

Moving towards personalised cancer care

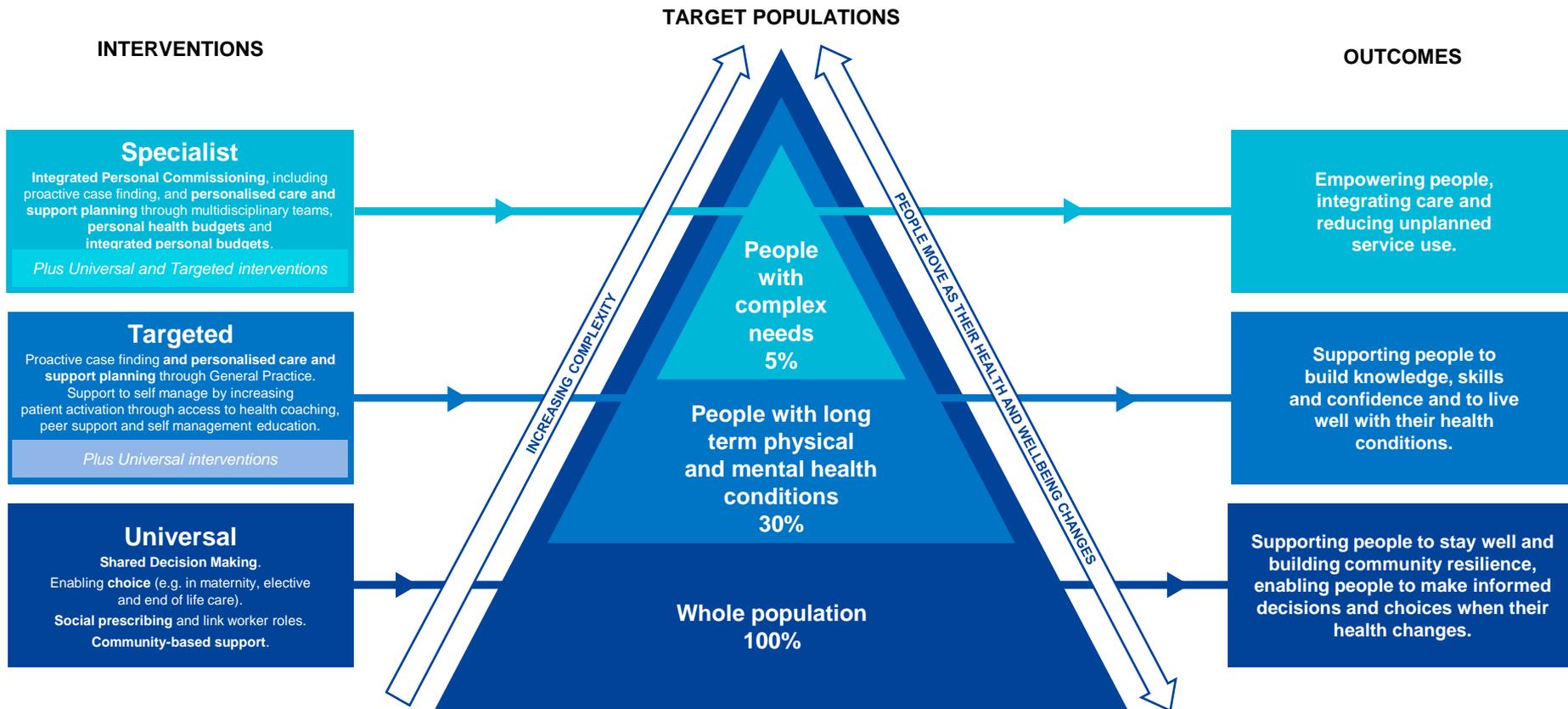
Personalised care national agenda

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Comprehensive Model for Personalised Care

All age, whole population approach to Personalised Care



Personalised Care Operating Model

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

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.

(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)



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

SHIFTS TO...



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



Being asked 'What's **the matter** with you?'



Being asked 'What **matters** to you?'



Not having the information and support you need to make informed health and wellbeing choices and decisions.

SHIFTS TO...



Having the information and support you need to make **informed choices and decisions**.



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



Being valued as an **active partner** in conversations and decisions about your health and wellbeing.

