change with a small number of cases and use the associated intelligence as the basis for further investment. When taking this approach, CCGs must consider how to lawfully obtain the data generated by personal health budgets to effectively monitor and analyse their impact.

2.8 Co-Production

Further information on co-production can be found on the NHS England webpage (<https://www.england.nhs.uk/publication/co-production/>)

2.8.1 Summary

Co-production fundamentally recognises and understands how people can contribute to care and support at all levels. It increases the scope for people to profoundly influence and shape the support they receive as an individual and as a community. It also enables strong working relationships built on direct, regular contact with senior managers and proximity to decision-making. This models the changed relationship between people with complex health needs, the VCSE sector and statutory services that is central to personalised care.

In addition to supporting organisations to embed co-production as the norm, the Universal Personalised Care document includes the commitment to:

- 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 personal health budget to have access to advocacy.

2.8.2 Contracting & Working with Partners

Co-production should be a key element of implementation plans for the NHS Long Term Plan and it should be included at both STP/ICS and at a local place level. The plans should clearly demonstrate leadership and commitment to co-production. Robust co-production plans are particularly important when planning implementation of the personalised care model. It is recommended that commissioners and providers embed co-production in their processes for all service reviews and transformation programmes. A local policy would be helpful to outline the key components of working together with people to design interventions that are meeting the needs of people in a way that matters to them.

The Service Development and Improvement Plan (SDIP) can be an appropriate mechanism of specifying the requirement of co-production. With few exceptions, every item on the SDIP should make reference to how co-production may be implemented.

Co-production at a local level should be inclusive of all stakeholders including VCSE, education and wider communities. A stakeholder analysis will inform those who need to be included and actively participating. However, it is also important to pay particular attention to the role of people who will benefit from personalised care and

within that those in diverse or those people who find services harder to access. The NHS England approach to strategic coproduction ensures that the voice of people with lived experience of personalised care is at the heart of local policy, strategy and implementation plans.

2.8.3 Service Specification

The level of co-production that is appropriate will vary but there can be element of co-production for most services and interventions.

When considering wording for a service specification consider what beneficial impact co-production might have, the scale of the service, and the flexibility that can be offered in the service and then set expectations accordingly.

“Co-production fundamentally recognises and understands how people can contribute to care and support at all levels. It increases the scope for people to profoundly influence and shape the support they receive as an individual and as a community. It also enables strong working relationships built on direct, regular contact with senior managers and proximity to decision-making.

The service provider should ensure there is a co-production plan in place and that they actively involve individuals in care design where possible. The following should be considered as part of the provider plan:

1. Develop a co-production strategy that demonstrates leadership, values and commitment to practice. This includes nominating a lead person and an organisational commitment to developing a co-production.
2. Connect with local people with lived experience of the service. Connecting with local people recognises the importance of co-producing services with people who have lived experience of care and support.
3. Ensure there are tangible outputs that are measurable and outcome-focused and demonstrate the difference co-production has made at all levels. This is about reviewing and recognising the role of co-production within the local service and using this understanding to further inform the development and the contribution people with lived experience of care and support make.”

2.8.4 Digital and IG Considerations

When co-producing any service or intervention, consider the information sharing requirements and if necessary, complete a Privacy Impact Assessment (PIA) for each stakeholder.

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Chapter 3: Financial Models and Budget Setting

CHAPTER SUMMARY

1. METHODS FOR FUNDING PERSONALISED CARE
2. METHODS FOR IDENTIFYING COHORTS
3. RECOMMENDATIONS FOR PLANNING EXPANSION OF PERSONALISED CARE

3.1 Methods for Funding Personalised Care

It is important that areas develop methods for withdrawing funding from existing contracts. This will enable commissioning organisations to shift funding around the health and care system, and to build community capacity and invest with new providers, including VCSE organisations. The following options are suggested as potential options for developing opportunities for funding personalised care.

It is important to recognise that these methods are not mutually exclusive. Most areas that are implementing personalised care and personal health budgets at scale are using two or more of these methods – both separately and alongside one another. It is crucial to maintain stability of the provider sector throughout this process, since whilst personal health budgets (and direct payments in particular) will remove funding from existing contracts, the provider will need to be able to continue offering services, particularly in the short term. Providers may also see this development as an opportunity to increase their business and become a provider of choice. While there may be alternative providers available for some services, this is unlikely to be the case for all services that are provided. Therefore, some of the methods below are focused on maintaining the stability of providers, particularly in the short term, and giving them the opportunity to adjust to the introduction of personal health budgets.

The list of potential options developed so far:

- Double-funding
- Use of local Commissioning for Quality and Innovation (CQUIN) framework
- Introduction of gain/risk-sharing agreements
- Providers manage personalised care budgets (Individual Service funds)
- Reducing growth in existing contracts or surplus in existing contract funding
- Individualised commissioning and spot purchasing
- Identifying areas where there are current issues in service provision
- Capitated budgets and top-slicing
- Money follows the person.

3.1.1 Double-funding

Currently, personal health budget numbers remain relatively small beyond NHS CHC and other individually commissioned areas of NHS care. The staged introduction of personal health budgets in services that are currently block contracted can involve an element of planned and time-limited double-funding to allow local evidence and confidence to build. However, as local implementation scales up, this will not be sustainable in the longer term.

3.1.2 Use of local CQUIN

One way of making progress may be to use local CQUINs. These incentive schemes could make some provider income contingent on pre-agreed quality goals, for example personalising existing services or offering personalised care and support plans. They have the advantage of supporting progress (and some CCGs have used them to introduce personalised services). However, they have the disadvantage that they may not offer people as much choice and control as would be ideal. Current CQUIN guidance should be consulted for requirements of developing local schemes.

Examples of where local CQUINs can be utilised are listed below. This is a non-exhaustive list.

- Training workforce to deliver personalised care and support plans
- Developing pathways and processes to deliver personalised care and support plans/ shared decision making/ self-management approaches
- Developing pathways and processes to deliver personal health budgets to a new cohort such as wheelchairs
- Test personalised approaches on small cohorts with a view to agreeing substantive funding arrangements if well evaluated
- Funding scoping work for integrated pathways that offer personalised care across organisational boundaries

3.1.3 Introduction of gain/risk-sharing agreements

Immediately taking significant amounts of money out of existing contracts risks destabilising providers. This could be mitigated in the short term by gain/risk-sharing agreements. So, if, for example, there is a significant saving by the CCG, the provider could receive some of that income which in the short term would reduce the impact it has on them. This then also gives the provider some time to respond by adjusting or reducing its service provision over time, rather than being immediately affected.

3.1.4 Providers manage personalised care budgets

As providers are likely to be those most affected by the introduction of personal health budgets, they could be given responsibility to manage their introduction. This would mean the provider is expected to run the personalised care and support planning process and offer the person the scope for genuine choice and control, including around the provider's own services. In practice, this could mean the provider sub-contracting with other providers, particularly for notional budgets.

This would likely aid their financial planning and mitigate the risk to them because with the provider running the personalised care and support planning process, they will have a better idea as to whether personal health budget recipients are opting for services from that provider or from elsewhere. This contrasts with the CCG running the personalised care and support planning process, where all provider income affected may be viewed as being 'at risk'. However, it may also risk providers restricting choice so that people access their own services, to mitigate the risk to their income. Therefore, the commissioner would need to clearly articulate, within the service specification, the expectations and cover this as part of their contract monitoring and review. Potentially, areas could consider developing a locally determined CQUIN to further incentivise the development of personal health budgets.

Personal wheelchair budgets are often managed by the provider and are a good example of this approach. Offering a personal wheelchair budget is now the recommended alternative to the previous voucher scheme. Further information on how personal wheelchair budgets can be managed by a provider can be found in the NHS England 'Frequently Asked Questions' document (<https://www.england.nhs.uk/personal-health-budgets/personal-wheelchair-budgets/frequently-asked-questions>).

3.1.5 Reducing growth in existing contracts or surplus in existing contract funding

Rather than explicitly removing funding from contracts, contract growth (such as the nominal growth reflecting inflation) could instead be reduced. This would make funding available that could be used for personal health budgets, or for personalised care in existing services more generally. This may be easier to do than explicitly reducing contract value since this is money the provider did not have.

3.1.6 Individualised commissioning and spot purchasing

Personal health budgets have been easier to introduce in NHS CHC than for other services. This is partly because there is already a history of individualised commissioning, and so the funding is not coming out of a large population-based contract. There are other services that are individually commissioned including Section 117 aftercare in mental health, wheelchair provision and potentially some other community equipment services. Targeting these areas to begin with will help to build up the culture around personalising services and the evidence that it can be a helpful thing to do, for people's outcomes and for spending across the system.

3.1.7 Identifying areas where there are current issues with service provision

Some demonstrator sites have identified services where there are currently high vacancy rates and are offering personal health budgets from the surplus within contracts. They have found that the provider has been more willing to release funding here as the provider has a significant waiting list for these services. In practice, the sites that have done this have done so by allowing people to access the same service from different providers in the local area. It is, however, a small step to

move from this to offering the person a personal health budget from the funding released.

Similarly, personal health budgets and personalised care could be used where there are current service issues around the quality of the service, or recognised gaps in provision. This is likely to help highlight that personalised care can solve existing problems in the system and may help to build support across the CCG.

