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Network Contract Directed Enhanced Service

Personalised Care: Social prescribing; shared decision making; digitising personalised care and support planning

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Introduction

1.1 This document sets out guidance to support Primary Care Networks (PCNs) in delivering the personalised care requirements of the Network Contract Directed Enhanced Service (DES). Supplementary information is provided in annexes at the end of this document, which can be used to support implementation of the requirements.

Universal Personalised Care

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

1.3 The six key components of personalised care (the first three of which are the focus of the personalised care requirements within the Network Contract DES) include:

- Shared decision making (SDM)
- Personalised care and support planning (PCSP)
- Social prescribing and community-based support (SP)
- Choice
- Supported self-management (SSM)
- Personal health budgets (PHBs) and integrated personal budgets (IPBs)

1.4 Further information about personalised care and each of the components can be found here

Guidance to support implementation of Personalised Care requirements in the Network Contract DES

2.1 **Proactive Social Prescribing – community development**

- By 30 September 2022, as part of a broader social prescribing service, a PCN and commissioner must jointly work with stakeholders including local authority commissioners, VCSE partners and local clinical leaders, to design, agree and put in place a targeted programme to proactively offer and improve access to social prescribing to an identified cohort that experience health inequalities. This plan must take into account views local population health needs and views of people with lived experience.

- From 1 October 2022, commence delivery of the proactive social prescribing service for the identified cohort.

- By 31 March 2023 review cohort definition and extend the offer of proactive social prescribing based on an assessment of the population health needs and PCN capacity

2.2 This builds on the existing requirement that *'a PCN must provide a social prescribing service to their collective patients. This service can be provided by either directly employing Social Prescribing Link Workers or by sub-contracting the provision of the service to another provider. Regardless of which option a PCN chooses to deliver, the PCN should be employing or engaging at least some Social Prescribing Link Worker resource in accordance with section B3 of Annex B of the Network Contract DES Specification.'*

2.3 To deliver the Proactive Social Prescribing aspects of the requirements, PCNs may wish to:

- Use Population Health Management (PHM) data and intelligence from Social Prescribing services and the Health Inequalities Improvement Dashboard in conjunction with lived experience to identify the patient cohort(s);
- Work collaboratively with local partners to inform service design for accessible and sustainable provision for the patient cohort(s);

- Set targets for improved access and monitor performance against these; for example, reviewing referral targets and outcome measures;
- Utilise funding from the [additional roles reimbursement scheme](#) to increase service capacity where available; including, if possible, recruiting specialist Social Prescribing Link Workers with specific skills or knowledge for the patient cohort(s) identified;
- Implement the national social prescribing minimum dataset[1], including demographic data collection, when introduced in 22/23.

2.4 As set out in the Network Contract DES, PCNs must:

- Record referrals using the SNOMED coding system.

2.5 **Shared Decision Making (SDM)**

- The Personalised Care Institute 30 min e-learning refresher training (and other PCI accredited training) for SDM conversations are recommended resources for any PCN clinical staff.

- By 31 March 2023, a PCN must audit a sample of their Patients' current experiences of shared decision making through use of a validated tool and must document their consideration and implementation of any improvements to SDM conversations made as a result.

2.6 Shared Decision Making is a fundamental principle of good quality consultations between clinicians and patients. The focus of the Network Contract DES requirement is on improving the quality of those conversations by providing PCN clinicians an opportunity to refresh their skills and to develop a better understanding of their patients' experience of involvement in decision making conversations about their care and treatment.

2.7 Training recommendations for SDM

2.8 The Personalised Care Institute curriculum (2020) articulates the values, behaviours and capabilities required by a multi-professional workforce to deliver personalised care. The eLearning course on SDM (and other equivalent PCI-accredited SDM learning), although not compulsory, covers aspects of communicating and building relationships with patients, as well as to engage, enable and support them.

2.9 Quality Audits

2.10 There are a number of available tools that enable patient experience of SDM to be measured. It is recommended that CollaboRATE or SDM Q9 are routinely used in order to measure patient experience; for more information on patient shared decision making see the recently published NICE SDM guideline. Their key characteristics are:

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[1] Potentially as part of the Community Services Data Set, or equivalent

- CollaboRATE – a 'fast and frugal' patient-reported measure of SDM containing 3 brief questions that patients, their parents, or their representatives, complete following a clinical encounter
- SDM-Q9 – 9 item questionnaire that measures the extent to which patients are involved in the process of decision making.

2.11 Further information on these and other SDM tools can be found on the Shared Decision Making Futures Platform and clicking on 'Measurement'.

