We have been working together to consider what the requirements set out in the NHS Long Term Plan mean for our residents, staff and health and care partner organisations across north central London (NCL). We have a collective commitment to deliver changes that will improve the health and wellbeing of residents and have listened to what residents told us is important to them.

We have developed a draft NCL delivery plan for personalised care and are now seeking the engagement and involvement of all local partners, stakeholder and residents to refine and finesse these plans. Over the next two months, we will cross-reference, financially cost and finalise our plan for submission in November.

*If you have any comments, queries or think we have missed important points relating to any of the sections please get in touch with Sarah D'Souza (*sarahd'souza@nhs.net*).*

1. Introduction

Personalised care is at the heart of the long-term plan, supporting people to have more choice and control over the approaches and interventions they choose so they can take an active role in their own care and are enabled to work in partnership with health and care professionals.

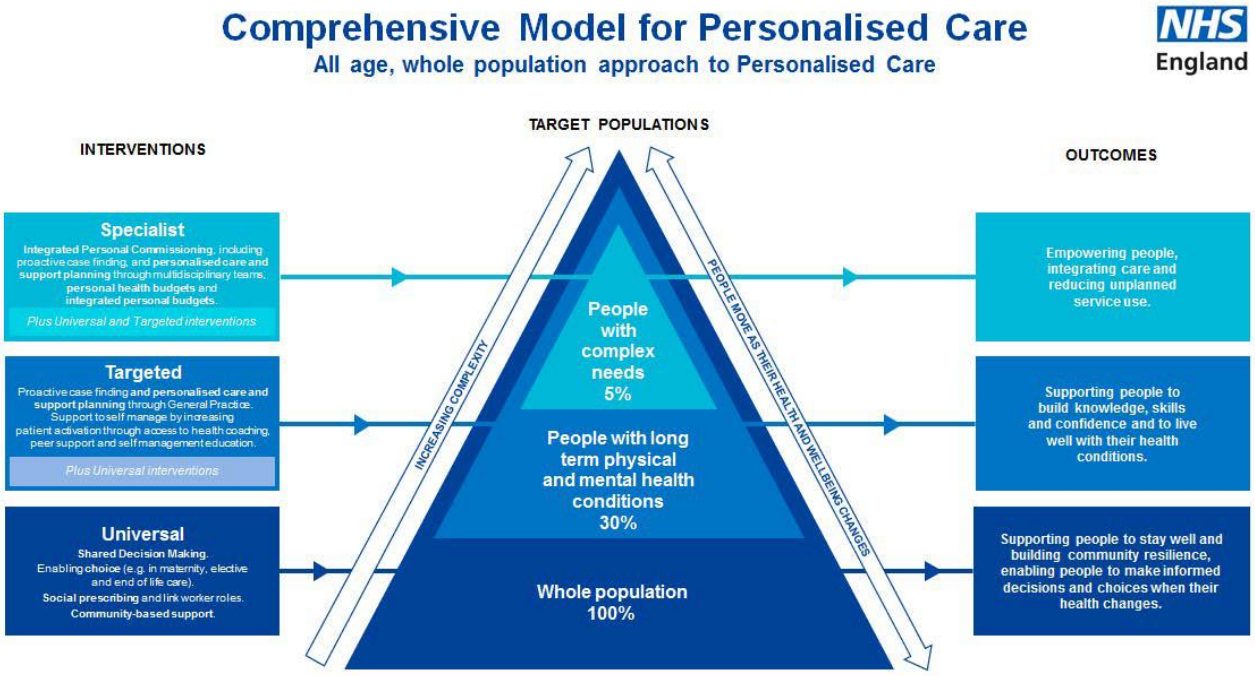
North Central London (NCL) believe delivery of the six key components of personalised care enable the successful delivery of the Long Term Plan (LTP), working in partnership with our population and system partners from all sectors. The CCGs of NCL have always demonstrated engagement and leadership in delivering personalised care and for this reason, NCL CCGs collectively have in place numerous initiatives, or services, that support the Universal Personalised Care programme, however more work is underway to link these programmes together. Greater co-ordination at NCL level should mean that the CCGs are better able to share best practice, learning, expand good practice from a borough-level to a STP-level and provide a more consistent care experience for patients across NCL. Existing and planned work is outlined below. The six components of personalised care are as follows:

- **Enabling choice:** Legal right to choice of provider in respect of first outpatient appointment and suitable alternative provider if people are not able to access certain services within the national waiting time standards.
- **Social prescribing:** Referral to a link worker who is able to connect the person in to local community based support.
- **Shared decision making:** Where there is a point in a pathway where a decision needs to be made where there are options available, people are supported to understand the options available to them and are able to make decisions about their preferred course of action.
- **Supported self-management:** Increasing the knowledge, skills and confidence of a person in managing their own health and care through interventions such as health coaching or peer support.
- **Personalised care and support planning:** Proactive and personalised care and support planning which focuses on the clinical and wider health and wellbeing needs of the individual. Conversations should focus on what matters to the individual and will be delivered through a six-stage process.
- **Personal health budgets:** Funding allocated to the individual to manage their identified health and wellbeing needs against planned and agreed parameters with their local CCG.

Across North Central London STP, CCGs are embracing the personalised care agenda, with CCGs already delivering on many different elements. In order to ensure we have a strategic approach to personalised care we are commencing with a baseline activity which will enable the

STP to gain a granular picture of all the excellent practice which is currently underway, and to develop a cohesive plan with partners to support the STP vision for care provision for NCL.

2. Implementation of the six components of the NHS Comprehensive Model for Personalised care



Source: NHS England (2019) Universal Personalised Care. Implementing the Comprehensive Model

As part of our efforts to embed personalisation across NCL, we will ensure that we have:

- Updated contracts and specifications with providers to reflect personalised care
- Considered the potential barriers to implementation of shared decision making and personalised care and developed plans to address barriers identified
- Worked with local voluntary and community sector providers to develop the market beyond the NHS for social prescribing
- Developed our infrastructure for management and delivery of PHBs, as well as supported the market to develop to enable greater choice in PHB market
- Develop our ability to measure personalisation, in particular through use of tools which capture patient activation

2.1. Enabling choice

Choice of provider at the point of first outpatient referral is offered universally across North Central London, along with the opportunity to choose a suitable alternative provider if people are not able to access services within the national waiting time standards. We will work together to ensure that information on patients legal rights to choice are publicised and promoted and that information about services remains up to date and available to the public. We will identify a named NCL executive for choice who will maintain and develop the NCL choice policy. Through our contract management of providers we will ensure that they, as well as the wider integrated care system, are aware of provider obligations in regards to choice.

The CCGs in NCL will ensure that:

- All elective referrals made by GPs in NCL are delivered through the e-RS system
- All five CCGs in NCL are compliant with the minimum standards in the Choice and Planning and Improvement Guide.

2.1.1. Key performance indicators

Personalised Care Components	Maximum potential scale	Ambitious but achievable goal by 2023/24	NCL Targets – 2023/24	NCL Targets – 2028/29
Enabling choice, including legal rights to choice	Whole population benefits through choice of GP and everyone who attends an outpatient appointment, approximately 90 million outpatient attendances per year. Part of 'universal' tier of Comprehensive Model	Legal rights to choice are maintained throughout wider system transformation, with 100% of elective referrals exercising choice through e-RS and 100% of CCGs compliant with the minimum standards in the CCG Choice Planning and Improvement Guide	100% compliance with the minimum standards in the CC Choice Planning and Improvement Guide.	100% compliance with the minimum standards in the CC Choice Planning and Improvement Guide.

2.2. Social Prescribing

North Central London has a rich history of social prescribing. The formation of the new primary care networks provide the foundation from which a social prescribing system can be developed and delivered at scale. NCL recognise 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). NCL commissioners regard social prescribing as a key programme that meets the PSED equality and health inequalities requirements.

The strategic vision for social prescribing in NCL has been developed by the STP's *Social Prescribing and Supported Self-management Advisory Group*. This group has been meeting for the past 18 months and brings together colleagues from the NHS, Local Authorities and Voluntary, Community & Social Enterprise (VCSE) sector from each of the 5 NCL boroughs. It provides a forum to share best practice in social prescribing as well as build consensus and collaborate on STP-wide priorities.

