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Network Contract Directed Enhanced Service

Personalised Care: Proactive social prescribing and shared decision making

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Guidance to support implementation of Personalised Care service requirements

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).

1.2 The Personalised Care service was introduced in 2022/23 with a focus on two particular components of personalised care – social prescribing and shared decision making.

Proactive Social Prescribing

2.1 The contractual requirement states:

- As part of a broader social prescribing service, the PCN must review its targeted programme to proactively offer and improve access to social prescribing to an identified cohort with unmet needs. This offer must take into account views of people with lived experience.
- A PCN must deliver the proactive social prescribing service for the identified cohort.
- A PCN must review cohort definition(s) and continue to extend the offer of proactive social prescribing based on an assessment of the population needs and PCN capacity.

2.2 This builds on the existing requirement that *"a PCN must provide its Patients with access to a social prescribing service".* 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:

- Work collaboratively with local partners, including people who have accessed the social prescribing service, to review experiences and outcomes, and to identify opportunities for improvements to service design and delivery for accessible and sustainable provision for the patient cohort(s);
- Use Population Health Management (PHM) data along with insights from the Health Inequalities Improvement Dashboard and from local partners, to identify additional or alternative patient cohort(s) to whom the service offer could be extended;
- Consider identifying cohorts that experience health inequalities as set out in the Core20PLUS framework, or High Frequency User groups, as outlined in additional guidance "Supporting High Frequency Users through Proactive Personalised Care". This may include working with other roles such as health and wellbeing coaches and care coordinators. Appendix 3 provides details of the training and support available for these roles;
- Set targets for improved access and monitor performance against these; for example, reviewing referral targets and outcome measures;
- Use 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;

2.4 As set out in the Network Contract DES, PCNs must record referrals using the SNOMED coding system. See Appendix 2 for details of codes.

Shared Decision Making (SDM)

2.5 The contractual requirement states:

- A PCN must continue to implement any remaining improvements to shared decision making conversations as outlined in its documented considerations following its sample audit of patients' experiences of SDM [which was required to be performed during 2022/23 through use of a validated tool].

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 seeking feedback from patients about their experience of involvement in decision making conversations about their care and treatment and using this feedback to inform quality improvement plans.

2.7 PCNs can continue to learn lessons from the audit they completed in 2023/24 and implement and remaining improvements from the resulting plan.

Quality Audits

2.8 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. Their key characteristics are:

- 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.

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

2.10 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 linking audits with patient reviews as part of the Quality Outcomes Framework.

2.11 PCNs may also wish to combine and compare their audits with other patient experience or outcome measures, such as the GP Patient Survey, or feedback for individual clinicians as part of clinical revalidation.

2.12 To assist in reviewing records to identify patients who have participated in shared decision making conversations, PCNs may wish to make use of the SNOMED codes outlined in Appendix 2.

Training recommendations for SDM

2.13 The Personalised Care Institute curriculum (2020) articulates the values, behaviours and capabilities required by a multi-professional workforce to deliver personalised care. The PCI provides a 30 minute eLearning course on SDM as well as other equivalent PCI-accredited SDM learning, including in-person and team-based learning. These training courses are not compulsory, but cover aspects of communicating and building relationships with patients, as well as to engage, enable and support them.

2.14 In recognition of the current capacity pressures in primary care, completion of SDM training has not been included as a contractual requirement for 2023/24. However, where capacity allows, we encourage PCNs to consider how this training might contribute to their improvement plans for shared decision making practice, and could be a helpful action to take where quality audits of patient experience of shared decision making indicate room for improvement.

Appendix 1: Useful links and details

Listed below are some useful additional information and guidance relating to personalised care.

Universal Personalised Care

Chapter one of the NHS Long Term Plan 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.

