Memorandum of Understanding for Personalised Care Demonstrator Sites

Between

NHS England

And

Nottinghamshire Integrated Care System

This Memorandum of Understanding (MOU) sets the terms and understanding between the following parties:

National Health Service Commissioning Board (NHS CB), operating under the name of NHS England

And Nottinghamshire Integrated Care System (ICS)

This Memorandum of Understanding covers the period 1 April 2019 – 31 March 2020

Background

Personalised care is one of the five major, practical changes to the NHS that will take place over the next five years, as set out in Chapter One of the NHS Long Term Plan[1]. Universal Personalised Care: Implementing the Comprehensive Model[2] (UPC) sets out how we will do this by 2023/24. It is the delivery plan for personalised care across England, introducing the Comprehensive Model for Personalised Care and the standard models for the six, evidence-based, interlinked components, together with four enablers. This work follows several years of evidence-based research and local approaches, working with people with lived experience, community groups and a wide range of stakeholders.

UPC sets out 21 actions to be delivered with partners from across national and local government, and organisations from across health, care, voluntary and community-based sectors including clinicians, professionals and people with lived experience. These actions built on progress made in areas already delivering the Comprehensive Model for Personalised Care and include introducing quality standards and building on metrics to demonstrate impact; developing workforce skills and working with Royal Colleges to update their curricula.

[1] www.longtermplan.nhs.uk

[2] https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/

The key commitments and actions by 2023/24 are:

1. That we deliver universal implementation of the Comprehensive Model for Personalised Care[3] across England, which fully embeds the six standard components - shared decision making; personalised care and support planning; enabling choice; social prescribing and community based support; supported self-management; and personal health budgets and integrated personal budgets - across the NHS and the wider health and care system. This includes demonstrating early, full delivery of the Comprehensive Model and its enablers across a number of Integrated Care Systems (ICSs) and Sustainability and Transformation Partnerships (STPs) (action 2 of UPC).

2. Personalised Care will benefit up to 2.5 million people, ensuring they have the same choice and control over their mental and physical health that they have come to expect in every other aspect of their life;

3. Shared Decision Making will be embedded in 30 high value clinical situations in primary care, secondary care and at the primary/secondary care interface where it will have the greatest impact on experience, outcomes and cost.

4. Over 1,000 trained social prescribing link workers will be in place by 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. Social prescribing link workers connect people to wider community support which that can help improve their health and well-being and to engage and deal with some of their underlying causes of ill health.

5. 200,000 people will have a personal health budget so they can control their own care, improve their health experiences and experience better value for money services;

6. 750,000 people will have a personalised care and support plan, including people with long term health conditions, people at the end of life, and pregnant women;

7. 75,000 clinicians and professionals will be enabled to develop their skills and behaviours through practical support to use personalised care approaches in their day-to-day practice

Purpose

[3] https://www.england.nhs.uk/personalisedcare/comprehensive-model-of-personalised-care/

In order to achieve the scale committed in the Long Term Plan, Demonstrator sites are required to build on the good work that has come before and demonstrate how Personalised Care can be delivered at scale across Nottinghamshire ICS geographies including Primary Care Networks and Health and Wellbeing board areas. This will show how the model brings the six components of Personalised Care together and will demonstrate how the model:

- improves people's health and wellbeing, joins up care in local communities, reduces pressure on the health and care system and drives efficiency;

- helps people with multiple physical and mental health conditions make decisions about managing their health, so they can live the life they want to live based on what matters to them, as well as the evidence-based, good quality information from the health and care professionals who support them;

- recognises that, for many people, their needs arise from circumstances beyond the purely medical, and will support them to connect to the care and support options available in their communities.

This Memorandum of Understanding sets out the expectations and deliverables for sites and roles and responsibilities of all parties to work together to continue to scale and spread Personalised Care within Demonstrator sites and beyond, in order to realise the ambitious commitments described above.

Responsibilities

All Personalised Care Demonstrator Sites will make a commitment to implement and evaluate the Comprehensive Model for Personalised Care at scale as a core business embedded in, and aligned to other local strategic plans.

