Supporting people to manage their own health, wellbeing and care
2017/ 18 Commissioning intentions prepared by HLP Personalisation & Self-Care programme

1. Overview

People who manage their own health, wellbeing and care have improved experience of care, increased choice and reduced demand for high-intensity acute services. The NHS Five Year Forward View calls for a radical upgrade in prevention and public health, and greater engagement with people and communities to harness the energy and potential they have. There is a growing body of evidence showing that a diverse and wide range of person-centred and community-centred approaches lead to improved outcomes and significant benefits for individuals, services and communities. This has been demonstrated through improved mental and physical wellbeing, contributing towards NHS financial sustainability and wider social outcomes[i] [ii]. A commitment to supporting people to manage their own health, wellbeing and care was clear from the 30 June London Sustainability and Transformation Plan submissions with plans to rollout digitally enabled self-care a key part of local digital roadmaps. However, 40% of people have low levels of knowledge, skills and confidence to manage their health and wellbeing[iii]; 44% say they would like to be more involved in making decisions about their care[iv]; and research shows that people want a multi-channel offer - in achieving personalisation through an online account and making it easier to self-serve[v].

The health and care system can do much more to support people to make improved and informed choices and to be more active in managing their own health, wellbeing and care.

2. Success in 2020

Londoners are more proactive in their care and report improved outcomes due to their enhanced role in shared decision-making. Supported by a vibrant and diverse supply market and new digitally-enabled processes, self-care becomes the norm. New Care Models empower Londoners to take control of their health and wellbeing drawing upon a wider network of support made available by family, friends, voluntary and community groups, as well as heath and care services when needed. This results in:

a) **Care decisions are shared, helping to reduce unwarranted variation and supporting patients to make informed choices.** Patients are routinely and systematically involved as active partners with clinicians in clarifying acceptable care, treatment or support options and choosing a preferred course of action. Decision aids to help people think are widely utilised to help patients and clinicians think through the pros and cons of different care, treatment or support options.

b) **Care planning and self-management is hardwired into how care is delivered.** Meaningful care planning takes place for people with long-term conditions or ongoing care needs which guides the choices and actions of the patient and their professional team. This care plan is digital and can be shared between care settings and is owned by, and useful for, patients, their families or carers. People living with long-term health conditions or care needs are offered support to improve their confidence and their capacity to manage their own health and wellbeing. This is achieved through greater take-up of evidence based approaches such as self- management education, peer support, health coaching and group based activities

c) **Personal Health Budgets and integrated personal budgets, including NHS and social care funding, are available to everyone who could benefit (in line with Mandate requirements).** In each CCG area at least 1-2 people per 1,000 of the population has a PHB or integrated personal budget incorporating NHS funding. PHBs should be in place for NHS Continuing Healthcare and Continuing Care, people with high cost packages of support (e.g. people with a learning disability); and in specific areas where the model will deliver a positive impact (e.g. end of life care, mental health).

d) **Social action beyond the NHS helps people improve their health and manage their wellbeing.** CCG and local authority commissioners support the local population in building community capacity and resilience. Social prescribing and Expert Patient Programmes are widely available to the public through primary care and whole population care models. Strong partnerships between the NHS, statutory partners and voluntary groups deliver health prevention and support for patients, carers and their families. Shared

leadership promotes community- based activities aiming to strengthen local skills, knowledge and resilience to improve health and wellbeing.

3. New commissioning intentions for 2017/18 and how they can help the NHS achieve the vision as set out in Chapter 2 of the Five Year Forward View

Ahead of the 2017/18 planning round, HLP's Personalisation and Self-Care Programme is encouraging CCGs across London to signal the following commissioning intentions to local providers:

a) Extend an existing CQUIN or agree a new local incentive scheme for shared decision-making. NHS England's 'where to look' packs can help target local populations. Once local populations have been identified then commissioners should check whether decision aids are available to help patients and professionals reach decisions that take account of the personal preferences of the individual. Commissioners should consider incentivising the utilisation of decision aids for specific populations as well as the appropriate training of staff which could be quality assured by adopting the CollaboRATE measure

b) Extend an existing CQUIN or agree a new local incentive scheme for person-centred care planning and self-management. Patients who are frail, reaching the end of their life, are socially isolated or lonely, have dementia or complex co-morbidities spanning physical health, mental health and social care, as high consumers of health and care services, are the most likely to benefit from an **integrated care plan**. Local providers should be incentivised to routinely undertake structured conversations between patients and practitioners to identify individuals' goals and the support needed to achieve them. A single integrated care plan should be outcomes based ("what matters to me"), owned by the individual and, when explicit consent given, key information is accessible through digital channels to other professionals involved in their care and support. In terms of **self-management**, providers should be incentivised to offer tailored support based on need (including anticipatory care planning, social prescribing, health coaching and personal health budgets) alongside ongoing reviews of individuals' support needs to ensure it reflects changing goals, needs and priorities. There are a number of useful resources available to support health literacy and digital health literacy .

