

Personalised Care in Primary Care

The NHS Long Term Plan (LTP) sets out that personalised care will be business as usual across health and care services, reaching 2.5 million people by 2023/24. Personalised care means people have choice and control over the way their care is delivered, based on 'what matters' to them and their individual strengths, needs and preferences. As such personalised care is everyone's business in Primary Care Networks (PCNs), providing more options, better support and joined up care at the right time. It is part of the cultural change at the heart of PCNs, providing a positive shift in power and decision making that enables people to feel informed, have a voice, be heard and be connected to each other and their communities. People must be at the centre of a more sustainable health system with services shaped around their needs and preferences.

The [Comprehensive Model of Personalised Care](#) identifies six evidence-based and interlinked components, including shared decision making, personalised care and support planning, supported self-management, social prescribing and community-based support which are already used by professionals in primary care.

The [Network Contract DES Specification 2020/21](#) provides reimbursement for three personalised care roles based in PCNs: social prescribing link workers, health and wellbeing coaches and care coordinators. Supporting information on these three roles can be found in the [Network Contract DES Guidance 2020/21](#). The introduction of health and wellbeing coaches and care coordinators from 01 April 2020 is in addition to the existing social prescribing link worker role which has been in place since July 2019.

Working together through a single point of access, these three roles reduce and support the workload of GPs and other staff by supporting people to take more control of their health and wellbeing and addressing wider detriments of health such as poor housing, debt, stress and loneliness. Their contribution enriches the skill mix of primary care teams. As a result, people have improved lives, benefit from timely access to health services, and are supported to develop skills and confidence to manage their own health and wellbeing.

These roles are intended to become an integral part of the core general practice throughout England, embedding personalised care within PCNs and supporting all professionals to take a personalised care approach.

Personalised care has the potential to reduce health inequalities. Through these roles, PCNs will be able to consider the specific interventions and support that could help to address health inequalities or exclusion, potentially improving the lives of people with a variety of health and wellbeing challenges.

From within their Additional Roles Reimbursement sum¹, a PCN may determine the number of social prescribing link workers, health and wellbeing coaches, and care coordinators that can be engaged or employed, taking into account their overall workforce considerations and needs. PCNs may also wish to use volunteers alongside these personalised care roles to support people to access the help they need.

In line with the requirements of the [Network Contract DES Specification 2020/21](#), each PCN must ensure that patients have access to a social prescribing service. To comply with this, a

¹ The Additional Roles Reimbursement sum is the allocated funding each PCN has access to as per the Network Contract DES Specification to support the employment or engagement of additional roles.

PCN may either directly employ social prescribing link workers or sub-contract the provision of the service to another provider.

Personalised Care Additional Roles

We encourage PCNs to engage personalised care roles – social prescribing link workers, health and wellbeing coaches, and care coordinators – as these roles will be able to support the COVID-19 response through embedding personalised care approaches.

Social Prescribing Link Worker

Social prescribing link workers give people time and focus on what matters to them, using personalised care and support planning and health coaching approaches to help them gain more control over their lives and improving health and wellbeing. They connect people to local community groups and agencies for practical and emotional support, and to activities that promote health and wellbeing (such as the arts, sports or natural environment). Link workers collaborate with local partners to enable community groups to be accessible and sustainable and help people to start new groups and activities, working closely with local volunteers to extend their offer.

Social prescribing helps to reduce health inequalities (in relation to timely access and outcomes), wellbeing inequalities and pressure on clinicians by addressing the wider determinants of health, such as debt, poor housing and physical inactivity, by increasing people's active involvement with their local diverse communities.

Health and Wellbeing Coach

Health and wellbeing coaches work with people usually over a number of sessions to support them to develop their knowledge, skills and confidence to become active participants in looking after their own health. They guide and support people to reflect on and change their health related behaviours to help them reach their self-identified health and wellbeing goals.

Health and wellbeing coaches tend to work with people with one or more long term conditions such as type 2 diabetes or COPD, or with risk factors for developing a long-term condition, providing support for issues such as weight management, managing chronic pain, living with depression, and anxiety.