This may be something that can be used for short-term problems, and to build up the evidence and practice locally to persuade more people as to the benefits of personalised care and personal health budgets. It could also be used in the longer term – so rather than the provider attempting to recruit to vacant posts, the personal health budget becomes the new method of service delivery for the relevant people.

3.1.8 Capitated budgets and top-slicing

The principle behind these two potential methods is similar – that money is removed from a contract. This funding is then used to offer people personal health budgets. In this way, the contract value with the provider is gradually reduced over time as personal health budget numbers and the scope of personal health budgets increase.

If it is done through a capitated method, this would mean for example that an average cost per person, across a patient cohort, is removed from the contract to fund personal health budgets. The average cost may need calculating, through using information available about activity and costs in the contract, or information gathered through the linked data set for the cohort.

If the information is not available to be able to do it through a capitated method, then areas could consider using national and local population and prevalence data to form a basis for agreement. Based on estimates of the likely continued activity within the contract, the activity outside the contract with the contracted provider (i.e. the provider will receive payment but by another route) and the activity outside the contract with other providers, it will be possible to agree an amount to come out of the contract value to fund personal health budgets. It is important that areas obtain the best information available to them to inform the decision-making process.

3.1.9 Money follows the person

The ultimate aim is that money follows the person, supporting them to choose the services that most benefit them. This could be from existing health and care providers or from new providers. In this way, the commissioning system supports the person to achieve better outcomes. At present, it may be that relatively inflexible commissioning is preventing people from accessing services that may be most beneficial to them.

This is likely to be a gradual process. Not all services a person currently receives will be suitable for offering them choice and control – for example, people with type 1 diabetes will need insulin, and so there is no realistic scope for choice and control around the service itself, although there may be scope around who delivers the service and where. There may be benefit in including services and health needs such as this within the personalised care and support plan, but there is likely to be

less benefit in offering the person a personal health budget where they do not have any realistic choice of services.

In contrast, there may be some service areas where there is scope for the person to do something differently and choice and control may be beneficial, but that this is not possible at this stage. For example, if the CCG cannot remove money from a particular service area due to a significant risk of destabilisation of that service, it may be most sensible to not include that service within a personal health budget at this stage. If this is the case, the CCG and the provider should think about how that money can be freed up in due course.

3.2 Identifying Cohorts

3.2.1 What is a Personalised Care Cohort?

The personalised care cohort is a subset of the whole population, within a given area, who may benefit from personalised care. The cohort is derived directly from the strategic commissioning decisions made by the local health and care economy. As areas are unlikely to be able to implement personalised care and personal health budgets for all the potential cohorts simultaneously, a degree of prioritisation is likely to be required. Whilst this could be informed purely by the strategic commissioning aims, there will also be practical considerations to take into account around contracting and where adequate information is available and accessible. For example, for people to have genuine scope for choice and flexibility around both personalised care and personal health budgets, they need to be able to choose different services, from both existing and new providers. This means that it must be possible to release money from existing contracts, which could still be spent on services from the original provider or could end up elsewhere. Therefore, if some contracts are easier to release funding from than others, this may influence the cohort identification and may result in some changes in the order of prioritisation identified through strategic commissioning, including the Joint Strategic Needs Assessment and STP/ICS plans.

Groups felt to be particularly appropriate for personalised care and personal health budgets include, but are not limited to:

- People with multiple long-term conditions
- People with frailty
- People with severe and enduring mental health problems
- Children, young people and adults with complex needs, including learning disability and autism
- Adults in receipt of NHS CHC or those in receipt of children and young people's continuing care
- Protected or diverse groups who may traditionally have issues accessing care.

The groups above are not exhaustive, nor are they neatly defined. In practice, it is also likely that some recipients of both personalised care and personal health budgets will fit into more than one of the groups outlined above.

3.2.2 Why does it need to be defined?

It is necessary to understand the groups of people for whom personalised care is likely to be suitable. This will help with implementation, as well as maintaining clarity around why the interventions are being introduced.

For the local health and care economy it enables commissioning and provider organisations (including VCSE organisations and private providers) to develop appropriate plans and strategies to support that group of people - sometimes addressing long-term inequalities in an area. Frontline health and social care practitioners will be able to identify those who could be supported via personalised care, and providers will therefore better understand the market for their services, enabling more choice to be developed.

Defining the cohort also enables a focus on a group of people. It allows processes to be developed that address specific challenges associated with the characteristics of that group. When attempting to link activity data, it is often easier to obtain agreement for a linked data set for a defined group rather than a blanket population. From a commissioning perspective, it may be possible to limit contract changes to services applicable for that group only.

From the person's point of view, a clear definition of who can currently be offered a personalised care approach can help to ensure that everybody meeting those criteria is given the opportunity to be involved. It can also help to explain why some groups may not currently be included in the work – for example because the CCG is starting with a particular cohort before expanding to other areas.

It is also important to maintain flexibility in who can be included within the respective programmes. Some people in cohorts where personalised care seems a natural fit will not want to take up the offer of more choice and control, and traditional services will need to be maintained for this group. Similarly, some people within cohorts where personalised care approaches are not considered as a matter of course could still benefit from the approach. CCGs should therefore maintain flexibility and think about the person rather than applying blanket rules to cohorts.

3.2.3 Methods to define a cohort

Areas have used a range of methods to define the cohorts for whom they are introducing personalised care. These include, but are not limited to, the following:

- Linking with other initiatives. Personalised care can link with other programmes within NHS England or local areas, for example, all personalised care sites are part of the Transforming Care Programme (TCP) for people with a learning disability.
- Identifying areas with poor outcomes. Some sites have used personalised care to improve care for groups that are currently poorly served in the local area – this may have been identified through strategic commissioning discussions, liaison with people receiving services, through VCSE organisations, through an analysis of complaints, or another method.
- Linking with areas with strong local support. Personalised care gains the most traction when supported by both senior leadership within the organisation and locally respected clinical leaders. As such, some

personalised care cohorts have developed through the enthusiasm of local clinicians who can see the potential benefits for the groups that they work with.

- Looking at cohorts of people who use multiple services. As personalised care aims to improve people's outcomes through better coordination of care, as well as more personalised care and support, looking at groups of people who access care from a range of settings and providers may help to identify people for whom the approach could be beneficial.

In general, sites have identified one cohort and then used the learning from this process to move on to the next areas of focus.

3.2.4 Identifying people within the cohort

Once the overall group has been defined, the next step is to identify people who meet the criteria for the work. The following are examples of how a cohort can be identified.

Methods for identifying who may be suitable for Personalised Care and Personal Health Budgets	
Children and young people (age 0-25) with complex needs.	Multiple long-term conditions.
Those in receipt of children and young people's continuing care.	Stratified risk score from Adjusted Clinical Group tool or similar.
Children and young people identified by nurse assessors, education healthcare or looked-after children team.	People identified by their GP or a frequent attender in primary and secondary care services.
National Quality and Outcomes Framework (QOF) register.	People already part of local initiatives for this cohort.
Children and young people receiving support from social care.	Adults in receipt of NHS CHC.
Children and young people known to local VCSE organisations.	Local QOF register.
	People known to local VCSE organisations.
Learning disability.	Mental health.
The list of people eligible for section 117 aftercare services.	The list of people eligible for section 117 aftercare services.
The Transforming Care cohort.	Local QOF register, especially for dementia.
People receiving ex-Supporting People services.	People identified by local acute trusts as frequent emergency attenders.
Risk registers for people placed out of county.	Individual patient placements and similar local funding arrangements.
People known to local VCSE organisations.	People known to local VCSE organisations.

3.2.5 Equality and Health Inequalities

In order to meet the requirements of the Public Sector Equality Duty (PSED) under the Equality Act 2010 and the duty to have regard to reduce health inequalities under the Health and Social Care Act 2012, all commissioners must assess their approaches to delivering personalised care in regard to equality and health inequalities. The process to screen and then assess will be guided by local policy and process. Local templates will help commissioners to think through the impact of the work on addressing equality issues and reducing health inequalities as outlined commitments in the NHS Long Term Plan.

The following list is by no means exhaustive, but it includes examples of positive action as part of having 'due regard' to reduce health inequalities and promote equality:

- Remove or minimise disadvantages suffered by people due to their protected characteristics- people experiencing a disadvantage connected to that characteristic- for example ensuring information is available in accessible format to meet the needs of people with learning disability or those who English is not their first language;
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people- for example prevalence of certain conditions that might be higher in some ethnic groups;
- Encouraging people from protected groups to participate in public life / other activities where their participation is disproportionately low; for example positive action to ensure under-represented groups can access a service
- Evidence of how the work will help reduce health inequalities.

Commissioners are encouraged to actively consider their population needs in regard to personalised care. When considering population groups for the universal personalised care model components, including personal health budgets, commissioners should actively consider diverse groups or those who may find services difficult to access.

3.3 A Practical Approach to Expansion

The NHS Long Term Plan sets a clear expectation that a total of 2.5 million people will benefit from personalised care by 2023/24, aiming to double this to five million people within a decade (2028/29). In the next few years, NHS England expects numbers to continue to rapidly increase and envisages that personal health budgets will become a routine model in some areas of NHS-funded care.

The success of personal health budgets, and personalised care more generally, will be reliant on the shifts in culture of the NHS, the people who work within it and the people who use the services. It is helpful to consider how moves towards a more personalised approach to commissioning can be developed and expanded over time. For example, it is unlikely that areas can simultaneously look at all the potential ways of extracting money out of contracts/commissioning for personalised services purposes.