c) Negotiate with providers for a proportion of block funding from all out of hospital contracts to be used for personal health budgets which will be promoted through local social prescribing schemes and expert patient programmes. Block contracts present barriers to offering people choice and control. In order to release funds for Personal Health Budgets, CCG commissioners need provider's time and input to review current funding and contracts and how they can be used to help PHBs to be taken up by a wider cohort of people. Provider's concerns about the potential destabilising effect of this on local provision are understood. Commissioners are therefore encouraged to work with all providers of out of hospital services to explore:

[1] A local risk-share agreement releasing portions of block contracts.

[2] Extending an existing CQUIN or developing a new scheme which will incentivise providers to free up a percentage of the block contract to be prioritised for the wider uptake of PHBs and enable the supported transition to a more diverse local supplier marketplace. Guidance available from Leeds South and East CCG on unblocking contracts in specialist children's services.

d) Increase the existing provision and use of Expert Patient Programmes and Social Prescribing Schemes. Expert Patient Programmes (or Chronic Disease Self-Management Programmes) have favourable economic evaluations - investment by health services, leads to savings by health services[vi]. They promote self-efficacy and greater self-management of health. It may be a quicker win to develop and expand existing programmes such as these, with a review to ensuring they are operating according to best evidence and practice, and effectively measuring the health, social and financial outcomes. They could more explicitly include social prescriptions, and provide information about the range of sources of help and support within their communities. In tandem with this, local Social Prescribing coverage should be extended to mainstream populations (i.e. people who do not have an existing long term condition) and cover the whole life course to include parents and guardians of children and young people.

e) Gain a commitment from local providers to work with a range of stakeholders to promote information and access to community based resources and help build local capacity to support vulnerable people. Commissioners should encourage providers to utilise local online directories, which are available in every London borough, with professionals' sign-posting appropriate patients to information on additional resources that can aid their care and support. Mental health and community health providers can also help build local capacity by inviting representatives of voluntary sector organisations and other key agencies like the London Fire Brigade to participate in standard and routinely scheduled training courses (i.e. MECC, Safeguarding, MHFA etc). The London Fire Brigade carried out 85,000 visits within vulnerable people's homes in 2015 and the Brigade are keen to formally rollout 'safe and well' visits across London in 2017. Local providers should be encouraged to build formal relationships with the London Fire Brigade so that they can access their free resources (building and meeting room space for promotion of local health initiatives), as well as develop processes to receive appropriate referrals from the London Fire Brigade and social housing providers.

4. Support you can expect from the Healthy London Partnership to implement the above

a) *Personalisation and Self-Care Programme*

- Promoting good practice and enablers to support the rollout of Personal Health Budgets and Integrated Personal Commissioning across London
- Personalisation and Self-Care Case for Change (April 2016)
- Population health and financial modelling and analysis on the Return on Investment of Social Prescribing Schemes, Expert Patient Programmes and both combined (September 2016)
- Commissioners Guidance on Operationalising Social Prescribing (November 2016)
- *Fire as a Health Asset* pilots commence (January 2017)
- Guidance on how to optimise usage of local online directories (March 2017)
- Contributing standards for the development of personalised apps – e.g. integrated digital care plan (2017/18)

b) *London Digital Programme*

- Document exchange (structured and unstructured documents) STP pilots commence (Q2 2017/18)
- End of Life Care Plans and Crisis Care Dataset STP pilots commence (Q3 2017/18)
- Online Passport (Passport) STP pilot commence (Q4 2017/18)

c) *Transforming Primary Care Programme (Proactive workstream)*

- Strategic Commissioning Framework Financial Model (August 2016)

Shaun Crowe
Personalisation and Self-Care Programme Lead
Healthy London Partnership

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[i] Nesta (2013) The business case for people powered health England: Nesta / Innovation Unit
[ii] Realising the Value (2016) At the heart of health: realising the value of people and communities England: Nesta and The Health Foundation
[iii] Ellins J, Coulter A (2005) How engaged are people in their healthcare? Health Foundation
[iv] CQC Inpatient Survey (Survey) Item 32
[v] NHS England (2015) Customer contact programme, research and analysis: Understanding customer priorities through conjoint testing England: PA Knowledge Limited
[vi] Nesta (2013) The business case for people powered health England: Nesta / Innovation Unit