Personalised care and social prescribing in the NHS Long Term Plan

Long Term Plan: 5 major practical changes to the service model

1. We will **boost 'out-of-hospital' care**, and finally dissolve the historic divide between primary and community health services.
2. The NHS will **redesign and reduce pressure on emergency hospital services.**
3. **People will get more control over their own health, and more personalised care when they need it.**
4. **Digitally-enabled primary and outpatient care** will go mainstream across the NHS.
5. Local NHS organisations will increasingly **focus on population health** and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere.

Long Term Plan commitments

- 1.39. **We will roll out the NHS Personalised Care model across the country, reaching 2.5 million people by 2023/24 and then aiming to double that again within a decade**.

- 1.40. As part of this work, through **social prescribing** the range of support available to people will widen, diversify and become accessible across the country. Link workers within primary care networks will work with people to develop tailored plans and connect them to local groups and support services. **Over 1,000 trained social prescribing link workers will be in place by the end of 2020/21** rising further by **2023/24,** with the aim that **over 900,000 people** are able to be referred to social prescribing schemes by then.

A new primary care workforce

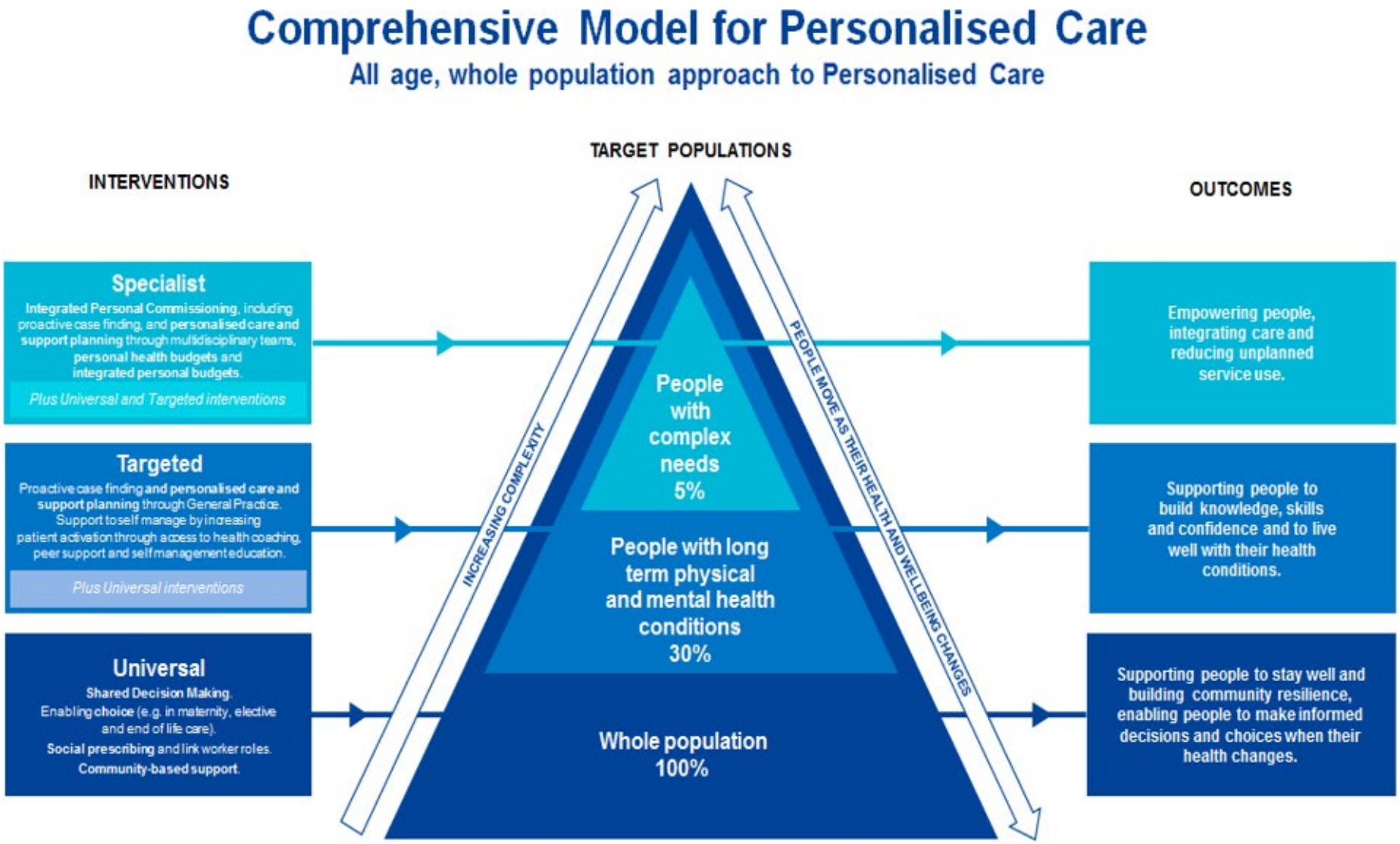
5 additional reimbursable roles:

- clinical pharmacists (incoming 2019)
- social prescribing link workers (incoming 2019)
- physician associates (added 2020)
- first contact physiotherapists (added 2020)
- first contact community paramedics (added 2021)

*"By 2024 [all the above roles] will have become **an integral part of the core general practice model throughout England** – not just 'wrap around' support that could instead be redeployed at the discretion of other organisations."*

Five Year Framework for GP Contract Reform

This means a comprehensive whole population approach:



Personalised Care Operating Model

NHS

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 (All tiers)

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)

LEADERSHIP, CO-PRODUCTION AND CHANGE ENABLER

COMMISSIONING, CONTRACTING AND FINANCE ENABLER

WORKFORCE ENABLER

DIGITAL ENABLER

Optimal Medical Pathway

Social Prescribing and Community-Based Support
Connect people to community-based approaches to make the most of community and informal support by enabling professionals to refer people to a 'link worker', based on what matters to the person (All tiers)

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 (Targeted and Specialist)

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 lead to integrated personal budgets for those with both health and social care needs (Initially Specialist)

Five Year Framework for GP Contract Reform

- NHS England will provide funding directly to primary care networks (PCNs) for a new, **additional social prescribing link worker to be embedded within every PCN multi-disciplinary team**, through the Network Contract Direct Enhanced Service (DES).
- Starting from July 2019, at **100% reimbursement** of the actual on-going salary costs, up to a maximum amount (£34,113) GP Contract Reform, section 1.26. The percentage will neither taper nor increase during the next **5 years**, giving networks maximum confidence to recruit to the full.
- Existing practice suggests that many PCNs may **choose to fund a local voluntary sector organisation to employ the link workers on behalf of the network**. The contractual arrangement will be for local areas to decide, but the funding will be routed via the Network Contract DES.
- Funding will also be available to **all PCNs** across England, including local areas where link workers are already embedded in primary care multi-disciplinary teams.

Key elements of social prescribing in primary care networks

Link workers in primary care networks

Social prescribing link workers will be **embedded within PCN multi-disciplinary teams** to;

- provide personalised support to individuals, their families and carers to take control of their wellbeing, live independently, and improve their health outcomes
- develop trusting relationships by giving people time and focusing on ‘what matters to them’
- take a holistic approach, based on the person’s priorities, and the wider determinants of health
- co-produce a simple personalised care and **support plan** to improve health and wellbeing
- introduce or reconnect people to **community groups and services**
- evaluate the individual impact of a **person’s wellness progress**
- record referrals within GP clinical systems using the national **SNOMED** social prescribing codes
- support the delivery of the comprehensive model of **personalised care**
- draw on and increase the **strengths and capacities of local communities**, enabling local VCSE organisations and community groups to receive social prescribing referrals.

Social prescribing and care navigation

- Complementary, but different!
- Care navigators are existing practice staff. They may direct people within the practice and are also trained to do ‘active signposting’, to listen and give people information about community groups and services.
- Care navigation works best for people who find their own way to community groups, who can make their own connections.
- Social prescribing link workers are employed specifically to help people who struggle to make their own connections, who wouldn’t get to a group or service on their own.
- Link workers (and their volunteers) introduce people to community groups. They take them along to their first session, where needed.

How can local partners maximise this funding opportunity?

CCGs will be encouraged to bring local partners together to **develop a shared local plan for social prescribing (by June 2019)**, incl. local authorities, primary care networks, VCSE leaders, existing social prescribing connector schemes and other partners.

Plans should include:

- how partners will **build on existing local social prescribing** connector schemes to avoid duplication and maximise impact
- how social prescribing link workers will be embedded in all **primary care networks** across the local area
- how additional link workers will be **recruited locally**
- shared commitment to **support for the VCSE sector and community groups** to receive social prescribing referrals, through funding and development support.

Templates are available from NHS England: england.socialprescribing@nhs.net

NHS England publications and resources

- Summary Guide to Social Prescribing
- Universal Personalised Care
- NHS Long Term Plan
- Five Year Framework for GP Contract Reform
- NHS England has set up an online learning platform to share the latest resources. To join the platform, please contact england.socialprescribing@nhs.net

Thank you