General conditions on Demonstrator Sites

Personalised care is a system leadership and integration model and so participating in the programme comes with expectation that each site will:

1. **Leadership, Planning and governance**

- Commit to embedding Personalised Care into the local Five-Year Plan due to be submitted to NHS England in the Autumn. This must include or be underpinned by a plan that articulates a clear vision and actions to be taken at neighbourhood, place and system level to ensure Personalised Care is embedded across the ICS to include enablers – Strategic Coproduction, workforce, digital and finance and commissioning/contracting requirements.
- Fully implement & spread the whole Comprehensive Model for Personalised Care across the whole of Nottinghamshire ICS, complementing and building on

the local Population Health Management/integrated care approach as well as the sustainability and expansion plans developed by the site in 2018/19

- Ensure there is cross system (i.e. NHS, Local Authority, VCSE, and people with lived experience) leadership for personalised care, through named Senior Responsible Officers (SROs) – both clinical and commissioning, who will sponsor and drive the work locally.
- Ensure sufficient Programme Management capacity to deliver Personalised Care as described herein in addition to identifying named leads already embedded in the system who are responsible for delivering/enabling Strategic Coproduction, workforce, digital and finance, commissioning and contracting requirements and evidence/evaluation.
- Ensure clear governance for Personalised Care, including senior sponsorship for the work across the ICS and including people with lived experience.

- Central to the delivery of the Long Term Plan is the continued development of Integrated Care Systems. They are a practical way to deliver on the "triple integration of primary and specialist care, physical and mental health services, and health with social care". The demonstrator programme for 2019/20 will focus on integrated system change with the Integration Accelerator Pilot sites identifying what is needed to join up around health and social care assessments. As integration is fundamental to the Long Term Plan, it is expected that all demonstrators will add to the integration narrative, including highlighting local examples of integrated approaches to assessment, planning and personal budgets to embed Personalised Care.

2. Engaging with the NHSE programme

- Work with their NHS England Personalised Care Team to complete the Personalised Care self-assessment for each 'place' within the ICS/STP, develop delivery plans, review progress and identify support needs, and engage with support requested and made available as a result of this. This is to include regular communication with site programme managers, and SROs as set out below.
- Share their learning with NHS England, other demonstrators and wider systems through:
    - participating in the 'National Personalised Care Collaborative', which will meet approximately five times a year;
    - participating in programme manager meetings;
    - contributing to an online network;
    - Promoting the work they are undertaking, through:
        - One 800 word blog to engage new people to personalised care and reach to the parts demonstrator programmes cannot reach.

        - One hour long webinar showcasing the work of the area;
        - Three examples of practice which could be a link to a video, a document that helps others to implement a component/enabler, a personal story, some raw material entered onto a case study template.
    - In addition to the requirement to embed the whole Personalised Care Model across the whole ICS, Demonstrators are required to facilitate geographical spread of Personalised Care through mentorship of non-demonstrator sites. This includes supporting national and regional collaboratives and offering bespoke support to non-demonstrators on elements of the model and leadership for change on a national and regional basis – this may be through webinars, sharing documents and resources or through direct conversations with other areas.
    - Where implementing the model for new groups such as carers or exploring different enablers such as utilising the Better Care Fund to implement Personalised Care, share this information and learning with NHS England to further inform policy development and national roll-out.
    - Support national work to understand the impact on health inequalities through sharing stories and case studies that demonstrate how this can be done

- Promote attendance of relevant senior people from across the system at Finance, Commissioning and Contracting Regional Networks, the Royal College of General Practitioner's Person Centred Approaches Network of Champions, PHB regional networks, Social Prescribing regional networks, and any other relevant Communities of Practice that are identified as facilitating development and transformation in relation to embedding Personalised Care.

3. Understanding progress

- Provide quarterly reporting against key activity projections (see Schedule 3). Engage in quarterly 'structured conversations' with the Personalised Care team, to understand local progress with implementing personalised care and adjust support arrangements accordingly.

Deliverables by end of March 2020:

Achieving scale: All Personalised Care Demonstrators will agree levels of activity for people experiencing personalised care which reflect local and national ambitions for the programme. For Nottinghamshire ICS this has been agreed at:

- 6% of population to experience Personalised Care by March 2020 – see Schedule 3 for breakdown of numbers by component

- Nottinghamshire ICS must meet their IAF trajectories for the year in relation to Personal Health Budgets as a minimum. However, we would like to see sites who are able, working to exceed IAF trajectories and engaging with national support to do so.