The six key components of personalised care are:

- Shared decision making
- Personalised care and support planning
- Social prescribing and community-based support
- Choice
- Supported self-management
- Personal health budgets and integrated personal budgets

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

Proactive Social Prescribing

GPs report that they are spending a considerable amount of time on non-health issues with patients during consultations, with patients raising issues relating to personal relationships, housing, unemployment, welfare benefits and social isolation. Social prescribing connects people to non-medical support to address these issues and other unmet needs which can lead to a reduction in the use of NHS services, including GP appointments and A&E attendances, as demonstrated in the following case studies:

- Supporting High Intensity Users in Dudley
- Using a population health management approach to identify vulnerable people needing more proactive support in Bedfordshire, Luton and Milton Keynes
- Supporting children and young people with mental health needs in Stort Valley and Villages PCN

The following resources provide further information on social prescribing and the development of proactive, personalised care approaches:

- The NHS England social prescribing webpage provides an overview of social prescribing and social prescribing link workers in the NHS;
- PCN reference guide for social prescribing link workers, which provides additional guidance and support to PCNs to deliver access to a social prescribing service per the PCN DES, of which the proactive social prescribing service should be linked;The National Academy for Social Prescribing (NASP) have synthesised some of the evolving evidence base for social prescribing;
- YouTube video from the National Association of Link Workers explains the approach and elements required to deliver proactive social prescribing;NHS England provided guidance on the development of a proactive, personalised care model for High Frequency Users of services as part of a letter to systems on winter resilience plans;
- UCL Partners have produced an Introduction to the Proactive Care Frameworks which outlines a proactive approach to long term condition management in primary care.

Shared Decision Making

The principles of shared decision making are outlined in the GMC ethical guidance on 'Decision making and consent' (2020) and included in pre-registration curriculae for GPs and physiotherapists. Training in SDM is also included as part of induction for the International Nursing Programme, International Allied Health Professional Programme and for social prescribing link workers, health and wellbeing coaches and care coordinators.

The ruling in Montgomery v Lanarkshire Health Board (2015) reinforced that doctors have a duty of care to ensure that patients are informed of the risks involved in any recommended treatment, and of any reasonable alternatives. Involvement in decision making is also a patient right in the NHS Constitution and included in the CQC fundamental standards for person-centred care and consent.

The following resources are of relevance to the Shared Decision Making service requirement:

- The NHS England Shared Decision Making Summary Guide
- A full list of SDM guidance and resources is available here and on the NHS Futures Platform
- NICE guideline on Shared Decision Making

Additional resources

To access any additional resources relating to personalised care, please join our collaborative space on NHS Futures, sign up to the Personalised Care Bulletin 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.

Leadership for Personalised Care is a suite of programmes that are funded or part-funded by NHS England to support clinical and non-clinical leaders at all levels to put personalised care into practice. Recordings are available on the YouTube Channel. To stay updated, please join the mailing list.

Appendix 2: SNOMED coding

The following SNOMED codes can be used to support delivery of the Personalised Care service requirements and Investment and Impact Fund indicators:

- For Proactive Social Prescribing:
  - 871731000000106 - Referral to social prescribing service (procedure)
  - 871711000000103 – Social prescribing declined (situation)

- For Shared Decision Making
  - 815691000000107 - Shared decision making (procedure)
  - 815711000000109 - Shared decision making with patient decision aid (procedure)
  - 815731000000101 - Shared decision making without patient decision aid (procedure)
  - 815751000000108 - Shared decision making with decision support (procedure)
  - 815791000000100 - Shared decision making without decision support (procedure)

Appendix 3: Additional Roles for Personalised Care

The Additional Roles Reimbursement Scheme (ARRS) includes three roles which are central to 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 improved self-management of health and wellbeing, community engagement, tackling health inequalities, and supporting discharge from hospital.

All three 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 and in Annex B of the Network Contract DES contract specification.

In depth information about training, supervision, competencies and scope of the roles can be found in the Workforce Development Frameworks:

- for social prescribing link workers
- for health and wellbeing coaches
- for care coordinators.

Details of our online collaborative spaces for the different roles are provided below:

- Social prescribing collaborative platform – to join, please email england.socialprescribing@nhs.net
- Care co-ordinators collaborative platform – to join, please email england.supportedselfmanagement@nhs.net
- Health and wellbeing coach collaborative platform – to join, please mail england.supportedselfmanagement@nhs.net.