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



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



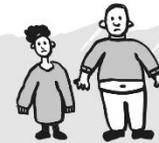
You and your health and care professional **sharing knowledge, expertise and responsibility** for your health and wellbeing.



Feeling **powerless** against a complex health and care system.



Working in partnership with health and care professionals and **sharing power**.



A **'One-size-fits-all'** approach to meeting your health and wellbeing needs.

SHIFTS TO...



Having more **choice and control** so your health and wellbeing needs are met effectively in a way that makes sense to you.



Having to tell your story **again and again**.



Only needing to tell your story **once**.

Significant delivery of Personalised Care

Shared decision making



SDM embedded into:

- Musculoskeletal elective care pathways across 13 CCGs
- Respiratory elective care pathways in 8 CCGs

Personalised care and support planning



- 142,904 people had a personalised care and support plan

Enabling choice



- 100% of CCGs have now completed Choice Planning and Improvement self-assessment
- Of these, 76% report compliance with all 9 choice standards

Social prescribing & community-based support



- 166,708 referrals
- 331 link workers employed in local areas

Supported self management



- 128,450 patient activation assessments (including PAM equivalent measures)
- 166,708 people referred to community-based support
- 130,335 people referred to self-management education or health coaching

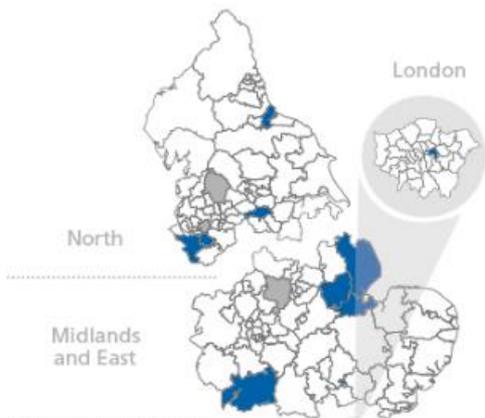
Personal health budgets & integrated personal budgets



- 40,344 PHBs by December 2018
- Up 43% in last 9 months alone
- Over 15% jointly funded with social care
- 72,647 Personal Maternity Care Budgets delivered by December 2018 across 36 CCGs

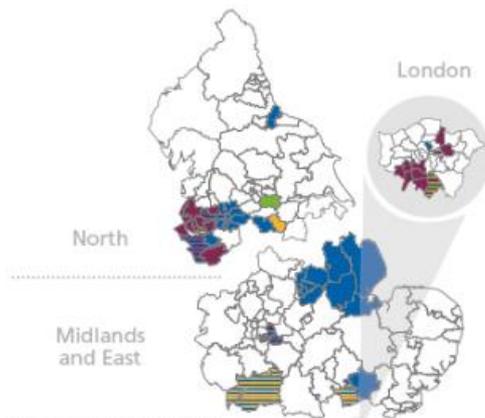
Expansion of personalised care over last 3 years

Original IPC areas (2016/17)



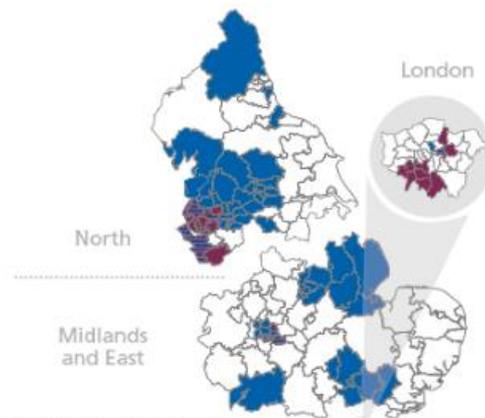
■ IPC areas ■ End of Life Care testbeds

Expansion (2017/18)