The component specific deliverables to achieve scale are that sites must:

- Complete the Shared Decision Making Self-Assessment Checklist in one or more of the 30 high priority clinical situations and deliver actions in one or more of the four key Shared Decision Making foundations based on a quality improvement plan;

- Achieve 100% Compliance with all 9 Choice Standards using the Quality Assurance Framework developed by the National Choice Team;

- Ensure consistent delivery of supported self-management programmes that seek to increase the knowledge, skills and confidence of people to better self manage their long term conditions including health coaching, self-management education and peer support;

- Agree a CCG/NHS Provider/Local Authority site within the Demonstrator to be the lead site for ICS that can deliver additional PAM licences via partnership agreements;

- Bring local partners together at a placed-based level in Q1 to develop shared local social prescribing plans for 19/20. These plans should include:

    - How additional link workers will be recruited locally, using the new national Primary Care Network Direct Enhanced Service link worker funding and embedded in every local Primary Care Network multi-disciplinary team across the /STPICS.
    - How Primary Care Networks will be supported to use the SNOMED social prescribing codes and implement the Common Outcomes Framework for measuring the impact of social prescribing on people and community groups.
    - How the VCSE sector will be supported to receive social prescribing referrals and how local community assets will be nurtured.

- Build sufficient and sustainable capacity locally to deliver Personalised Care and Support Plans in line with trajectories in Schedule 3 for this year and to increase this number in subsequent years. Capacity must be suitably trained and

resourced to ensure that Personalised Care and Support Plans meet the NHS England Key Features.

- In relation to Personal Health Budgets, deliver the following:
    - At least 85% of CHC home care packages in a local area are delivered through a PHB
    - Development and implementation of a Personal Wheelchair Budget offer.
    - Aim to ensure that by March 2020 PHB/Integrated Personal Budgets are available to at least four groups (to include s.117 eligible patients) by each CCG, moving to a position where no single group make up more than 50% of all PHB/IPB recipients in a local area
    - Aim to ensure that at least 40% of PHBs in a local area are managed as a direct payment or third-party budget (note that this excludes personal wheelchair budgets). This is good practice to ensure a mix of approaches in a local area but all individuals still have the choice to manage the money as a notional, third party or direct payment.

Achieving 'spread': Demonstrators will need to show that the geographical spread of personalised care within their site is expanding in 19/20 and that the model is being used to improve outcomes for new groups of people and services where this makes sense locally. A crucial vehicle for spread of Personalised Care will be Primary Care Networks. Spread of Personalised Care beyond demonstrators will also be supported through the shared learning ask of sites above to promote the work but also in particular the mentorship requirements detailed above.

Demonstrating impact: All Personalised Care Demonstrators will actively engage with all reporting and evaluation activity associated with the programme, providing robust and timely information on outcomes, user experience, costs etc in order to continue to develop the local and national business case/evidence base. This will include:

- reporting activity as agreed towards the Personalised Care minimum dataset
- use of the social prescribing common outcomes framework
- supporting national work to build the financial business case for personalised care by engaging as above with information but also by developing local datasets based on national templates on service use for people taking up personalised care (initially in secondary healthcare).
- sharing case studies which show the impact of personalised care for people and for the system, including standardised content and utilising templates provided by the programme

[INSERT FOR ACCELERATOR SITES Integration Accelerator Pilot sites are asked to meet the following targets (see annex for more detail):

Sustainability planning: There are some key sustainability deliverables that relate to enablers to the Personalised Care model, namely that each site must**:**

Strategic Coproduction:

- Actively promote the NHS England Peer Leadership Academy and online equivalent or any other Personalised Care development programme that the Personalised Care Group may develop.

- Ensure sustainable approach to supporting people with Lived Experience to increase their knowledge, skills and confidence to contribute in equal partnership with the system.

Workforce:

- Ensure that training, development and support for the workforce to deliver Personalised Care across the six components of the Personalised Care model are included in the ICS Workforce/Organisational Development Strategy.

- Engage with workforce work taken forward by the Personalised Care Group to facilitate spread and scale of the model locally and nationally

Digital:

- Understand digital requirements for Personalised Care and ensure these are included in local and strategic digital developments.

Finance, Commissioning and Contracting:

- Commit to ensuring that 100% of service specifications for community contracts include the requirements to deliver Personalised Care, aligned with the requirements in the 2019/20 NHS Standard Contract.