2.12 PCNs are also encouraged to consider the sample size and timing of the audit(s) in order to ensure the information received is useful to inform improvements in SDM conversations. For example, PCNs may wish to consider starting by auditing 10% of their adult population with type-1 diabetes after the annual QOF reviews.

2.13 **Preparing for 2023/2024: Digitising Personalised Care and Support Planning**

2.14 In 2023/24, the following is intended to become a contractual requirement:

> By 31 March 2024, a PCN must have worked with other PCNs, their commissioner and local partners, to implement digitally enabled personalised care and support planning for care home residents.

2.15 This future requirement aligns with and builds on the provision of personalised care and support plans (PCSPs) to all care home residents as part of the Enhanced Health in Care Homes (EHCH) service. This guidance should therefore be read in conjunction with the EHCH implementation framework, specifically section 4.3.

2.16 To deliver this requirement, PCNs will need to work collaboratively within their local health and care system; for example, with Integrated Care Boards (when formed) and in particular with care homes, to implement digitally enabled personalised care and support planning across multiple settings of care. Digitally enabled personalised care and support planning will mean that these plans can be shared across systems and settings. See digital page on Future NHS for more detail on the benefits and national ambition for digital PCSP. This work will need to align with wider digital transformation within an Integrated Care System (ICS) footprint, for example the Shared Care Records programme and Digital Social Care Records. It will be the responsibility of PCNs to agree with their commissioner and partners how best to implement digital PCSP in their area, taking into consideration, existing digital systems and infrastructure, available funding, digital maturity within the ICS and other digital activity.

2.17 There is no nationally mandated digital system or process for digital PCSP for care home residents but PCNs and their commissioner will need to comply with the National Data Alliance Partnership Board (DAPB) PCSP Information Standard and any updates.

2.18 PCNs, their commissioners and partners should ensure alignment with the key criteria of PCSP and national ambitions for digital PCSP for care home residents. It is therefore recommended that PCNs begin preparatory work as soon as possible to ensure successful implementation by April 2024.
Further, more detailed guidance is in development will be published on the personalised care Digital - Personalised Care Collaborative Network - FutureNHS Collaboration Platform.

Appendix 1: useful links and details

Personalised Care Institute
https://www.personalisedcareinstitute.org.uk/your-learning-options/

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

Additional resources

To access any additional resources relating to personalised care, please join our collaborative space on NHS Futures or contact england.personalisedcare@nhs.net if you would like to sign up for our newsletter or want to arrange some tailored support from one of our regional teams.

There is also a Leadership Academy programme for personalised care. The programme is accessible to all with recordings on the YouTube Channel. To stay updated, please join the mailing list here. Useful resources in support of specific sections of the guidance are listed below:

Proactive social prescribing:

https://www.england.nhs.uk/personalisedcare/social-prescribing/support-and-resources/

Shared Decision Making:

The NHS England Shared Decision Making Summary Guide:
https://www.england.nhs.uk/publication/shared-decision-making-summary-guide/
NICE guideline on Shared Decision Making:
https://www.nice.org.uk/guidance/NG197

Appendix 2: Additional Roles for Personalised Care

The Additional Roles Reimbursement Scheme (ARRS) includes three roles for personalised care delivery including social prescribing link workers, health and wellbeing coaches and care coordinators as part of the wider multidisciplinary team (MDT). The support they provide can be linked to the service requirements of the Network Contract DES, but they can also provide broader support to patients, carers and the wider PCN workforce. This can include community engagement, tackling health inequalities, supporting discharge from hospitals etc.

All three personalised care roles should have appropriate levels of training and supervision, as outlined in the Network Contract DES contract and detailed by the Personalised Care Institute (PCI), to effectively carry out their role. The roles are distinct but complementary and have the greatest impact when fully embedded into MDTs.

Further information on the roles can be found in the scheme guidance at: https://www.england.nhs.uk/wp-content/uploads/2019/12/network-contract-des-additional-roles-reimbursement-scheme-guidance-december2019.pdf

Training and support for new roles

- Welcome pack for care coordinators and H&WB coaches

- Care co-ordinators collaborative platform – an online space to access and share resources, ideas, and information. Email england.supportedselfmanagement@nhs.net to join.
- Health and wellbeing coach collaborative platform - an online space to access and share resources, ideas, and information. Email england.supportedselfmanagement@nhs.net to join.
- 4 day health coaching training accredited by PCI
- PCI- Training, Supporting and Embedding New Personalised Care Roles in PCNs webinar
- UCLPartners – Introduction to the Proactive Care Frameworks