Implementing the comprehensive model of personalised care

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NHS England and NHS Improvement
What is Personalised Care?

- **Personalised Care can benefit everyone** - from people with chronic illness and complex needs to those managing long term conditions and those with mental health issues or struggling with social issues which affect their health and wellbeing.

- **It helps them make decisions about managing their health** so they can live the life they want to live based on what matters to them, working alongside clinical information from the professionals who support them.

- **This is in response to a one-size-fits-all health and care system** that simply cannot meet the increasing complexity of people’s needs and expectations.

- **Evidence shows that people will have better experiences and improved health** and wellbeing if they can actively shape their care and support.
What Personalised Care means to me

1. Working in partnership with my clinician & wider care team
2. Choosing from the available options
3. Building my knowledge, skills & confidence
4. Connecting to help & support in my community
5. Designing my own plan, supported by professionals
6. Managing my own budget & support, with help if I choose

WHAT MATTERS TO ME

Personal Health budgets & integrated personal budgets
Personalised care & support planning
Health coaching & supported self-management
Social prescribing
Shared decision making
Enabling choice
What Personalised Care means to me

Personalised Care: A shift in relationship between health and care professionals and people.

- Being seen only as a patient with symptoms for separate conditions that need treating.
- Not having the information and support you need to make informed health and wellbeing choices and decisions.
- Feeling powerless against a complex health and care system.
- Working in partnership with health and care professionals and sharing power.
- You and your health and care professional having knowledge, expertise and responsibility for your health and wellbeing.
- Only needing to tell your story once.
- Having more choice and control so your health and wellbeing needs are met effectively in a way that makes sense to you.

Being asked what the matter with you?

Being asked what matters to you?

Being asked what is wrong with you and how your health needs will be met.

Being seen only as a patient with symptoms for separate conditions that need treating.

Being seen as a whole person with skills, strengths and attributes as well as needs to be met.

Health and care professionals believing they have all the knowledge, expertise and responsibility for your health and wellbeing.

A one-size-fits-all approach to meeting your health and wellbeing needs.

Universal Persor
Personalised Care to become ‘business as usual’

- Personalised Care will become ‘business as usual’ for the health and care system, with 2.5 million people benefiting by 2023/24, and 5 million by 2028/29 as set out in the recently published [NHS Long Term Plan](https://www.england.nhs.uk/personalisedcare/upc/comprehensive-model/).

- Personalised Care is one of the five major, practical changes to the NHS that will take place over the next five years and our action plan [Universal Personalised Care](https://www.england.nhs.uk/personalisedcare/upc/comprehensive-model/) confirms how we will deliver this.

- Key commitments by 2024 include ensuring 200,000 people have a Personal Health Budget and 900,000 people will be referred to social prescribing.

- A Personalised care Service Specification being developed for the DES from 2020/21
Comprehensive Model for Personalised Care
All age, whole population approach to Personalised Care

**TARGET POPULATIONS**

- **People with long term physical and mental health conditions 30%**
- **People with complex needs 5%**
- **Whole population 100%**

**INTERVENTIONS**

- **Specialist**
  - Integrated Personal Commissioning, including proactive case finding, and personalised care and support planning through multidisciplinary teams, Personal Health Budgets and integrated personal budgets.
  - Plus Universal and Targeted interventions

- **Targeted**
  - Proactive case finding and personalised care and support planning through General Practice.
  - Support to self-manage by increasing patient activation through access to health coaching, peer support and self-management education.
  - Plus Universal interventions

- **Universal**
  - Shared Decision Making
  - Enabling choice (e.g. in maternity, elective and end of life care)
  - Social prescribing and link worker roles
  - Community-based support

**OUTCOMES**

- Empowering people, integrating care and reducing unplanned service use.
- Supporting people to build knowledge, skills and confidence and to live well with their health conditions.
- Supporting people to stay well and building community resilience, enabling people to make informed decisions and choices when their health changes.
Operating Model for Personalised Care

WHOLE POPULATION
When someone’s health status changes

30% of POPULATION
People with long term physical and mental health conditions

Cohorts proactively identified on basis of local priorities and needs

Shared Decision Making
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 their personal preferences and, where relevant, utilising legal rights to choice.

(Personalised Care and Support Planning)
People have proactive, personalised conversations which focus on what matters to them, delivered through a six-stage process and paying attention to their clinical needs as well as their wider health and wellbeing.

Review
A key aspect of the personalised care and support planning cycle. Check what is working and not working and adjust the plan (and budget where applicable).

Optimal Medical Pathway

Social Prescribing and Community-based Support
Enables all local agencies to refer people to a “link worker” to connect them into community-based support, building on what matters to the person, and making the most of community and informal support.

Supported Self Management
Support people to develop the knowledge, skills and confidence (patient activation) to manage their health and wellbeing through interventions such as health coaching, peer support and self-management education.

(Personal Health Budgets and Integrated Personal Budgets)
An amount of money to support a person’s identified health and wellbeing needs, planned and agreed between them and their local CCG. May include integrated personal budgets for those with both health and social care needs.

Digital Enabler

Commissioning, Contracting and Finance Enabler

Leadership Co-production and Change Enabler

Workforce Enabler

Universal Personalised Care Group
Personalised Care commitments in Long Term Plan

Roll out the Comprehensive Model for Personalised Care across England, reaching 2.5 million people by 2023/24 and aiming to reach 5 million people by 2028/29 (para 1.39)

- Accelerate roll out of Personal Health Budgets... Up to 200,000 people will benefit from a PHB by 2023/24 (para 1.41)
- Over 1,000 trained social prescribing link workers by 2020/21 and 900,000 people referred to social prescribing link workers by 2023/24 (para 1.40)
- Ramp up support for people to self-manage their own health (para 1.38)
- People have choice of options for quick elective care, including choice at point of referral and proactively for people waiting for six months (para 3.109)
- Support and help train staff to have personalised care conversations (para 1.37)
- Use decision-support tools (para 3.106) and ensure the least effective interventions are not routinely performed... potentially avoiding needless harm (para 6.17viii))
Robyn Chappell: “A PHB changed my life”

Robyn suffered from a spinal injury when she was 21 which left her tetraplegic and needing 24 hour care.

Robyn’s care was managed by a home care agency which specialised in spinal injury, and they provided live-in personal assistants (PAs). The agency expanded and found it difficult to retain staff, meaning that in 2014, 36 different PAs came into Robyn’s home to help her. This was very impersonal and left Robyn feeling unsafe.

A PHB meant that Robyn could employ her own PAs through direct payment. Now, she has just two live-in PAs who rotate their shifts.

“I now control my own care and have my life back”, Robyn says. “I have a great relationship with my PAs, and I have even returned to work!”