Health and wellbeing coaches are skilled in coaching, communication and behavioural change skills and are able to work alongside people (individually or in groups) at their starting point to encourage and support them to become more engaged in managing their own health.

Care Coordinator

Care coordinators play an important role within a PCN to proactively identify and work with people, including the frail/elderly and those with long-term conditions, to provide coordination and navigation of care and support across health and care services.

They work closely with GPs and practice teams to manage a caseload of patients, acting as a central point of contact to ensure appropriate support is made available to them and their carers; supporting them to understand and manage their condition and ensuring their changing needs are addressed.

This is achieved by bringing together all the information about a person's identified care and support needs and exploring options to meet these within a single personalised care and support plan, based on what matters to the person.

Care coordinators could potentially provide time, capacity and expertise to support people in preparing for or following-up clinical conversations they have with primary care professionals.

How the Primary Care Network (PCN) supports these roles?

PCNs should ensure a robust infrastructure and support offer is in place for social prescribing link workers, health and wellbeing coaches and care coordinators. This includes (not exclusively):

- Supporting staff access to appropriate induction, training, line management, peer support and ongoing supervision as set out in the [Network Contract DES Specification 2020/21](#)
- Promoting multidisciplinary and cross-agency working, including referrals to other members of the multidisciplinary team, to enable staff to fulfil the requirements set out in the Network Contract DES Specification, and coordinate and integrate care and support to people and families
- Promoting an inclusive multidisciplinary team approach within and between practice teams so that staff actively champion personalised care, including shared decision making within the PCN, provide education and specialist expertise, and contribute to the wider aims and objectives of the PCN to improve and support primary care
- Providing access to other healthcare professionals, electronic 'live' and paper-based record systems of the PCN's Core Network Practices, as well as access to admin/office support and training and development as appropriate

In line with [COVID-19 guidance](#), social prescribing link workers must have access to:

- GP IT Systems and smart cards so they can access patient notes and record referrals;
- Video and remote consultation software; staff are actively encouraged to use this technology where appropriate;
- Equipment to work remotely (laptop, phone, VPN token);
- Individual NHS Mail accounts, to enable secure sharing and transfer of data in line with GDPR requirements.

These facilities should also be available for health and wellbeing coaches and care coordinators. Additionally, PCNs should consider:

- PAM training, resources and the PAM tool to support people with lower levels of activation to develop the knowledge, skills, and confidence to manage their health and wellbeing, whilst increasing their ability to access and utilise community support offers;

- Rooms and venues for meetings which are available to other PCN staff for consultations.

PCNs may wish to consider how social prescribing software, including electronic referrals, case management, access to a directory of services and reporting could be used to support these roles.

These roles must be embedded within the PCN as fully integrated roles within the multidisciplinary team delivering healthcare services to patients and have access to the support outlined previously.

Experience shows that many PCNs may choose to fund a local voluntary sector organisation to employ social prescribing link workers on behalf of the network. This approach will build on existing local social prescribing schemes and avoid duplication, enabling social prescribing link workers (wherever they are employed) to work together as a wider team across the local area.

Supervision & Training

A PCN's Core Network Practices must identify a first point of contact for each social prescribing link worker, health and wellbeing coach and care coordinator, for general advice and support and (if different) a GP to provide supervision. This could be provided by one or more named individuals within the PCN. The health and wellbeing coach must also have access to regular supervision from a health coaching mentor. In addition to this, formal and individual group coaching supervision must come from a suitably qualified or experienced health coaching supervisor

A PCN will ensure the social prescribing link workers, health and wellbeing coaches, and care coordinators can discuss patient related concerns and be supported to follow appropriate safeguarding procedures (e.g. abuse, domestic violence and support with mental health) with a relevant GP.

Currently under development and due to launch in September 2020, the Personalised Care Institute (PCI) convened by the Royal College of General Practitioners has the primary role of setting the core curriculum and training standards for all healthcare staff in personalised care, based on the Universal Personalised Care Model. This includes social prescribing link workers, health and wellbeing coaches and care coordinators. The PCI will also develop and establish an assurance process for training providers, a register of assured providers and a single point of access for e-learning in personalised care.