The advisory group has created system design principles for social prescribing services based on the Comprehensive Model for Universal Personalised Care and offers recommendations to PCNs on developing their social prescribing offer, recruiting link workers and integrating them into the local health and care system. The advisory group has also created an outcomes and evaluation framework for measuring the impact of social prescribing and is working with the NCL Digital Accelerator and NHS England to promote digital integration of social prescribing records and electronic referrals into the voluntary sector.

Social prescribing link workers will work alongside existing commissioned link worker and care navigation services funded by the NHS and local authorities. It is anticipated that the number of link workers working in PCNs will grow year on year for the next five years through the *Additional Roles Reimbursement Scheme* in the new GP contract and that provision of funding from 2020 onwards will be based on population size. This will ensure this workforce will continue to grow and social prescribing is a core element of health and care system. We will focus on supporting link workers as a new part of the primary care workforce through peer networking and through training and development.

NCL will support link workers to develop local borough-based partnerships with their local authority and voluntary and community sector (VCS) colleagues. We will also coordinate our commissioning of social prescribing services as a system to maximise use of resources and ensure we get the most

from our commissioned VCS services. Social prescribing link workers will act as a one-stop social prescribing connector service and will connect people to community groups and VCS organisations.

In addition, as the STP rolls out its HealtheIntent population health management software to PCNs, we will develop social prescribing population registries for each PCN. This will allow link workers to identify people who would benefit from social prescribing interventions and create targeted, proactive interventions for their local populations along with operational protocols for priority groups, such as those who:

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

The CCGs in NCL will develop a map of existing community assets, high impact interventions and any gaps in provision within each PCN as well as the development of a whole system strategy for the development of community based approaches.

2.2.1. Key performance indicators

Personalised Care Components	Maximum potential scale	Ambitious but achievable goal by 2023/24	NCL Targets – 2023/24	NCL Targets – 2028/29
Social prescribing and community-based support	Around 5% of the population, or around 3 million people, benefit from social prescribing per year as part of the 'universal' tier of the Comprehensive Model	1,000 trained link workers recruited by 2020/21 and 900,000 people referred to social prescribing link workers by 2023/24	2020-21: - 30 trained link workers recruited in NCL. 2023-24: - 148 link workers recruited in NCL. - 23,950 referrals made to link workers.	47,899 referrals made to social prescribing link workers in NCL. Number of link workers in 2028-29 is yet to be confirmed; dependent on funding.

2.3. Shared Decision Making

Shared decision making, whilst not a new concept, is one which requires a conscious shift in approach for both the individual and staff. In 2019, representatives from each of the NCL boroughs participated in a series of shared decision making workshops hosted by UCL Partners to increase understanding of shared decision making and learn which cohort(s) of patients the approach can be most effective for. Workshop attendees recognised that local staff would require more support and training in order to apply the SDM approach routinely in all service areas.

Collectively, NCL have run several personalised care pilots, drawing on the values of shared decision making. Through these pilots, therapeutic or alternative treatment options have been explored with patients, in order to better meet individual needs. This work will be expanded upon through the *Structured Medication and Optimisation Review*, as per the primary care network (PCN) Directed Enhanced Service (DES) specification, whereby PCN members will support direct tackling of the over-medication of patients, including inappropriate use of antibiotics, withdrawing medicines no longer needed and support medicines optimisation more widely. It will also focus on priority areas, including (but not limited to):

- Asthma and COPD patients;
- Care home residents;
- Frail elderly;
- Patients with complex needs, taking large numbers of different medications.

- Stop Over Medication for People with learning disabilities or autism programme (STOMP).

NCL will ensure clinicians involved in decision making have access to accredited training. NCL will establish clinical and programme governance relating to all projects which seek to implement shared decision making within clinical pathways, which will include peer review processes and clinical champions within each local area. As part of the CCGs work with UCL Partners, the CCGs are exploring the use of the three-item tool collaborate, which will support the evaluation and monitoring of shared decision making in NCL.