Therefore, areas could consider a staged approach, as set out below:

- Start with current 'spot purchases' or 'cost per case' contracts. This includes NHS CHC and Section 117 aftercare for mental health, individually commissioned learning disability services as well as, potentially, community equipment services.
- The next stage could be looking at where the provider is struggling to provide the contracted service since it is likely to be easier to release funding for personal health budgets in such areas. This could, for example, be where there are high waiting lists, high vacancy rates or dissatisfaction with the service currently provided. This could also include instances where there are gaps in provision.
- Following on from the above, the providers could have responsibility for introducing personalised care and running the personal health budgets process for some groups of people.
- Looking at frequent attenders in A&E, and users of emergency services more generally may indicate people whose care is not meeting their needs, or where people are not accessing services. This may be a good place to consider the use of personal health budgets, since such people are likely to be low in volume, high in cost and so with significant potential to both improve their outcomes and reduce the costs to the overall system.
- The final stage is taking money out of the large contracts – for health, this includes community services, mental health and acute care contracts. Initially, this would be for direct services commissioned through personalised care and personal health budgets. In the longer term, it may be feasible to release funding from services indirectly affected by the introduction of personalised care.
- Other potential services to explore include areas that are subject to other policy reform based around personalised care. This includes; the Children and Families Act 2014, SEND reforms and Transforming Care and the Care Act 2014. CCGs may also wish to consider making personal health budgets a routine delivery model for NHS CHC and children and young people's continuing care.

Finally, where contracts are coming up for renewal it will be helpful to develop personalised care inserts for specifications, to ensure all contracts both in and out of scope, since personal health budgets reflect personalised care and support planning, community capacity, and co-production. The next chapter sets out in more detail how to use the Commissioning Cycle to plan and implement personalised care.

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Chapter 4: Contracting & Commissioning

CHAPTER SUMMARY

1. THE COMMISSIONING CYCLE FOR PERSONALISED CARE
2. USE OF THE NHS STANDARD CONTRACT
3. MONITORING AND EVALUATION OF PERSONALISED CARE
4. MARKET SHAPING AND DEVELOPMENT

Commissioning for personalised care includes developing flexible outcome-focused approaches to service delivery, and opportunities for people to have choice and control over the achievement of improved outcomes. Personalised care will also contribute to narrowing and reducing health inequalities as true needs are met. This chapter of the handbook therefore supports commissioners (CCGs, CSUs, STPs/ICSs and Local Authorities) to develop the robust commissioning and contracting arrangements required for implementation of personalised care. It describes the steps required within commissioning and contracting.

The personalised care programme is jointly sponsored across health, social care and education. Therefore, this section will address the considerations to ensure partnership success. However, it will focus predominantly on the commissioning and contracting work required in the NHS. This reflects that the NHS is the area which has the biggest challenge in contracting at this stage. It also reflects that local authorities have developed a contracting environment which already enables personalised commissioning, and therefore they are significantly further ahead than health with personalised commissioning and contracting. Areas implementing personalised care so far have requested support for commissioning of health services, rather than for social care or for education.

4.1 The Commissioning Cycle

The commissioning cycle (set out in Figure 2) is a useful tool to support planning for personalised commissioning. It includes timescales for planning and implementation. This chapter will use the commissioning cycle to set out approaches to developing personalised commissioning and contracting.

Figure 2: The Commissioning Cycle



Courtesy of The NHS Information Centre for health and social care. Full diagram available at: www.ic.nhs.uk/commissioning

Stage 1: Planning

At a ‘high level’ this stage follows the work setting out the local ambition of the area, informed by strategic plans including those of the STP/ICS, the Local Health and Wellbeing Board, applicable Joint Strategic Needs Assessment and other locally identified priorities. It is an explicit statement of ambition for the coordination of work across health, social care, public health and children’s services.

The statement of ambition sets out short, medium and long-term intentions for the programme. This includes, at a high level, a discussion of which groups are to be included, and the overall aims for the programme. This can be supported by work around alignment with local priorities, for example, or where the commissioners are already aware there are underlying issues and health inequalities. The ambition will be integrated across health and social care.

As set out in Chapter 2 & 3, cohort identification is an important part of planning for the introduction of personalised care. Within this work it will be important to

understand current contracts. In practice, this means having good information about what is commissioned, the quality and cost of those services, and what the current gaps in provision may be. This will help to give an indication of what services could be included within personalised care. It is possible that some contractual arrangements could convert to a more personalised approach relatively easily, which may include cost per case arrangements, spot purchases and some tariffed services.

The planning phase should include partner organisations. It should also include VCSE organisations and people with lived experience of accessing services, to help ensure that the introduction of personalised care is co-produced with people who will be directly affected.

A joint response and commissioning plan should reflect any opportunities available to jointly commission services, including the consideration of Section 75 arrangements to enable joint commissioning and coordination across health and social care. Informal arrangements around joint commissioning may also be considered here.

Early engagement with the providers affected may be beneficial at this stage as well. This could help with the development of personalised approaches to current services, greater understanding of the current offer, development of unit costs and identifying what could be included within a budget. It can also help to identify where immediate changes could be made, for example through in-year variations and amendments.

Stage 2: Funding Approaches

Once a local plan is agreed with partners, commissioners need to start looking at options for implementation. Historically, NHS funding has been contracted through population-based contracts - including block contracts. Spot purchases have been used for discrete services, mostly within high-cost, low-volume services or within the acute sector via tariff arrangements. To realise the ambition within the NHS Long Term Plan, NHS commissioning needs to develop flexibility to offer more person-based commissioning. This includes personalised care and specifically, personal health budgets.

It is important in this part of the cycle to develop a good understanding of the underpinning information and to build on what has already been done in stage one. While much of this work is about developing one or more approaches to release funding from existing contracts, it should also include continued work around understanding the contracts, particularly around the activity currently delivered and the unit costs of that activity.

It is also key to ensure that existing providers have the opportunity to respond - as well as VCSE organisations and private providers. Some providers have been involved in the programme and are proactively developing their services according to the feedback coming through the personalised care and support plans and

personal health budgets. See Chapter 3 for the full detail on potential funding methods.

When commissioning and contracting for personalised care, especially for personal health budgets, it may be important to fund some of the support services required rather than only direct care services. This could, for example, include peer support and local area coordination. Such services should improve the quality of the personalised care and support plan. As they are likely to be more preventative, they may also serve to reduce demand for services in the longer term.

Commissioning for local area coordination and peer support services will likely need to be a gradual process. This will mean releasing funding bit by bit, showing savings and building evidence and then expanding the provision of the services. It may be possible for some CCGs and local authorities to proceed more quickly, depending on their local circumstances.

Stage 3: Personalised Commissioning

The next stage is to agree the approach to shifting to personalised commissioning – including which services will be covered in the forthcoming year. Most areas will find a staggered approach to delivering their strategic plan objectives is the most realistic.

The commissioner should then formally notify the provider of its intentions to move towards more personalised contracting arrangements through commissioning intentions, including clarity of scope, pace and scale. Depending on the timing within the contracting cycle, this could be through contract variation or contract intentions. Organisations must ensure due diligence and consideration of the NHS Standard Contract Technical Guidance, including notice periods, if an amendment is required in year.

Contract amendments and variations are then negotiated between the commissioner and the provider, in line with the NHS standard contract. It should also reflect the local ambition for personalised care and personal health budgets set out in commissioning intentions. The Finance section of the FutureNHS Collaboration Platform provides example text commissioning intentions (<https://future.nhs.uk/connect.ti/system/home>).

The contract will also need monitoring. Contract monitoring arrangements should reflect the reporting of activity against the five key shifts of personalised care. Monitoring should also include activity within the re-negotiated contract to ensure accurate data to support scale and spread. This level of data interrogation is useful to confirm under-trading or over-trading, and potentially to identify arrangements that the commissioning organisation may not be aware of.

Finally, the new model of personalised care and personal health budgets should be clearly articulated within the service specifications and should include the

expectations of providers to deliver the six key shifts of personalised care within the operating model of personalised care.

Stage 4: Monitoring, review and next steps

As part of contract monitoring and management, the CCG and local authority will need to develop metrics that reflect programme priorities that are embedded within the contract monitoring and management arrangements locally. The key performance indicators (KPIs) should reflect the contract priorities. These could include:

- Proportion of people who have a personalised care and support plan
- Achievement of outcomes in personalised care and support plans
- Proportion of people who have personalised care approaches such as shared decision making and self-management
- Proportion of people who access social prescribing
- Proportion of people who have a personal health budget or integrated personal budget
- Patient and carer satisfaction and experience
- Demonstration of co-production in service development
- Total funding being spent through personal health budgets, and personalised care.

External monitoring beyond the individual contract may be useful to assess the impact on people's outcomes and experience. It may also help to identify any potential shift and opportunity to further shift future contracts to reflect choice.

As well as contract monitoring, the commissioning organisations should think about implementation for the following year. This includes considering forthcoming priorities, including the expansion of the programme to cover other potential cohorts and to increase the number of budgets within existing cohorts. For those already involved in the personal health budget programme, it is also to expand the proportion of the services that they access that could be included within a personal health budget. For example, if there is scope for the person to benefit from choice and control but it is not possible to offer them that in the current year due to contractual challenges, plans should be developed to do this in subsequent years.