- In relation to the above requirement to commit to Personalised Care explicitly in the Five Year Strategic Plan for the ICS submitted in the Autumn, ensuring that operational plans that underpin this commitment take account of commissioning/contractual implications including approaches to capitation and the percentage of contract value or population to be released for expansion of the PHB offer in line with local priorities.

- Good practice would see Demonstrators expanding their Direct Payment PHB offer to a group or service area previously tied up in block contract arrangements, ensuring sustainable contractual arrangements to underpin the releasing of the resource (sites should identify the amount of resource to release that meets locally identified needs).

- Actively explore with NHS England the opportunity to identify money within the system and through Long Term Plan financial planning that can be invested in Personalised Care to demonstrate ongoing commitment to the model beyond the Demonstrator Programme and to facilitate sustainability going forward.

- Work collaboratively with the local voluntary and community sector and other relevant partners including the wider public sector to develop finance contracting and commissioning approaches that support sustainable models of delivery and scaling of innovative provision by the local voluntary and community sector to ensure a broad range of community-based approaches is available to their population.

- Contribute to development of a personalised care dashboard as per Action 19 in UPC

Responsibilities of NHS England

The NHS England delivery programme will support sites in the following way,:

- a Personalised Care Site Lead who will be the main person supporting sites to deliver their objectives. They will ensure good communication between the national programme and the site, and access to timely and effective support. They will be responsible for supporting sites to review progress, providing direct support and coordinating input from the 'team around the site'.
- a 'team around the site' – a coordinated approach bringing relevant expertise from areas of work across PCG to support Nottinghamshire ICS. This will include access to support from Shared Decision Making, Finance, Commissioning and Contracting, Information Governance, Lived Experience, PHBs, Supported Self-Management, Personalised Care and Support Planning, Social Prescribing and Choice.
- access to the 'National Personalised Care Collaborative' which will meet five times a year and will build confidence and capability to lead large scale change.
- access to programme manager calls, workshops, webinars, events and action learning opportunities, and the offer of in-site workshops
- bespoke local support on priorities identified between the site and Site Lead, including from a range of national voluntary partners and suppliers.
- access to an online network to share good practice, hear about events and discuss emerging issues with colleagues from across the programme
- support for the local area to connect into national and regional system leaders and policy working groups to escalate key issues.

NHS England will agree a personal support plan with individual sites.

£225,000 will be made available from NHS England in 2019/20 to support this work.

This will be spent as follows:

What	**Amount**
Programme management costs	

VCSE organisation engagement	
Co-production with people with lived experience and families	
Finance and analytical support	
Evaluation support (including comparison groups)	
Investment in development of personalised care approaches (choice, shared decision making, social prescribing, supported self-management, health coaching and peer support, personalised care and support planning and personal health budgets and integrated personal budgets) in line with this MOU	
Staff training and development	
IT	
Travel, expenses, overheads	
Total	

Each site will agree arrangements for payment of the support funding with NHS England. In line with normal practice, funding will be supplied at point of need, specifically in regular payments through the year rather than as a one-off lump sum. It is proposed that this is as two payments, 70 per cent on the signing of the MOU, and 30 per cent in October 2019, subject to delivery of the deliverables listed above. It is proposed that Nottinghamshire ICS payment is made Nottingham City CCG and NHS England will set up a purchase order to enable this, and inform the site of the reference number so they can invoice as agreed.

Governance and reporting

National governance for the programme will be through the Personalised Care Advisory Board, which will oversee the governance of Personalised Care Demonstrator Sites and Integration Accelerator sites. Operational management of the programme will be overseen by the NHSE Personalised Care Group's Senior Management Team. The Personalised Care Programme Board will be co-chaired by NHSE and the LGA. It will receive a quarterly report on progress in the sites.

Intellectual property

Any materials developed as part of this project and information gathered will remain the property of NHS England. Apart from published personal stories where consent has been obtained, any confidential and sensitive information will be made anonymous.

Legal basis of this MOU and liability

This MOU is not intended to be contractually binding in a court of law or to give rise to any other legally enforceable rights or obligations, nor does this document constitute an offer to purchase or to supply services or goods on the terms set out in this document or at all.