2.3.1. Key performance indicators

Personalised Care Components	Maximum potential scale	Ambitious but achievable goal by 2023/24	NCL Targets – 2023/24	NCL Targets – 2028/29
Shared decision making	Any health and care conversation where a decision is to be made, as part of the 'universal' tier of Comprehensive Model	Shared decision making embedded in 30 high-value clinical situations in primary care, secondary care and at the primary/secondary interface where it will have the greatest impact on experience, outcomes and cost	March 2020: Embed SDM in initial clinical priority areas: o atrial fibrillation, hypertension and high cholesterol o MSK: for people with hip, knee, shoulder and back pain o For interventions (including chemotherapy) in the last year of life that offer limited benefit o Medication optimisation in care homes. o COPD: increase access to pulmonary rehabilitation. Shared Decision Making embedded in 30 high-value clinical situations in primary care, secondary care and the interfaces of these settings.	Maintain 2023-23 targets. 2028-29 targets are to be confirmed.

2.4. Supported Self-Management

In order to deliver person centred care we need to support individuals and carers to be engaged and informed. Through the commissioning of self-management support programmes e.g. Expert Patient programme, we can raise people's skills, knowledge and confidence so they feel able to take an active role in their own care. Across NCL, providers such as Whittington Health, through their self-management support and behaviour change services, have shown the benefits of this approach. For many health conditions people are already making choices and taking control of how to manage their health needs, including the use of peer support and expert advice.

Self-management services in NCL are closely linked to social prescribing services, however self-management services have a stronger educational focus, upskilling people to minimise the volatility of the wider determinants of health. For many health conditions people are already making choices and taking control of how to manage their health needs, including access to expert advice and peer support.

NCL will ensure that there is proactive identification of people's knowledge, skills and confidence in managing their own care through use of Patient Activation Measures. Where appropriate, we will ensure that people are referred on to the most appropriate self-management education programme.

We are aware that each of our CCGs already have a range of self-management education programmes. These include support for specific long term conditions, such as for Diabetes or COPD, or more generally for building confidence and peer support through programmes such as the Expert Patients Programme. However, we will seek to map and standardise this offer so that our health and care staff are aware of the offer across NCL.

2.4.1. Key performance indicators

Personalised Care Components	Maximum potential scale	Ambitious but achievable goal by 2023/24	NCL Targets – 2023/24	NCL Targets – 2028/29
Supported self-management	4.6 million people with long-term conditions who also have low levels of knowledge, skills and confidence, within the 'targeted' tier of the Comprehensive Model	Continue to increase the opportunities for people to benefit from supported self-management approaches	122,410 people in NCL, with long-term conditions are supported to self-manage through levels of knowledge, skills and confidence.	244,819 people in NCL, with long-term conditions are supported to self-manage through levels of knowledge, skills and confidence.

2.5. Personalised Care and Support Planning

As a system we are ensuring that local people have personalised conversations with health and care staff based on what matters to them will be essential in the development of personalised care in NCL, where appropriate to do so. In NCL we will begin with reviewing existing areas where assessment, planning and decision making is carried out with the aim of improving existing support planning arrangements so that they are personalised and focus on what matters to individuals, whilst also paying attention to their specific clinical and wider health and wellbeing needs. Delivery will require the integrated care partnerships in each of the CCGs to mobilise support to delivery of personalised care. Examples of areas of focus are as follows:

- **End of life care:**
    - Coordinate my Care (CMC) will be implemented across NCL. This is an urgent care plan digital tool which enables patients and their clinicians to make plans together about the kind of care they would like to receive, what matters to them and where they would like to receive that care. This plan can then be seen across the system including London Ambulance Service, NHS 111 and primary care. The development of the Coordinate my Care personalised care and support plan is currently incentivised through Locally Commissioned Services (LCS) by two of the five CCGs in NCL and to support the successful implementation across all of NCL we will review opportunities to increase the scope of the LCS to the remaining three CCGs. Additionally, working with Providers to develop Advanced Care Plan policies where needed; setting out expectations that non palliative care clinicals create CMC records for their patients (e.g. NMUH have recently launch their policy- this work, as well as the related CQUIN, will be reviewed by the other acute providers in NCL with the view to scaling use of the policy beyond the North Middlesex)
    - Developing work delivered to date on the Enhanced Care in Care Homes Frameworks
    - Ensuring that there is a strong and consistent information and advice offer in place for patients in place across NCL allowing patients to make informed decisions about their