4.2 Use of the NHS Standard Contract

Where strategic objectives and then subsequent local commissioning plans are made, they need to be enacted with providers through contracting procedures. This is initiated through mechanisms and tools in the NHS Standard Contract such as commissioning intentions and contract variance. The following gives brief guidance on how each section of the contract can be utilised to support local personalised care planning and implementation.

4.2.1 Schedule 2M: Development Plan for Personalised Care

In 2019-20, the standard contract has an additional requirement which was included in response to the published Comprehensive Model for Personalised Care. It aims to support implementation of personalised care and the roll-out of personal health budgets at a local level. Local implementation arrangements can be set out within this schedule. Actions set out in Schedule 2M could focus on making across-the-board improvements applying to all the Provider's services – or on pathways for specific conditions which have been identified locally as needing particular attention. This schedule can capture the processes and agreements made as part of the commissioning cycle.

4.2.2 Commissioning Intentions and Contract Variances

Commissioning intentions are used prior to contract negotiations. They set out the intentions of the commissioner to the provider. These can be high level indicators of a direction of travel or more specific details of commissioning plans. These are often precursors to negotiating the contents of a new contract. Where agreed the details will be entered into the appropriate schedules of the contract. The Finance section of the FutureNHS Collaboration Platform (<https://future.nhs.uk/connect.ti/system/home>) has examples of generic wording for commissioning intentions where a commissioner wishes to implement components of personalised care.

If contracts are already agreed and in place a local variation can be used to introduce contract changes in year. These are proposed by the commissioner, or provider, to the other party. Where agreed the detail is confirmed in the final variance and are added to the existing contracting documentation as an amended contract. Examples of wording for local variances are included in the Finance section of the FutureNHS Collaboration Platform (<https://future.nhs.uk/connect.ti/system/home>). It is important to note that where there is a potential change in contract value, there will be rules regarding when the financial impact of the variance can take effect but funding for personalised care should not be about new money but money that would have been spent on that person's care using already commissioned NHS services. A template and further guidance on the use of local variations can be found on the NHS Standard Contracts website¹⁷.

4.2.3 Schedule 6D: Service Development and Improvement Plan

The Service Development and Improvement Plan or SDIP, allows the parties to record action which the provider will take, or which the parties will take jointly, to deliver specific improvements to the services commissioned. SDIPs offer an excellent route through which commissioners and providers can agree a programme of work to implement all or part of the components of the Comprehensive Model for Personalised Care.

The intention of SDIPs is not to require significant additional investment from commissioners or providers; rather, it is to encourage joint management action to tackle these important priorities to the extent possible within available resources.

¹⁷ <https://www.england.nhs.uk/nhs-standard-contract/>

It is recommended that all providers have an SDIP that clearly sets out the key deliverables for personalised care within the year along with key milestones. The SDIP can then be reviewed in contract monitoring processes to assess achievement against the agreed plan.

4.2 4 Schedule 2A: Service Specifications

Service specifications are one of the most important parts of the contract as they describe the services being commissioned and can, therefore, be used to hold the provider to account for the delivery of the services, as specified. Commissioners and contractors need to be aware of the requirements of personalised care and ensure that service specifications with providers reflect the requirements of this changing landscape.

The paragraphs for each of the specific key components of the model have been given in Chapter 2 and these are examples of wording that can be inserted into NHS Standard Contract Service Specifications. They can be used as they stand for general inclusion or can be modified for specific service or cohort use.

It is recommended that the opportunity to include the key components of personalised care is taken for ALL new or revised service specifications. All services will be able to include at least some aspects of personalised care. With time, commissioners should be aiming for all their service specifications having at least a generic reference for implementing personalised care for the people the service concerns.

The final agreed wording can be inserted as a titled paragraph under section 3.2 Service Description/ Care Pathway of the Service Specification. The wording can also be used in local grant agreements.

It is recommended that, where appropriate, there is a measure of successful application. An agreed outcome measure or quality indicator would be added to section 5.1 Applicable Quality Requirements and then in Schedule 4 of the Particulars under Quality Requirements. These measures need to be considered in regard to the weight of impact of personalised care on each contract they are applied to.

4.2.5 Contract Management

All contracts will require some form of contract management process. For larger value contracts this is often a monthly review meeting with agreed protocols for reporting and monitoring. Smaller value contracts will usually have less frequent contact in place but with similarly clear processes for sharing information and monitoring.

The following are key principles that commissioners may want to consider when managing their local contracts.

- Personalised care as a standing agenda item for all meetings
- Robust short-term monitoring as new personalised care initiatives are agreed and put into place to ensure they are meeting the agreed objectives

- Proportionate long-term monitoring regimes for successfully implemented personalised care initiatives
- Where appropriate, cost monitoring for personal health budgets
- Review Service Development and Improvement Plans for personalised care action plans
- Processes for reporting risk
- Continued emphasis on co-production and real-time feedback from service users
- Liaison with associates for larger contracts – are the initiatives working well for all areas that the contract covers?

4.2.6 Use of Grant Agreements

Grants can be used to provide financial support to a voluntary organisation which provides or arranges for the provision of services. Grants may be used for low value arrangements with VCSE organisations that provide personalised care services such as social prescribing. NHS England has published a template Grant Agreement and guidance on the use of the model. These are available on the NHS England contracts website (<https://www.england.nhs.uk/nhs-standard-contract/grant-agreement/>). The model grant agreement is non-mandatory and is for local adaptation as required.

4.3 Monitoring and Evaluation

Evaluation is required to monitor the effectiveness of personalised care to support people to meet their needs and identified outcomes. These processes enable the health and care system to know whether personal health budgets and personalised care are having the anticipated impact and, if so, build an evidence base to expand the programme further. This evidence then informs future strategic commissioning decisions. Evaluation and monitoring of personalised care interventions are important because:

- CCGs have a responsibility to ensure that personalised care initiatives and personal health budgets are used to meet the agreed health and care needs of those who receive them
- CCGs have a responsibility to manage the risks associated with personal health budgets and minimise the risk of fraud
- Information gathered from the review of personalised care initiatives and personal health budgets can contribute to the national understanding of the benefit of this approach and inform strategic commissioning decisions
- CCGs and other statutory bodies are obliged to submit accounts and other publicly available reports on all aspects of spend.

When considering the processes required, it is essential that the approach is proportionate to the value and risk of the personalised care initiatives or personal health budget(s) under consideration. For example, those personal health budgets which are taken as direct payments are likely to be subject to a higher level of scrutiny as the inbuilt checks in the process are less than those for a third party or notional budget. However, the defined processes within an organisation must not

limit the inherent flexibility, and hence benefit, of a person having more choice and control over the care and support they receive.

4.3.1 Monitoring spend through Personal Health Budgets

The CCG undertakes monthly financial monitoring of all expenditure to ensure that the financial health of the organisation is known and understood. This includes spend with acute trusts, community health care organisations and all aspects of care and support that the CCG funds. As part of this, the total spend on personal health budgets will be reviewed to ensure that it is within the expected range, to enable the CCG to forecast and manage expenditure.

As part of the personalised care and support planning process, regular reviews are carried out to ensure that the care plan or personal health budget is helping to meet the person's outcomes in the anticipated way. For people with a direct payment, an initial three-month review, followed by annual reviews, is required as a minimum, but it is good practice to carry out reviews at this frequency for all personal health and integrated personal budget holders. Some CCGs choose to carry out monthly reviews for the first three months to ensure that both the person and the commissioning organisation are comfortable with the plan and how it is working.

The financial review of a personal health budget should be carried out at the same time as the review of the personalised care and support plan, to give a rounded picture of whether resources are being used effectively and to avoid overburdening the person with reviews - particularly at the beginning. Finance roles are rarely patient-facing, so combining the monetary review with that for the care and support plan can assist conversations about spend and help to answer queries more easily.

4.3.2 Evaluation of Personal Health Budgets

The review of personal health budgets is an essential part of evaluating their effectiveness - both for the person and the financial system. As the scope of personalised care and personal health budgets expands, their contribution to system financial sustainability, whilst maintaining or improving outcomes, needs to be demonstrated. This is true at both a national and local level. It should cover both direct and indirect effects of personalised care and personal health budgets, as well as taking into account the administrative costs of setting up personalised care and personal health budgets.

A linked data set, where available, gives a baseline cost and activity level for a person prior to taking up a personal health budget. Through the review process, and with appropriate consent from the person, a comparison can be carried out between past and current costs of care and support. This enables an evaluation of both costs and the impact on services across all sectors.

Any financial evaluation should be considered in conjunction with achievement of outcomes and the person's experience. Cost savings should not be achieved to the detriment of the person's care.

The evaluation information can be used in several ways:

- Direct cost comparison to indicate whether there is a cost saving through use of a personal health budget. This can inform local planning for the expansion of personal health budgets to other patient groups.
- Contribution to the national programme evaluation where data will be aggregated to gain an understanding of the national impact.
- Review of impact on services to inform commissioning intentions and to ensure that services are not being unduly penalised financially by the introduction of personal health budgets; for example, better self-management of a condition, enabled by a personal health budget, may keep a person out of hospital but increase the demand on district nurses.
- CCGs are encouraged to share this information with NHS England in an anonymised form to contribute to the national evaluation of personalised care and personal health budgets.