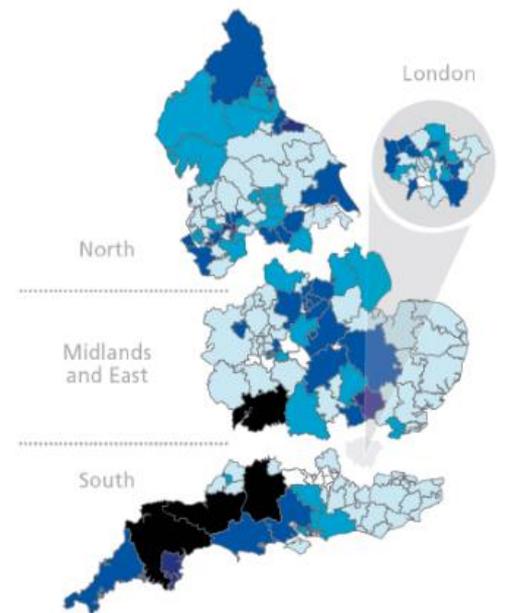
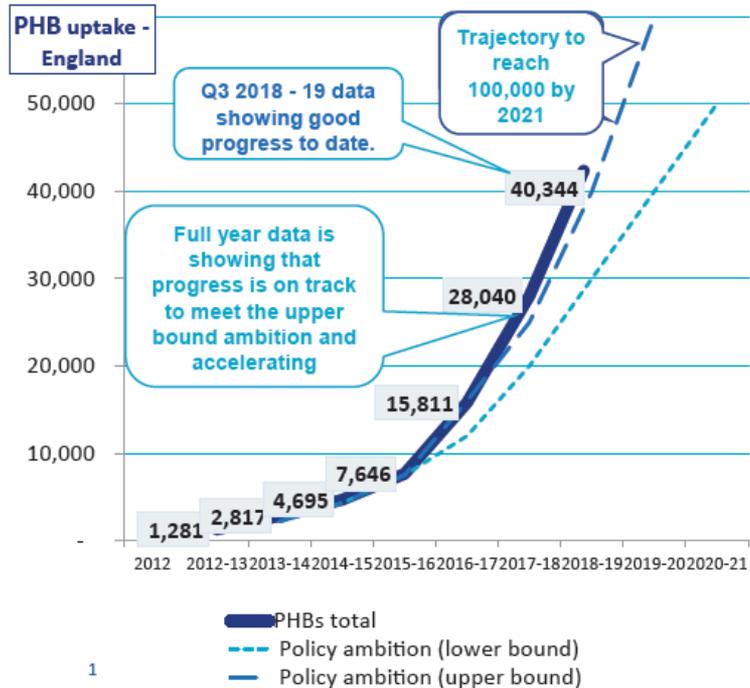
■ IPC expansion ■ Substance Misuse ■ Social Prescribing
■ Personal Maternity Care Budgets

Expansion (2018/19)



■ Demonstrator areas ■ Personal Maternity Care Budgets

Spread of Personal Health Budgets



Key: 1000+ 500-999 100-499 50-99 10-49 0-9

Number of personal health budgets by CCG As at March 2018

The difference personalised care makes

An independent evaluation found that people with a personal health budget had lower indirect costs with an average saving of **£1,320** per person per year.

For people with the highest needs there were savings on average of **£3,100** per person of per year.



Personal health budgets and Integrated Personal Budgets

86% people achieved what they wanted to with their personal health budget.



Personal health budgets provided an average 17% saving on the direct costs of conventional NHS Continuing Healthcare packages for home care.

End of life care



Two CCGs indicated a cost saving of 50% attributable to personal health budgets.



In one area personal health budgets enabled 83% of people to die in a place of their choosing, against a local average of 26%.



Supported Self-Management

Evidence from England shows people who have the highest knowledge, skills and confidence than those with the lowest levels of activation have



A literature review of over 1,000 research studies found peer support can help people feel more knowledgeable, confident and happy, and less isolated and alone.



fewer GP appointments



fewer A&E attendances

Social Prescribing and Community-Based Support



of GPs think social prescribing can help reduce their workload.

Personalised Care and Support Planning



Extensive evidence shows that people's well-being, satisfaction and experience improves through good personalised care and support planning.

- It has been shown to improve GP and other professionals' job satisfaction.
- There is some evidence of improved clinical outcomes and that it is at least cost neutral, with some evidence of small cost improvements.



Shared Decision Making

Clinicians and people routinely overestimate treatment benefits by

and underestimate treatment harms by



Shared decision making supports people to understand benefits and harms of options available and tends to reduce uptake of high risk, high cost interventions by



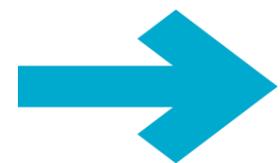
of adults report that they have had a conversation with a healthcare professional in their GP practice to discuss what is important to them.