end of life care e.g. in Barnet there is a range of support which will be linked into the PCN social prescription offer including AGE UK Barnet later life planning service commissioned by the local authority and the CCG, Dementia Community Support Services, IMHA
    - Children's palliative and end of life care is an important priority for NCL. Over the next five years we will work with local hospices, and NHS England to explore the potential to increase investment in children's palliative and end of life care services, including hospices.

- **Personal Health Budgets:** For all existing and new PHBs we will ensure that there is a personalised care and support plan in place for the individual. The personalised care and support plan will be a key feature in the pathway for offering a PHB.
    - Care and Support Plans will be co-produced and strengths based
    - Ensuring that each area within NCL has a local PHB steering group which will cut across CHC, MH and Children's

- **Complex care for children:**
    - For those patients assessed for continuing care (children) there is already a national assessment framework which requires the assessor to ensure the assessment and outcome of the assessment involves the child, young person and their families in the process.
    - In the same way, children and young people who are assessed as part of the development of an education, health and care plan (EHCP) should receive an assessment which is personalised and considers what matters to the child and their families.
    - In NCL, processes for continuing care and EHCP are already in place, however we will review processes on access to training and ongoing support to maximise the impact of support and care plans on personalisation. The focus will also extend to those care and support plans delivered by the Transforming Care Programme.

- **Mental Health:** To further build upon work to date to ensure that individuals have access to a range of support and services which are tailored to meet their individual needs, helping them to self manage their needs and where more complex presenting needs are present
    - further developing our approach to rolling out of PHB's for people with complex mental health needs
    - increasing health checks for the number of people with severe and enduring mental illness
    - ensuring that people have access to a range of resources to maintain and improve their mental health (e.g. Primary Care Link Workers are embedded within primary care within Barnet, social prescription model delivered via the Barnet Wellbeing Hub); developing local borough based mental health primary care support
    - Improving information sharing to support patients to tell their story once improve patient experience
    - Ensuring that there is a range of alternative provisions in place for people experiencing crisis to access support

As part of work with staff in the focus areas mentioned above, we will review their current training needs to ensure that staff are adequately trained in the delivery of personalised support and care plans. NCL are also developing our Electronic Patient Record, which will further facilitate the CCGs ability to offer a summary care and support plan in digital form. For each of the areas listed, we will

identify a personalised care and support planning lead who will act as a champion and will represent their area of focus within the programme.

2.5.1. Key performance indicators

Personalised Care Components	Maximum potential scale	Ambitious but achievable goal by 2023/24	NCL Targets – 2023/24	NCL Targets – 2028/29
Personalised care and support planning	5-10 million people in total benefitting, across both 'specialist' and 'targeted' tiers of the Comprehensive Model	750,000 people, including people with long-term conditions, people at the end of life and pregnant women	19,958 people have an active, personalised care & support plan in NCL. 1,996 clinicians trained.	39,916 people have an active, personalised care & support plan in NCL. 3,992 clinicians trained.

2.6. Personal Health Budgets and Integrated Personal Budgets

Across NCL there is an active network established to develop the rollout of PHBs across the area. At present, this includes Personal Wheelchair Budgets, Continuing Healthcare (CHC) and Children's Continuing Care on a 'right to have' basis. During 2019/20, the Section 117 cohort of patients will also become a 'right to have'.

PHBs have successfully been used within the Learning Disability and Autism work (previously called Transforming Care), demonstrating the impact of PHBs for Children and Young People who are part of this cohort. Currently an NCL mentor for PHB is employed to support the CCGs to develop local and system wide solutions to embedding PHBs.