4.3.3 Reporting Personal Health Budgets

NHS England requires information to be reported about personal health budgets in several different ways and for several different purposes. These have evolved since the beginning of the personal health budget pilot and are in the process of being rationalised where possible. This section sets out the current reporting situation and considers what CCGs need to record to supply the requested information.

Data is collected on all personal health budgets that have been active in-year across all age groups. It splits personal health budget numbers down into different conditions or cohorts, and whether the personal health budget is being taken as a direct payment. This collection is a formal mandatory data collection by NHS Digital. Returns are published on My NHS as part of the Improvement and Assurance Framework (IAF) dashboard.

The CCG IAF dashboard supports monitoring of the NHS mandate ambition by reporting the number of personal health budgets in place per 100,000 CCG population (based on the population the CCG is responsible for). The mandatory quarterly return to NHS Digital is the source of the data reported. More information can be found in the technical annex to the CCG IAF. CCGs will continue to report personal health budget trajectories as part of their Operational Planning. These trajectories show the planned progress towards CCGs' contribution to the mandate ambition. The personal health budget data collected and reported as part of the IAF will be used to monitor CCG progress towards meeting their trajectories.

The NHS CHC data collection records data on NHS CHC uptake and activity. This is to measure key aspects of the NHS CHC assessment process and the national framework for NHS CHC and NHS-funded nursing care (FNC). From a personal health budget perspective, this return collects the total number of people eligible for NHS CHC with any type of personal health budget in the year to date, and of those, the number who receive direct payments.

4.3.4 Evaluation of Other Personalised Care Initiatives

There are a multitude of potential benefits from implementing the Comprehensive Model for Personalised Care. The ability of areas to measure these will depend on several factors including cohort size, availability of shared data and capacity of teams to analyse.

Where there is opportunity to evaluate the impact of initiatives, it can be helpful to do so as it demonstrates quality and financial benefits. These are important in building the case for expansion and to instill confidence in the culture change. The following can be considered when designing evaluation frameworks:

- Measuring service user satisfaction including their willingness to recommend, feeling they have choice and control and achieving personal goals
- Measuring patient reported outcome measures or reportable clinical outcomes such as weight loss, HbA1C levels
- Measuring healthcare contacts and their reduction i.e. primary care, A&E attendances or community nurse contacts
- Measuring reduction in admissions or reduced length of stay
- Measuring reduction in coded clinical events such as Myocardial Infarction or Hypoglycaemic episodes
- Measuring workforce satisfaction
- Measuring cost savings attributable to personalised care such as reduced average expenditure on Continuing Healthcare through personal health budgets
- Analysis of available data including demographic data at population level (non-patient identifiable) to identify any potential inequalities of those accessing services.

It may be helpful to refer to case studies from other areas who have tested these initiatives. The following webpage gives examples of positive outcomes for personal health budgets, personal wheelchair budgets and social prescribing amongst others <https://www.england.nhs.uk/personalisedcare/evidence-and-case-studies/>.

4.4 Market Shaping and Development

Market shaping and development is about how the commissioners work with providers, both existing and new, to expand the range of services people can access. Different people are likely to benefit from different forms of support and services. Therefore, the more local commissioners can ensure a wider range of services, the more likely people are to benefit from the expanded choice and control available through personalised care. The aim of the market shaping and development work is to enable people to access services that are most suitable for their on-going care and support needs. Evidence shows that this improves their outcomes, which can also reduce total spending.

Market shaping and development involves three main areas of work:

- a) Developing intelligence. Developing a shared understanding of both the current and an ideal future market. Information can come from a number of

sources including, but not limited to, health and care practitioners, people with lived experience and their representatives, data on people's use of existing services, outcome analysis, views from existing providers and VCSE organisations. For existing services, this should cover both what services are working well for people and what services are not.

- b) Market structuring. Agreeing what needs to change. This can be done through co-production, gathering information about what people accessing services think is working and not working; through service data, including outcomes and quality information, feedback, input from practitioners and patient representative groups; and through wider policy shifts.
- c) Market intervention. Shaping the market, for example through co-production, tenders and procurement, incentives to personalise offers, advice to existing and emerging providers and social prescribing.

The Market Position Statement (MPS) is done as part of the general work around market development and is part of the wider activities around shaping the market. Further information on market shaping and the use of a Market Shaping Statement can be found in the Finance section of the FutureNHS Collaboration Platform (<https://future.nhs.uk/connect.ti/system/home>).

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Chapter 5: Information Governance and Data

CHAPTER SUMMARY

1. INFORMATION GOVERNANCE GUIDE
2. LINKING INFORMATION AND DATASETS
3. DIGITAL SOLUTIONS FOR PERSONALISED CARE

5.1 Information Governance (IG)

Organisations rolling out personalised care are already committed to protecting the personal information of their patients and service users. Implementing appropriate IG practices throughout the programme not only allows people's wishes to be respected, but also ensures that organisations are meeting the requirements of the General Data Protection Regulation (GDPR) and national best practice standards and guidance in this area. By agreeing a joint approach to managing risks to personal information, organisations involved in delivering personalised care can benefit from:

- A better understanding of the information requirements of the programme.
- Better working relationships with partner organisations and an increased understanding of best ways of managing personal data in a secure and confidential way.
- Confidence that their organisation is meeting legal requirements in this area and in doing so protecting the person, healthcare practitioners and the organisation from the negative effects of a data breach.
- Ensuring that people are fully informed about how their information is being used and are effectively involved in any decisions regarding this information.

This section provides brief information about how these benefits can be realised in relation to the information sharing aspects of personalised care. Commissioners will need to ensure they are familiar with each key concept listed below. Where available links to further information have been provided.

5.1.1 Privacy impact assessments (PIAs)

It is essential to ensure that all risks to personal information are considered as part of identifying and linking data. By understanding how people's data will be used and shared, it is possible to consider any risks to confidentiality and privacy and identify ways of minimising them. This will ensure that the person's information is protected, as well as providing the assurance to them that their personal information is being handled in line with current national guidance and data protection legislation.

One of the most effective ways of considering these risks is to carry out a Privacy Impact Assessment (PIA) on the programme. This could be for both linking and sharing data, and for the project/ programme more generally.

PIAs were developed by the Information Commissioner's Office (ICO) as a way of identifying and reducing privacy risks of specific projects and programmes of work, thus ensuring that these projects met the requirements of the GDPR. The ICO's Code of Practice for conducting PIAs, and related templates, can be found on their website (<https://ico.org.uk/media/for-organisations/documents/1595/pia-code-of-practice.pdf>).

5.1.2 Information Sharing Agreements

All parties involved in information sharing within the personalised care programme need to be aware of their responsibilities for protecting and managing people's information. This can be done through an information sharing agreement. This is a helpful way to ensure that all parties have signed up to a joint understanding of what data is to be shared, for what purposes, the legal basis for sharing this information and how it will be managed during and beyond the life of the programme.

It does not, in itself, provide a legal basis for information sharing but ensures that all parties are committed to the same best practice in relation to this data and will include information on the legal basis for information sharing. In personalised care, the implementation of personalised care and support planning processes may involve information sharing between health, social care, education and VCSE partners. An information sharing agreement would help document when and why this sharing needs to take place, its legal basis and the confidentiality and security requirements in relation to data sharing.

In some cases, a third party may be involved in processing data as part of the personalised care or personal health budget work. An example is where CCGs have used a private company to provide a data linkage service to the CCG, or who have managed direct payments directly to people. Here, there must be a written contract in place to cover this processing between the data controller and the data processor (a data processing agreement). For example, where a CCG is passing information to Shared Business Services (SBS), SBS would be acting as the data processor on behalf of the CCG (the data controller).

The Information Governance Alliance (IGA) is a source of advice and guidance about the rules on using and sharing information in health and care. They have a suite of useful resources which can be found on their website (<https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and---information-governance/information-governance-alliance-iga>). This includes the Information Governance Alliance Data Sharing Agreement template (https://digital.nhs.uk/binaries/content/assets/websiteassets/services/dars/nhs_digital_approved_edition_2_dsa_demo.pdf). The IGA has also provided further guidance around data controller issues in joint systems and considerations in working with VCSE organisations.

The Information Commissioner's Office provides more general guidance on data sharing in its Data Sharing Code of Practice (<https://ico.org.uk/for-organisations/guide-to-data-protection/data-sharing/>), and specific guidance on data controllers, data processors and contracting (<https://ico.org.uk/media/for->

[organisations/documents/1546/data-controllers-and-data-processors-dp-guidance.pdf](#)).

5.1.3 EU General Data Protection Regulation (GDPR)

In May 2018, the EU GDPR was implemented. NHS organisations have traditionally implemented many of the recommended IG practices and considerations but the GDPR strengthens these through robust guidance, statutory regulations and penalties for inappropriate and/or malicious use of personal data. The major implications for personalised care are summarised in the table below.