Choice



of people who booked hospital outpatient appointments online felt that they were able to make choices that met their needs.



Local examples of impact



WARRINGTON End of life

Personal health budgets in end of life care - 83% were able to die in a place of their choosing, against an average of 26%

One week's worth of traditional services funds six weeks of services commissioned through a personal health budget



BRADFORD Social prescribing

Health improvements included average 10 point increase in EQ-VAS scores

74% of people increased their mental well-being after being referred to the scheme



STOCKTON Care planning

12% reduction in unplanned admissions in 2017 within two GP practices

24% reduction in A&E attendances in 2017 within two GP practices



NOTTINGHAMSHIRE Personal health budgets

£25,000 saving in transport costs for siblings with very complex health conditions

Lease their own adapted vehicle through a personal health budget for journeys to day centre and respite, instead of a commissioned transport package

The NHS Long Term Plan

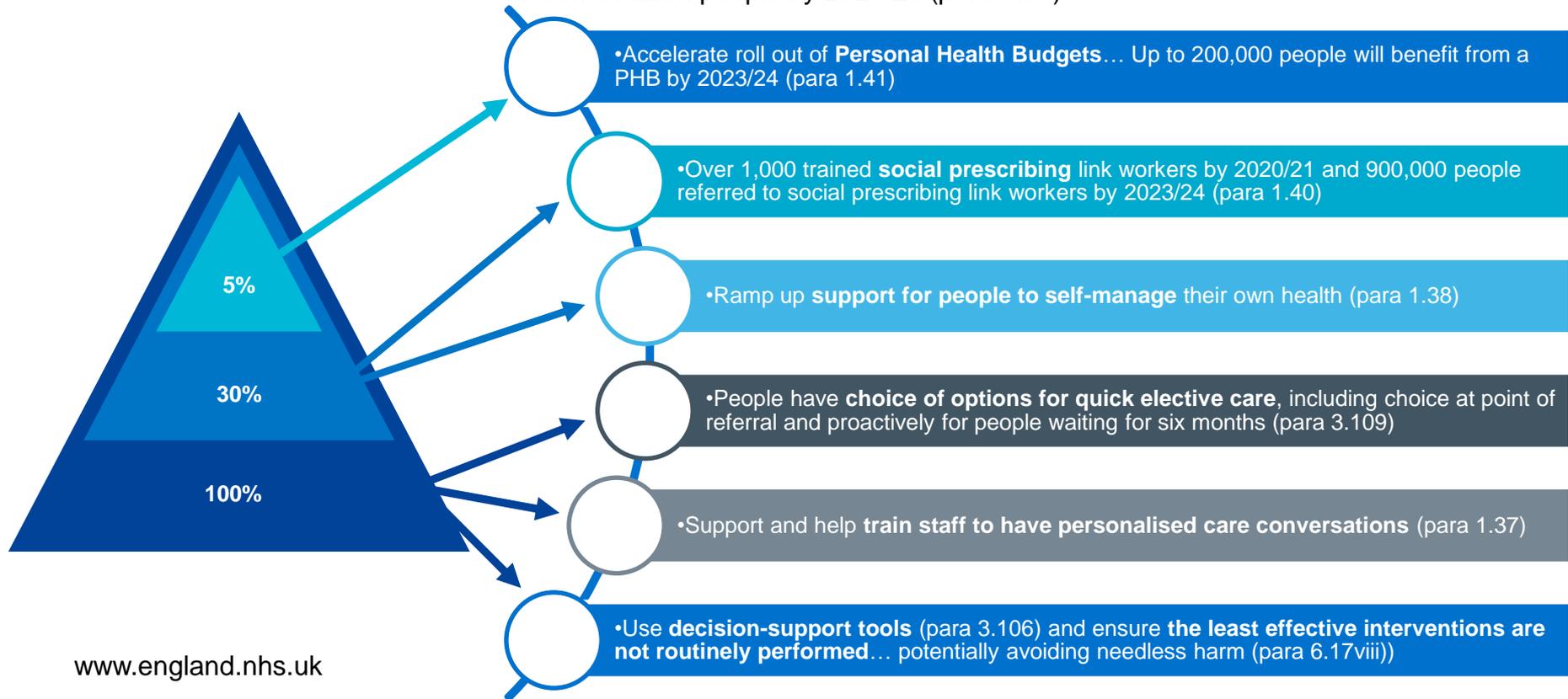
Chapter One sets out a new NHS service model for the 21st century. This will be achieved through the following five major, practical, changes over the next five years:

1. Boost 'out-of-hospital' care and dissolve the divide between primary and community services
2. 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



Specific Personalised Care commitments in LTP

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)



Other commitments that depend on Personalised Care

- Significant commitments to support care quality and outcomes, including applying the Comprehensive Model of Personalised Care to **end of life care** (para 1.42) and **dementia** (para 1.20)
- Enabling more personalised care and choice and control for people with **learning disabilities, autism or both** (para 3.34), **children and young people** (para 3.47), and **people with mental health conditions** (para 3.106)
- Personalised care and support planning approaches in **maternity** (para 3.13), **CVD** (para 3.70) and to support people to manage their condition in **work** (appendix on health and work)
- Expand supported self-management for people with **long-term conditions** (para 2.2), including **diabetes** (paras 3.79, 5.13), **respiratory disease** (para 3.85) and **MSK conditions** (para 3.107)
- Community pharmacies will also promote and support self-management for people (para 1.10)

- In addition to the above, personalised care is:
 - Recognised as enabling the shift to **digital** and vice versa (para 5.8-5.9)
 - Recognised as a practical enabler of **integration** (para 1.58)
 - To be supported and enabled through the **revised QOF** (para 1.11)

How will we deliver this?

Universal Personalised Care is the delivery plan for personalised care, and sets out 21 detailed actions to achieve the systematic implementation of the Comprehensive Model for Personalised Care. These actions are summarised below

Communications, partnerships and co-production

- Publish Comprehensive Model with standard models
- Behaviour and culture change campaign
- Support people with lived experience to be system leaders and build demand

Skills, behavior and culture change

- Training and support for clinicians and professionals
- Embed personalised care in pre- / post-training
- Embed shared decision making into specific clinical situations

Local implementation

- Deliver Comprehensive Model in ICS, STP and PCNs
- 3 Integration accelerators
- Effective mechanisms to enable choice and control
- Implement supported self-management approaches
- PHB expansion, increasingly by default

Community-based approaches

- Social prescribing link workers in all local areas
- Explore best models for commissioning and supporting voluntary sector

Transition and infrastructure

- NHS Personalised Care
- Digital and personalised care
- Personalised Care dashboard
- Health inequalities

Lever and incentives

- Introduce new legal rights to personalised care
- Embed and use levers and incentives
- Integrate model into wider transformation and frameworks
- Include wider funding streams

Impact and outcomes

- Evidence and impact
- National Impact Statement

What does this mean for cancer?

Personalised care for all patients and transform follow-up care:

- Surveillance and aftercare that is tailored to individual needs – supported self-management, shared care or complex case management.
- Personalised care to address holistic needs from diagnosis onwards, including needs assessment, care plan and health and wellbeing support. Focus on what matters to people and how best to support them
- Quality of life metric to demonstrate how well people are living beyond treatment.

The journey so far...

Personalised Care and Living With and Beyond Cancer working together to align programmes and build in the personalised care comprehensive model to the cancer recovery package:

- Personalised care and support planning development with Macmillan – ‘What about me? and what matters to me?’ added to the eHNA
- Testing PCSP in cancer pathways in Bradford – what does this mean for people, the system and professionals? Training for cancer staff in Bradford and Leeds
- Delivered share and learn webinars for the 19 cancer alliances on personalised care and cancer
- Developing the personalised care and support planning metrics to enable counting
- Personalised Care, Cancer and the Long Term Plan...

“By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support. This will be delivered in line with the NHS Comprehensive Model for Personalised Care”

Paragraph 3.64 NHS Long term plan

What next?

- Working with Macmillan on PCSP and embedding personalised care in their 'Right by you' strategy, linked into 19/20 personalised care test sites
- Continuing testing personalised care in Bradford, report of key learning in June
- 3 workshops at the NHSE Living With and Beyond Cancer conference at the end of April for people to learn more about the components of the model and how they operate in practice
- Currently finalising workforce development plans for 19/20, cancer workforce as a priority
- Embedded in our demonstrator programme to engage with local systems

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