No Party shall be deemed to be an agent of any other Party and no Party shall hold itself out as having authority or power to bind any other Party in any way.

Neither Party shall have any liability to the other Party for any redundancy costs arising either from delivery of the services or by the termination of the MOU, whether by the passage of time or any earlier termination.

Duration, variation and termination

There will be 'gateway' points in the programme when Demonstrator sites' ongoing participation in the programme will be reconfirmed and the MOU refreshed through the change control procedure following this to cover the next period in more detail. These gateway points will be:

- October 2019 – following review of Quarter 2 data and progress toward trajectories and following submission of Five Year Plan to NHS England, to include the vision and plan to embed the whole Personalised Care model across the whole system

The decisions above will be made by the Personalised Care Advisory Board following recommendations from PCG Delivery Leads. This MOU may be terminated early by the Demonstrator Site's Programme Board making a decision to leave the national programme, upon return of any appropriate programme management funds as agreed between the parties.

This MOU may be modified in accordance with the change control procedure detailed in the Appendix, schedule 2 by mutual consent by authorised officials from the NHSE Personalised Care Group and those of the Demonstrator site listed in Schedule 1.

If, during the course of 2019/20, separate MoUs are agreed between NHS England and Nottinghamshire ICS or individual CCGs within it, in relation to the personalised care programme, those MoUs will be added as annexes to this agreement, to facilitate coordination of all related activities in the locality.

This MOU shall become effective upon signature by the authorised officials from NHS England, and the Demonstrator site, and will remain in effect until modified or terminated by either the Personalised Care national programme or the Demonstrator Site, as agreed at either's Programme Board. For NHSE this is the Personalised Care Programme Board. In the absence of termination by the authorised Programme Boards this MOU shall end on 31/03/20.

Signed for and on behalf of

Name and Title:	
Signature:	
Date:	

Signed for and on behalf of

Name and Title:	
Signature:	
Date:	

Signed for and on behalf of

Name and Title:	
Signature:	
Date:	

Signed for and on behalf of

Name and Title:	
Signature:	
Date:	

Schedule 1

Nominated representatives

NHS England: James Sanderson (Director of Personalised Care NHS England)

_____ CCG: [Please insert name of lead CCG and nominated representative here]
_____ Local Authority: [Please insert name of LA and nominated representative here]

Schedule 2, see page 11 of main body of MOU

Change Control Procedure

[insert]

MoU Change Note (MCN)

Sequential Number	[insert]
Title	[insert]
Originator	[insert]
Date change first proposed	[insert]
Number of pages	[insert]

Reason for proposed change

{Please insert, using examples below:
- Continuation of the duration of the MoU term, from _____ to _____},

{- changes to pricing as follows: _____}

Full details of proposed change

{Please insert full details of the proposed change}

Details of likely impact, if any, of proposed change on other aspects of the MoU

{Please insert details or "None"}.

Date of Proposed Change

[insert]
Save as herein amended, all other terms and conditions of the MOU inclusive of any previous CCNs shall remain in full force and effect.

Signed for and on behalf of [insert]:

Name and Title:	
Signature:	
Date:	

Signed for and on behalf of [insert]:

Name and Title:	
Signature:	
Date:	

Signed for and on behalf of [insert]:

Name and Title:	
Signature:	
Date:	

Signed for and on behalf of [insert]:

Name and Title:	
Signature:	
Date:	

MOU schedule 3

You have agreed the following projections for the number of people that you expect to take part in your programme in 2019/20. You have agreed to provide activity data to enable progress against these projections to be monitored.

2019/20 PC total	51,195	2019/20 % Pop	4.9%

Measure	Basis of counting	How collected	2019/20 target
A. Patient activation measure (or equivalent)	People completing the Patient Activation Measure	NHSE PAM team	1615
B. Self-management	People referred for self-management support, health coaching and similar interventions	NHSE activity data collection	15000
C. Community – based support	People referred for social prescribing community groups, peer support and similar activities.	NHSE activity data collection	15000
D. Personalised care and support plans (total)	Number of plans or reviews	NHSE activity data collection	19580
D.2 Personalised care and support plans (excl those from PHBs)	Number of plans or reviews	NHSE activity data collection	16,680
E. Personal health budgets	Number of people with a personal health budget (includes integrated personal budgets)	NHS Digital collection	2,900