GDPR Guidance and Regulations
Consent Practices
<p>The NHS has traditionally been heavily dependent on consent as the legal basis for processing. The GDPR sets a high standard for consent, but the biggest change is what this means in practice for consent mechanisms. You need clear and more granular opt-in methods, good records of consent, and simple easy-to-access ways for people to withdraw consent. The act of indicating consent must be unambiguous and involve a clear affirmative action. The full detail of what constitutes consent/informed consent can be found on the Information Commissioner's Office webpage (https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/consent/whats-new/).</p>
Informing Individuals
<p>Individuals must be fully informed of how their data will be used/processed. The new regulation is explicitly clear on the information a controller is obligated to provide to a data subject when collecting personal information directly from them. Examples include; type of data to be collected, purposes of processing, retention term and storage/security arrangements. In addition, all people eligible must be able to understand the privacy information, including children of 13 years and older. Full considerations for privacy notices can be found the Information Commissioner's Office webpage (https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/individual-rights/right-to-be-informed/).</p>
Data Subjects / Natural Persons Rights
<p>GDPR extends and strengthens the rights of natural persons/data subjects. Data subjects now have the right to deletion/erasure/be forgotten, meaning that controllers are obligated to delete their data when that right is exercised. If a data subject objects to being processed, the controller is obligated to suspend processing while it is being contested – this is known as the right to restricted processing. This right also applies when a controller is legally required to keep data despite the data subject asking for it to be deleted. GDPR now requires Subject Access Requests (SARs) to be actioned without undue delay and within a period of one month. Controllers may extend the time period to process SARs where necessary up to a period of 3 months.</p>

Compliance
<p>GDPR recognises the need for increased accountability and therefore insists that organisations demonstrate compliance with the regulations. There is guidance on the ways in which this is achieved:</p> <ul style="list-style-type: none"> • Sound record keeping for processing activities • Appropriate technical and organisational security measures • Legally enforceable contracts when selecting a processor to ensure their compliance • Adopting a risk-based approach to demonstrating compliance • Testing • Privacy is implemented by design and default • For high risk processing, it is mandatory to carry out a Data Protection Impact Assessment • Every public body should have a Data Protection Officer <p>The NHS has traditionally adhered to much of the above, through the IG toolkit. Therefore, when implementing personalised care projects, wholesale changes are unlikely to be required.</p>
Processors
<p>Previously, the emphasis was primarily on the data controller to ensure data processing on all levels adhered to the regulation. GDPR increases the responsibilities of the data processor, with overall responsibility still with the controller. The regulation underpins this with strong contracts between controllers and processors. An example could be using a private company to provide direct payments to individuals in receipt of personal health budgets – it is essential to explicitly state how processing should take place in the contract, since otherwise the CCGs (the data controllers) will be ultimately responsible for any breach.</p>
Breaches
<p>The NHS has traditionally reported breaches to NHS Digital with more serious instances reported to the Information Commissioner's Office. GDPR now make the reporting of high-risk breaches, within 72 hours of being made aware, a law.</p>

5.2 Linking Information and Data Sets

Many programmes across health, social care and education are attempting to develop linked data sets. This means that activity information is linked at a person level across all settings: - primary care, acute care, community services, mental health services, social care, education and residential settings. It should also include data around prescribing and diagnosis to help give a full picture of the services that a person accesses and their overall health, care and education needs. For the purposes of personalised care and personal health budgets, it would ideally also include information about services accessed from VCSE organisations.

A linked data set can be developed in two ways. The ideal is at a population level using some form of pseudonymisation approach to link data in a non-identifiable

way, with everybody in a CCG population having their data linked systematically across all services they access, taking into account appropriate privacy concerns. This data gives intelligence around population health and service use and is a powerful data source for planning future commissioning priorities.

Linked data can also be developed starting with the person. In this case, data is linked at an individual level when a person gives their informed consent for the work to be done. This is likely to be a more labour-intensive process since the local area may not have developed the systems to enable easy data linkage at an individual level, across organisations, resulting in manual data collection. However, it is a practical approach where systematic linked data sets covering the whole population do not exist.

A linked data set is not an essential pre-requisite to develop personalised care or personal health budgets in an area and the lack of one does not prevent progress in any area of finance and commissioning. However, it can assist the ease of programme implementation as detailed in the following sections.

A linked data set makes it easier for a CCG because it includes:

- all services that a person accesses
- the costs of these services
- whether people are accessing services across a range of settings, and
- helps to identify which services and people may be most appropriate for the introduction of personalised care and personal health budgets.

A linked data set aids the development of more robust budgets, supports commissioning changes and enables local and national monitoring and evaluation of the interventions. It is possible to introduce personalised care and personal health budgets without a linked data set; however, evidence suggests it is more difficult to do so in a robust and sustainable way.

5.2.1 Benefits from a Linked Data Set

a) Cohort identification

Understanding activity data can assist in identifying the groups of people who would most benefit from a more personalised approach. Even without linking, an analysis of individual sector data can identify those people who may be attending particular services more than might be expected, suggesting that current provision is not proving effective in managing their condition. The use of risk stratification tools on population data can automate this process, as previously described.

b) Budget setting

A linked data set allows a more systematic analysis of what services a person is currently receiving and what may be suitable for inclusion within a personal health budget. It ensures both the person and the healthcare practitioner are clear about what services are being accessed and that these are not missed when setting an indicative budget.

c) Personalised care and support planning

Personalised care and support planning is covered in detail elsewhere in the Personalised health and care framework. Here, understanding historic service use can be helpful. Personalised care and support planning considers what is working, or not working for the person, and can be supported by information about what services are, or are not, being accessed.

d) Commissioning changes

An individual linked data set will indicate where current resource is being spent on a person's care. This gives an indication of which contracts should be reviewed to potentially free up resource to offer a personal health budget.

In some sectors, data quality is not at the level needed to develop a full linked data set. For example, some services do not record activity in enough detail to provide the necessary information. Here, the work around disaggregating existing contracts and reviewing commissioning arrangements can help provide intelligence and thus improve data quality.

e) Evaluation

The linked data set can be used to measure the impact of personalised care approaches, analysing how individuals and the system respond to personalised care interventions. For individuals, it will be clear whether they require additional provisions of care to what is in their care and support plan. By attaching costs to the units of data, mentioned in the next section, evaluators can determine if the system has benefitted by avoiding paying for care that would have been required without the intervention.

5.2.2 Including cost information in the linked data set

The activity data within the linked data set provides a useful understanding of a person's interactions with services. Patterns of use can be observed, and any changes can be analysed. However, to make full use of the data, costs need to be applied to the activity. This not only informs budget setting but also allows a health and care system to understand cost patterns within the pathway and ensure that costs are not being unduly 'shunted' to other providers. For example, a reduction in acute admissions (and therefore cost) may result in increased pressure on community services. Understanding and responding to this change can ensure that a system remains sustainable and no one organisation in the pathway is inadvertently penalised by the introduced change.

Including costs for the activity is not always straightforward. The detail of costs at a person level is not always available or robust. Possible approaches to this are detailed below.

a) Use of tariff

For items covered by the Payment by Results (PbR) system, primarily in the acute sector, there is a nationally established tariff for each unit of activity. Payment is made on this basis and thus is commensurate with the commissioner using the financial information to set a future personal health budget or integrated personal

budget. However, the majority of services, particularly in the short term, are unlikely to be covered by tariff.

The national tariff is adjusted by the market forces factor (MFF) for each organisation to recognise that unavoidable costs may vary in different parts of the country. The MFF gives additional reimbursement to providers to reflect these variations. When using tariff to cost activity in a linked data set, the MFF for each organisation included should also be taken into account.

b) Reference costs

All NHS providers complete an annual reference cost return that allocates their full costs of operation to units of clinical activity. NHS England publishes a summary of the national average amounts together with organisation level data. Local relationships may enable sharing of local reference cost data within a health economy. The allocation of overhead costs is at local discretion, so this may vary between providers. The process of averaging nationally goes some way to mitigate this variance, but local understanding of overhead apportionment is helpful when considering the impact that changes to the system may have on providers.

c) Local costs

Local cost information may also provide costs of activity. This is particularly relevant where tariff and reference costs may not be available, for example for some block contracts. However, the use of local costs can depend upon the relationships between the parties. It also carries the risk of embedding local inefficiencies into the budget setting process. Where local cost data is used, it is good practice in the early stages of personalised care and personal health budget development to benchmark these costs with other organisations. A straightforward way to do this is the use of the published national average reference costs discussed above. Benchmarking data is also available to members of the NHS Benchmarking Network.

It is anticipated that as personal health budgets and personalised care expand, the demand for good local data will increase to support commissioning and to help set budgets correctly. While the risk remains of embedding inefficiency into the system, it is important that the budgets set reflect local costs of services and are appropriate for the area. However, CCGs should not wait to fully understand local costs before proceeding with budget setting but should use alternative methods as described previously as an interim measure, whilst simultaneously continuing the work to determine local costs. As payments become more dependent upon the cost of individual activities, so the data quality is likely to improve to facilitate this.

It is particularly important to use local data when considering mental health services. Mental health activity is costed in 'clusters', which can contain a number of discrete services and interventions – some of these may be suitable for inclusion within a personal health budget or integrated personal budget, but some may not. Local intelligence is needed to understand what has been included within the cluster cost and how that cost then splits across the various activities within it.

d) Personal Social Services Research Unit (PSSRU)

Where data from national tariffs and national or local reference costs is not available (or it is viewed as unreliable) the PSSRU Unit Costs database can be used. This takes national information from across the country to estimate costs of every service across health and social care. While the information may not necessarily be applicable to a local area due to specific factors, it provides a benchmark for what a suitable cost estimate may be.

e) Education

Work continues to understand how both activity and cost data is collected and used within the education sector. NHS England is working with colleagues in NHS Digital and the Department for Education to develop this area of collaboration, linking the personalised care and SEND programmes.