PCNs should ensure that training for social prescribing link workers, health and wellbeing coaches and care coordinators is provided only by PCI-assured training providers or providers who are in the process of applying for assurance.

Referrals

Social prescribing link workers, health and wellbeing coaches and care coordinators work in partnership with other professionals as part of the general practice team and part of a wider multiagency integrated team, to help people review their needs and access the services and support they require to manage their own health and wellbeing.

Social prescribing link workers can take referrals from the PCN's core network practices and from a wider range of agencies including the PCN's members, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations.

Health and wellbeing coaches and care coordinators can take referrals from GPs, practice nurses, physician associates, practice pharmacists, first contact practitioners and other professionals working in primary care.

All three roles can also refer to other professionals within the PCN and to other appropriate agencies.

There are some similarities in how the three roles work together but each role offers a unique contribution, therefore it is key that a single point of access to the service is in place to ensure people receive the right support at the right time from the practitioner with the right competencies. This single point of access would generally be via the social prescribing link worker(s) who work in partnership with the other two roles to triage referrals as set out in the [Network Contract DES Guidance 2020/21](#).

Measuring the impact of social prescribing link workers, health and wellbeing coaches and care coordinators

The [Network Contract DES Specification 2020/21](#) requires core network practices of a PCN to use the relevant SNOMED codes. Annex B3.6. of the DES Specification document provides that a PCN must ensure that referrals are coded within GP clinical systems – as stated below:

Activity linked to social prescribing link worker(s) should be recorded using the following codes:	
871731000000106	Referral to social prescribing service (situation)
871711000000103	Social prescribing declined (procedure)
Referrals to health and wellbeing coaches should be recorded using the following code:	
1078371000000100	Referral for health coaching (procedure)
Activity linked to personalised care and support planning should be recorded using the following codes:	
1187911000000105	Personalised Care and Support Plan agreed (finding)
1187921000000104	Review of Personalised Care and Support Plan (procedure)
Additionally, PCNs may want to use the following coding to record when an assessment is done – this is an optional code.	
713579005	Assessment using Patient Activation Measure (procedure)

Patient Activation

Patient activation is of particular importance to the 15 million people living with [long-term conditions \(LTCs\)](#) who rely, more than most, on NHS services. 'Patient activation' describes the knowledge, skills and confidence a person has in managing their own health and care. Understanding people's activation levels, in particular, measuring patient activation using tools such as the [Patient Activation Measure \(PAM\)](#), enables care professionals to tailor their approaches to individual needs to improve their health outcomes, ensure a better experience of care and reduce unplanned care admissions.

What support is available?

Further information and guidance to help PCNs employ or engage social prescribing link workers and health and wellbeing coaches is available as follows:

1. Social prescribing, including reference guide and technical annex for primary care networks
<https://www.england.nhs.uk/publication/social-prescribing-link-workers/>
and additional resources to support recruitment and induction
<https://www.england.nhs.uk/personalisedcare/social-prescribing/support-and-resources>
2. Social prescribing case studies
<https://www.england.nhs.uk/personalisedcare/social-prescribing/case-studies/>
3. Social prescribing regional networks
<https://www.england.nhs.uk/personalisedcare/social-prescribing/support-and-resources/learning-coordinators/>
4. Health coaching, including summary guide and technical annex
<https://www.england.nhs.uk/publication/health-coaching-summary-guide-and-technical-annexes/>
5. Supported self-management approaches and the supported self-management evidence base
<https://www.england.nhs.uk/personalisedcare/supported-self-management/>
6. Patient activation and PAM®, including FAQs
<https://www.england.nhs.uk/personalisedcare/supported-self-management/patient-activation/>
7. Personalised Care Institute (PCI) website will be live from September and can be accessed at www.personalisedcareinstitute.org.uk. In the meantime, all enquiries can be made through info@personalisedcareinstitute.org.uk.
8. Personalised Care, including the comprehensive model of personalised care and Universal Personalised Care
<https://www.england.nhs.uk/personalisedcare>