The PHB mentor and NCL network provide peer support and the sharing of good practice, enabling the expansion of PHBs to different client groups. The plan for further development of PHBs is as follows:

- Over the next two years, the focus will be to expand the offer to other client groups including mental health and learning disabilities. Further expansion will then focus on long-term conditions and end of life. The NCL regional network will inform and support future contracting arrangements with providers to ensure patient choice and control.
- Develop clear financial and clinical governance which will include the establishment of the co-productive steering group to identify third party providers. In addition, we will establish a clinical steering group. This will also include the implementation of a PHB policy across all of the CCGs in NCL
- Develop patient and staff resources which can be shared with stakeholders and form part of the local offer.
- Review contracting arrangements with providers to allow for the expansion of PHBs, including the development of a third party service specification, co-productive SLA between patient and third party provider and work with LA to develop IPB framework

2.6.1. Key performance indicators

Personalised Care Components	Maximum potential scale	Ambitious but achievable goal by 2023/24	NCL Targets – 2023/24	NCL Targets – 2028/29

Personal health budgets and Integrated personal budgets	2 million people – those with long-term conditions or complex needs – can most benefit. All of these people would have a personalised care and support plan and majority would be in 'specialist' tier	200,000 people benefitting from PHBs or IPBs	5,322 people benefitting from PHBs or IPBs.	10,644 people benefitting from PHBs or IPBs.

3. Commissioning, contracting and finance

As we move forward it will be essential to develop a way of capturing and understanding individuals' choices in relation to meeting their health outcomes, this will enable us to assess our commissioning strategies and contracts in line with people's preferences and choices. Overtime we anticipate shifts in our commissioning activities to meet the changing shape of care.

To support providers to deliver care in accordance with the Universal Personalised Care Model, contracts will be reviewed to include the elements of personalised care, as per Section 2M of the new NHS England Standard Contract.

This has worked well in Islington, for example, where a Locally Commissioned Service Contract has encouraged the embedment of Collaborative Care and Support Planning (CCSP) in Primary Care over a four year period, ensuring individuals and carers are informed and engaged and clinicians work in partnership with patients through extended appointments to develop a care and support plan that captures individuals goals based on what matters to the person. This project has been a great success story, and is now being expanded to test the use of PAM as a patient segmentation tool, supporting a more personalised and targeted approach to care and support planning, enabling care and health professionals to connect patients with the right care and support, both statutory and other support, for example; link workers or peer coaches.

To ensure personalised care remains sustainable, NCL will identify key cohorts for whom personalised care offers will be expanded and local contracting and financial arrangements will reflect this. Once key cohorts have been identified, NCL will be better placed to determine which contract and financing approach NCL will take to deliver personalised care in the long term.

4. Digital

The delivery of Person Held Records across NCL is recognised as a key deliverable of the NCL Digital programme. The digital team is working collaboratively with NWL, demonstrator site for the Enabling Citizens workstream of the London LHCRE "One London" programme to ensure a shared specification for a PHR is agreed. Through this work and the "One London" programme we hope to commission a PHR that works for all Londoners recognising the mobility of our population:

- Islington – CMC records
- STP Patient survey – LTP response
- Looking at Social Prescribing Digital Enablers

5. Key next steps

NCL has strong engagement with local system partners including local people and the voluntary sector. There are several advisory groups in place e.g. Social Prescribing advisory group. We will be commencing lunchtime “sharing sessions” within each CCG area, to support staff to awareness, understanding and engagement with the personalised care agenda and themes to ensure it is considered as an important enabler in all service and commissioning developments.

The NCL CCGs have started to deliver against the Universal Personalised Care (UPC) overall objectives to varying extents. In order to address this variation, supporting a transition to aligned ICS working, the key next steps for NCL in delivering the UPC programme are outlined below:

- Identify a NCL Personalised Care SRO.
- Identify priority cohorts for which personalised care offers will expanded, with commissioning, contracting and financial consideration for this.
- Develop a NCL Commissioning, Contracting and Finance Approach for Personalised Care Delivery.
- Incorporating identified NCL Personalised Care key cohorts into local and/or integrated commissioning intentions.
- Ensure coproduction takes place regularly and at different scales; at a NCL level, borough level and localities level.