5.2.3 Quality of Data Systems

When linking data, it is important to consider the quality of that data and the potential pitfalls in subsequent work if the source data contains errors. The NHS Data Services for Commissioners (DSfC) programme is carrying out work to improve data quality in the NHS.

DSfC is looking to develop and introduce standardised data quality checks, via the Data Services Platform, that can be applied across different data sets and highlight where data quality is a concern. These checks will, initially, focus on:

- Completeness
- Validity
- Timeliness
- Use of defaults of/in data.

The DSfC programme will also look to develop accuracy checks by, for example, comparing patient demographic details against data held by the Personal Demographics Service, an essential check to ensure users of data are aware of any bias in the data which may impact its ability to link.

5.2.4 Updating the linked data set

As discussed above, understanding historic service use enables an area to identify those who could benefit from personalised care. It also helps; to understand the contracts currently supporting a person and to calculate the financial envelope for budget setting. However, the linked data set should be a live data source that enables on-going monitoring and evaluation of the impact of personalised care, demonstrating effectiveness or highlighting unexpected consequences of the change.

Data sources are updated with differing frequency – some monthly, quarterly or even annually. Whilst the ideal is a ‘real time’ data set where activity data is updated soon after the contact occurring, it is recognised that in many cases, this is not practical. It is important to understand the timeliness of the data being used for decision making, acknowledging any complications that this may cause, particularly around

degenerative conditions. As an interim step, areas should work to improve data timeliness in those sectors where it will have the most impact.

5.2.5 Issues with using historic data to estimate future spending

The linked data set is, by nature, a historic view of what has happened for a person. It can be powerful but should not be used to the exclusion of other considerations.

It is possible that one year's data is unrepresentative of the likely costs for the person. It could be an overestimate as the person had a year in which they accessed much more health service than usual, for example due to an unforeseen and unlinked illness, or because they have a fluctuating health condition. It could also be an underestimate as the person's health condition deteriorates. Therefore, information about past spending should be used as a guide and for information but not as a strict budget – in particular, information from a needs assessment should also be considered.

5.3 Digital Solutions to Support Personalised Care

The Comprehensive Model for Personalised Health outlines new ambitions for digital systems. In particular, personalised care and support plan systems and payment and auditing systems for personal health budgets. In addition to this it is increasingly expected that individuals are able to engage directly with systems, if they wish.

Functionality for digital systems is likely to support the following functions:

- Identification: of the highest priority candidates for personalised care and/or a personal health budget, and calculation of an indicative budget. This functionality should be within the capability of existing risk stratification tools
- Planning: joining up assessments and supporting creation of a personalised care and support plan
- Management and monitoring: a finance platform to enable effective management of personal health budgets and facilitate required transactions, with appropriate monitoring and audit
- Marketplace: access to a broad marketplace for the individual to purchase care and support in line with their care and support plan. This may include items and services such as therapies, personal care and equipment
- Community: to support health empowerment and service improvements, including access to peer support.

It is not anticipated that any one digital solution will deliver all functional areas, but it is expected that all solutions consider the range of end user perspectives and are developed with a view to being part of a single, coherent system.

5.3.1 Local digital solutions

Local areas will have a range of existing digital solutions and will be at different stages in their journey implementing personalised care and personal health budgets. Therefore, digital solutions to support personalised care must be flexible and designed to work within this context.

The table below sets out the actions that may help areas develop digital solutions for their area.

Implementing Digital Solutions	
	Action Detail
Action 1:	Decide on NHS geography: Decide whether to implement a system for personalised care in conjunction with neighbouring CCGs within the STP/ICS footprint, for example through partnerships established through the Local Digital Roadmap (LDR) process.
Action 2:	Join up with local authorities in the same geography: Include local authority adult social care departments and children's services in line with the STP/ICS approach.
Action 3:	Evaluate Existing Local Systems: Evaluate any relevant systems in use locally within the NHS or local authorities against the digital requirements for personalised care to identify the gaps. The process should include people with lived experience through co-production for those elements that they will be using. This may also identify different and more detailed local requirements.
Action 4:	Decide whether to develop or procure: Agree with partners whether one or more systems already in use locally can be extended for personalised care and public use under an existing contract, or whether new services need to be procured.
Action 5:	Establish the business case and funding model: Assess the system-wide benefits of empowering individuals to achieve higher quality of care through the scaling up of personalised care. An effective digital system will not be the single factor in achieving this but will be an essential enabler. The digital system(s) should be seen as a framework upon which local people, individuals and professionals, can develop more personalised approaches to care. Local areas should review their existing delivery models on the basis of achieving their local personal health budget ambitions. An efficient digital system should free up clinical and administrative effort.
Action 6a:	Depending on the outcome of Action 4, develop a system already in use locally If existing system(s) can be enhanced, develop a plan with partners and existing digital supplier(s) to deliver that.
Action 6b:	Or procure and implement If there is no locally used system that can be developed, then proceed to procurement and an implementation plan.

The requirement for digital systems to provide these functions directly to people with lived experience is not typical. It is therefore not surprising that the digital supply market is still developing to meet requirements. The challenge of implementing digital within personalised care will benefit from co-production with people with lived experience. To enable this CCGs should plan to:

- Include patients and carers with lived experience on the development of the specification and the interview panels
- Ensure co-production starts at the beginning of the development of the specification and not as an afterthought
- Fully explore the requirements of care and support planning by identifying the experiences patient and carers want to have using a service
- Understand what areas are important to the patient and carer
- Think through and work with their digital supplier about how they link the different patient datasets to summarise and tell their story once
- Facilitate engagement of digital suppliers with people with lived experience
- Include people with lived experience in consideration of issues of information governance, information sharing and privacy.

NHS England has published a document which provides further information on digital requirements for personalised care. It can be accessed on the NHS England website (<https://www.england.nhs.uk/wp-content/uploads/2017/02/it-requirements-personalised-care-feb17.pdf>). This document sets out the core requirements required from digital systems. An update to this guidance will be published during 2019.

5.3.2 Personal Health Records

Patients' Personal Health Records (PHR) will hold a care plan that incorporates information added by the patient themselves, or their authorised carer. Making care plans available to the patient and all clinicians caring for them will help ensure care is not duplicated, tests are not repeated and appropriate actions are taken in a timely manner. The PHRs will also hold data that the patient chooses to share with the NHS, including from monitoring devices such as digital scales or blood pressure cuffs. Patients who choose to join a condition monitoring programme will be able to benefit from insights from these data and will be monitored for combinations of symptoms that may indicate clinical events and result in contact from a health adviser or clinician to help the individual stay well. Patients and clinicians will also be able to add information about living circumstances which may require reasonable adjustments to be made. Further information on PHRs can be found on the NHS Digital webpage (<https://digital.nhs.uk/services/personal-health-records-adoption-service>).

Areas will want to ensure PHR data is collected consistently and made available across local areas to support joined up and safer care on a day to day basis. That is why NHS England are investing in a number of Local Health and Care Record Exemplars (LHCR) that will enable the safe and secure sharing of an individual's health and care information as they move between different parts of the NHS and social care. This system will ensure PHRs are interoperable.

The local health and care record exemplar programme is designed to support local areas that are already adopting best practice in the collection, protection and ethical use of health and care data to go further, faster and encourage others to follow swiftly in their footsteps. Further information on the programme can be found on the NHS England website

(<https://www.england.nhs.uk/digitaltechnology/connecteddigitalsystems/health-and-care-data/joining-up-health-and-care-data/>) or in the LHCRE summary document (<https://www.england.nhs.uk/wp-content/uploads/2018/05/local-health-and-care-record-exemplars-summary.pdf>).

5.3.3 NHS Log Term Plan commitment to digital advancement

Chapter Five of the NHS Long Term Plan sets out a wide-ranging and funded programme to upgrade technology and digitally enabled care across the NHS. These investments enable many of the wider service changes required for personalised care development. Over the next ten years they will result in an NHS where digital access to services is widespread, where patients and their carers can better manage their health and condition, clinicians can access and interact with patient records and care plans wherever they are, with ready access to decision support and AI, and finally where predictive techniques support local Integrated Care Systems to plan and optimise care for their populations. The following are examples of digital transformations already underway and which will likely have an impact for personalised care.

NHS APP

The NHS App is now rolling out publicly. The NHS App went into the Apple App and Google Play stores on Monday 31 December, with a web-based version due to launch in early 2019. The NHS App team are gradually putting more GP practices online; the plan is that there will be 100% coverage by summer 2019, with a public marketing campaign in September. There is a requirement for individual GP practices to review some of their system settings before they can go live and then all the functions of the NHS App will be available to the public in their area.

- When the GP practice is connected patients will be able to use the NHS App to:
 - book and manage appointments at their GP practice
 - order their repeat prescriptions
 - securely view their GP medical record
 - check their symptoms using NHS 111 online and the health A-Z on the NHS website
 - register as an organ donor
 - choose whether the NHS uses their data for research and planning.

NHS England aim to create an open environment to make it easier for developers to build enhancements that support specific communities, conditions, demographic groups or languages. The NHS login will allow for a single way for patients to identify themselves to a range of services.

WWW.NHS.UK

The website www.nhs.uk is developed to provide a range of health information to the public. The NHS website provides a trustworthy place for people to find health information, apps and register to access NHS services. It provides the following:

- Freely available articles, videos, tools and apps to help make the best choices about health and wellbeing
- Information about support and social care services for help with day-to-day living because of illness or disability
- The service search helps people find, choose and compare health, support and social care services in England. The site also publishes reviews and ratings across health and social care services
- The NHS website also publishes daily analysis of the health-related news stories hitting the headlines
- Social media is an important part of the NHS website service. Millions of people a month are reached via Facebook, Twitter and video channels such as YouTube
- Each month, millions of people also access NHS content via partner websites, applications and other internet-connected devices, including NHS organisations, local authorities and various well-known commercial companies.

To access presentations, latest updates, discussion forums and other resources on digital transformation in the NHS then access the webpage at

<https://www.nhs.uk/transformation/>.

In addition to these NHS wide developments, the NHS England Personalised Care team are launching a digital programme to specifically find solutions and enhancements for the delivery of personalised care in 2019/20. Further information will be made available on the NHS England website

[\(https://www.england.nhs.uk/personalisedcare/technology-to-support-personalised-health-and-care/\)](https://www.england.nhs.uk/personalisedcare/technology-to-support-personalised-health-and-care/).

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Chapter 6: Working within Integrated Systems

CHAPTER SUMMARY

- 5. INTEGRATION FOR PERSONALISED CARE: STP AND ICS SYSTEMS
- 6. PRIMARY CARE NETWORKS

6.1 Sustainability and Transformation Partnerships and Integrated Care Systems

NHS Sustainability and Transformation Partnerships (STP) or Integrated Care Systems (ICS) are central to the delivery of the NHS Long Term Plan. A Sustainability and Transformation Partnership or Integrated Care System brings together local organisations to redesign care and improve population health, creating shared leadership and action. They are a pragmatic and practical way of delivering the ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care. The Long Term Plan has set out clear objectives for Sustainability and Transformation Partnerships or Integrated Care Systems to improve the integration between wider health systems.

Sustainability and Transformation Partnerships or Integrated Care Systems are well-placed to support the implementation of personalised care. Not only will they support integration between organisations, but they are also able to support commissioners and providers in embedded the changes as scale. They can do this by agreeing comprehensive plans for their areas which will include opportunities for shared learning, pooling resource and system-wide change that is consistent across the area.

Funding flows and contract reform will support the move to Sustainability and Transformation Partnerships or Integrated Care Systems. A new Integrated Care Provider (ICP) contract will be made available for use from 2019. This contract will allow for the contractual integration of primary medical services with other services and will create greater flexibility to achieve full integration of care.

For the first time for 2019/20, each NHS Sustainability and Transformation Partnership or Integrated Care System will produce a local System Operating Plan (SOP), setting out local actions to deliver the long-term plan and local improvements. Schedule 8 of the 2019-20 NHS Standard Contract offers a way in which – at whatever level of specificity is felt to be locally appropriate – commitments made as part of a Local System Operating Plan can be given contractual effect. Exactly what to include in this Schedule 8 is a local decision, but there are a number of different options that may be relevant to building personalised care at this level including:

- If the Local System Operating Plan is sufficiently detailed to state specific actions which the Parties have agreed to take, these could be extracted and included in the Schedule
- Alternatively, this Schedule 8 could build on the high-level intentions of the Local System Operating Plan, identifying specific actions which:
 - the Provider will take to integrate its services with those of other local providers and to support those providers in delivering effective care for patients; and
 - the Commissioners will take to ensure that other local providers support this Provider in delivering the Services covered by this Contract effectively
- Specific actions could cover expectations around patient pathways (consistent signposting for patients of the most appropriate pathway; communication and support between providers when patients are transferring from one service to another); practical arrangements for ongoing liaison between different services involved with the same patient, including shared or interoperable IT systems; arrangements for multi-disciplinary working across providers; and so on
- And reference could be included in this Schedule 8 to participation in agreed partnership / governance forums and planning processes.

NHS England will be supporting Sustainability and Transformation Partnerships or Integrated Care Systems as they develop within this role and tools will be available on the finance, commissioning and contracting website as they are developed.

6.2 Primary Care Networks

Primary care networks (PCN) are groups of practices that collaborate locally, in partnership with community services, social care and other providers of health and care services. They allow practices to continue doing what they do best, while working together to share other services that require additional scale. Where emerging primary care networks are in place in parts of the country, there are clear benefits for patients and clinicians, and these approaches are emerging as the delivery model for primary care of the future. For example, the recent development of the 'Primary Care Home' approach (a type of primary care network) builds on a history of primary care working in more integrated ways, drawing together and sharing existing good practice, and provides evidence that network-based models can improve care for patients while at the same time supporting clinicians to live sustainable lives.

Primary care networks build on the core of current primary care and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. Clinicians describe a change so that their work isn't about reactively providing appointments to patients on a registered list, but proactively caring for the people and communities they serve. They should be based on GP registered lists, typically serving natural communities of around 30,000 to 50,000, which experience has shown is the optimal size for integrated locality-based working. Networks should be small enough to still provide the personalised care valued by both patients and GPs, but large enough to have impact and economies of scale through deeper collaboration between practices and others in the local health and social care

system. Networks will provide a platform for providers of care being sustainable into the longer term, and also allow primary care providers to play more of a role in system decision making.

Many STPs and ICSs have identified three system 'levels': neighbourhoods, built around primary care networks; places, integrating care between local hospitals, local authorities and other partners; and systems, which develop strategy based on population needs, allocate resources, and support collaboration across organisations to improve care.

Primary care will play a crucial role at all of these levels, with primary care networks central to the delivery of integrated care and at the heart of all successful ICSs. In local neighbourhoods, primary care networks will deliver integrated services. In places, primary care will interact with hospitals and local authorities, working together to meet the population's needs. In some systems, federations will operate at the place level to support primary care networks. Finally, at the system level, primary care as a provider will increasingly participate in system decision making.

As personalised care is expanded in areas, commissioners will be required to work closely with the primary care networks. The initial priorities will be for developing relationships with the network to enable achievement of shared system-wide goals. Specifically, primary care networks and their partners should consider implementing the comprehensive model for personalised care by:

- Systematically embedding personalised care and support planning and shared decision making as gateways into a personalised approach
- Ensuring that people who choose to enter a medical pathway are offered choice of provider
- Ensuring that local menus of options are developed for people with national and local priority health conditions
- Ensuring that social prescribing link workers are available at practice or network level to link people to community-based support
- Ensuring that people with long term conditions – especially those with low levels of knowledge, skills and confidence to manage their health and wellbeing (low levels of activation) – are identified and offered targeted support including health coaching, peer support, access to self-management programmes and social prescribing
- Ensuring that people with more complex needs are identified through proactive case finding and offered personalised care and support planning through access to a multidisciplinary team and the possibility of a personal health budget or integrated personal budget.

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Appendix 1:

Shared Decision Making: The Specific Clinical Situations

The following tables list the priority areas for shared decision making.

Shared Decision Making - High Value Conversations		
	Clinical area	Conversation
1	CVD – primary prevention	Anticoagulation management in AF
2	CVD – primary prevention	Statins for 10-year high CVD risk
3	CVD – primary prevention	Management of hypertension
4	MSK	Management of knee pain
5	MSK	Management of hip pain
6	MSK	Management of shoulder pain
7	MSK	Management of back pain
8	Respiratory	Early identification and management of asthma & COPD
9	CVD – aortic stenosis	TAVI
10	CVD - arrhythmia	Implantables
11	MH - Anxiety	Best management of mild/moderate anxiety
12	MH- Depression	Best management of mild/moderate depression
13-26	Evidence based intervention programme (13 out of 17 procedures relevant)	As per EBI programme Further details can be found on the NHS England webpage for evidence-based intervention programme (https://www.england.nhs.uk/evidence-based-interventions/)
27	Link with medicines value programme (18 medicines)	In care homes to optimise medication Further details can be found on the NHS England webpage for the medicines value programme (https://www.england.nhs.uk/medicines/value-programme/)

28-30	Medicines safety programme	<p>Top 4 riskiest medications</p> <p>Further details can be found on the NHS Improvement webpage for the medicines safety programme (https://improvement.nhs.uk/resources/national-medicines-safety-programme/)</p>
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Shared Decision Making: Evidence based intervention programme procedures	
	Intervention/ Procedure
1	Surgery for snoring
2	Dilatation and curettage for heavy menstrual bleeding,
3	Knee arthroscopies for osteoarthritis
4	Injections for non-specific back pain
5	Breast reduction
6	Removal of benign skin lesions
7	Grommets for Glue Ear
8	Tonsillectomy for sore throats
9	Haemorrhoid surgery
10	Hysterectomy for heavy menstrual bleeding
11	Chalazia (lesions on eyelids) removal
12	Removal of bone spurs for shoulder pain
13	Carpal tunnel syndrome release
14	Dupuytren's contracture release for tightening of fingers
15	Ganglion excision - removal of noncancerous lumps on the wrist or hand
16	Trigger finger release
17	Varicose vein surgery

Universal Personalised Care

Finance, Commissioning and Contracting Handbook www.england.nhs.uk/personalisedcare

The information provided in this framework can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request.

Please contact 0300 311 22 33 or email england.contactus@nhs.net