Coalition for Personalised Care

‘I love the work we do, and I hear the value every day’

The role of Personalised Care in Neighbourhood Health in North West London

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NHS
West and North London

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Executive summary

The Coalition for Personalised Care was commissioned by North West London Integrated Care Board (ICB) in early 2026 to provide a stocktake report into the use of Personalised Care alternative roles. Since this work was commissioned, North West London ICB has merged with North Central London ICB to form West and North London ICB. The reports' findings and recommendations in this report have therefore been considered in the context of the new organisation and its priorities.

The purpose of the report is to understand why West and North London ICB should continue to invest in Personalised Care roles, given straightened resources and competing priorities, and how this resource could be structured to meet some of the requirements of implementing the Neighbourhood Health Framework [1].

The Framework focuses on improving people's health and care outcomes, reducing health inequalities and helping people stay well at home. Personalised Care roles focus on the wider determinates of health and reducing local health inequalities, alongside building unique links with local communities and Voluntary, Community, Faith and Social Enterprise (VCSE) organisations.

West and North London ICB have a strategic opportunity to use the Personalised Care roles to maximise the potential of the Neighbourhood Health framework.

Because this commission predated the merger of the two ICBs, the report focuses on the eight boroughs of Westminster, Kensington and Chelsea, Ealing, Brent, Hammersmith and Fulham, Harrow, Hounslow, Hillingdon, formerly North West London ICB.

Comments from Personalised Care staff interviewed for this report illustrate the outstanding passion and commitment to making a meaningful difference:

"Working with our most vulnerable patients to problem solve very challenging situations where other supports have failed and supporting them to be heard where they have previously reported being invisible as an individual is a most rewarding role.." (Personalised Care staff).

"I celebrate the success stories when people thank you for changing their lives, for empowering them to make changes and action things. They feel they belong and are making connections." (Personalised Care staff).

There are three sections to the report:

1. **An overview of Personalised Care**, the roles and their impact nationally and locally.

2. **A stocktake of what is currently happening in North West London** using perspectives from a wide range of stakeholders and locally available data. This focuses on the following areas:
   - The West and North London Context
   - Employment trends: Alongside the traditional Personalised Care alternative roles, there are a number of blended roles or similar roles with different names. Employment models vary and there is a downward trend in numbers of people employed in Personalised Care roles via the Alternative Roles Reimbursement Scheme (ARRS).
   - Support for the Personalised Care roles: Evidence shows that where staff feel supported, they are more likely to stay in their role. There is variation across North West London in training and support for Personalised Care staff.Career progression is also highlighted as an issue.
   - The environment in which staff work: There is a strong correlation between job satisfaction and staff feeling they 'belong' within a team. This is explored in terms of their relationships with other primary care staff, multi-disciplinary teams (MDT) and Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations. The impact of inappropriate referrals is also explored.
   - Collecting data: There is inconsistency in how data about Personalised Care services and outcomes is collected. The measures themselves also vary from service to service, making it difficult to compare across different services or neighbourhoods.

3. **Recommendations for West and North London** to help to ensure Personalised Care roles are used most effectively across West and North London:
   1. Ensure Personalised Care roles are embedded within local delivery frameworks as part of the Neighbourhood Health Programme
   2. Use the Comprehensive Model of Personalised Care as the underpinning model of care for Neighbourhoods
   3. Understand the cost benefit of Personalised Care roles
   4. Include Personalised Care in strategic commissioning intentions for pathways
   5. Develop clear competencies frameworks for the Personalised Care roles
   6. Develop a comprehensive map of what Personalised Care roles are where
   7. Invest in ICB-wide training, supervision and peer support for all Personalised Care roles
   8. Maximise the opportunities for digital enablement
   9. Develop a standard set of local metrics to demonstrate impact

There is a lot already working well which can be built on in the delivery of Personalised Care within West and North London. The Personalised Care roles are a key part of the health and care workforce within the area.

As an integral part of multi-disciplinary teams in neighbourhoods, these roles are enablers for both the shift from hospital to community and from disease to prevention.

If invested in sufficiently, these roles will help the delivery of the goals within the Neighbourhood Health Framework.

However, it follows that not having sufficient Personalised Care role availability may have a negative impact on demand for GP appointments, and on acute and ambulance emergency care.

Delivering the Neighbourhood Health target of 90% of clinically urgent appointments being seen on the same day requires a blended staffing team, and for non-urgent demand to be seen by the most appropriate person, not necessarily the GP.

People with unmet clinically urgent needs will be more likely to attend ED. Vaccination and screening opportunities will be missed, and the health inequality gap will grow wider across populations.

In summary, a reversion to primary and community care being reliant solely on medicines prescribing or referral to clinical pathways will increase prescribing costs, secondary care referrals and reactive care. This would limit GPs' ability to provide holistic care and support for people within their local population.

If the Personalised Care roles workforce continued the current trend of declining numbers, the ability to meet the requirements of both Neighbourhood Health and the 10-Year Plan for Health would be in jeopardy.

This is not a hypothetical risk. Personalised Care ARRS roles in North West London have already fallen by 12.5% in FTE terms in 2025/26, with Social Prescribing Link Workers down 28% and Health and Wellbeing Coaches down 16%. Each of these roles is directly linked to delivery of the Neighbourhood Health Framework's five goals: reducing GP appointments taken up by non-medical need supports Goal 2 (same-day access for clinically urgent needs); care coordination for high-priority cohorts supports Goal 1; and reduced ED attendance, evidenced locally at between 57% and 68% for patients receiving social prescribing or neighbourhood navigation support, supports Goal 4. A continuation of the current rate of decline would directly erode the capacity West and North London ICB needs to meet the 90% same-day access target for clinically urgent appointments by March 2027.

For Neighbourhood Health to succeed, *"a fundamental reimagining of the roles, skills and ways of working across health and social care over the next decade."* [1] is required. This report aims to support that reimagining within the context of what Personalised Care roles can offer.

Contents

1. What is Personalised Care?

Evidence states that only about 10-20% of people's health outcomes are attributable to medical care. The rest is due to social determinants of health such as housing, diet, socio-economic status and education levels [2].

Over the last four decades, a range of approaches have been piloted to address this. NHS England, through the Personalised Care programme, brought together the learning from a range of prior health and social care programmes to synthesise the most impactful actions into the Comprehensive Model of Personalised Care [3, p17].

The Comprehensive Model of Personalised Care is a systemic and whole population approach to supporting people, no matter how complex their health and wellbeing needs are. It takes the wider determinants of health into account and asks, *'what matters to you?',* rather than focusing solely on *'what's the matter with you'* i.e. medical and condition specific interventions.

On a macro-level, the Comprehensive Model of Personalised Care applies to a whole population. The operating model shows how all of components of Personalised Care support people.

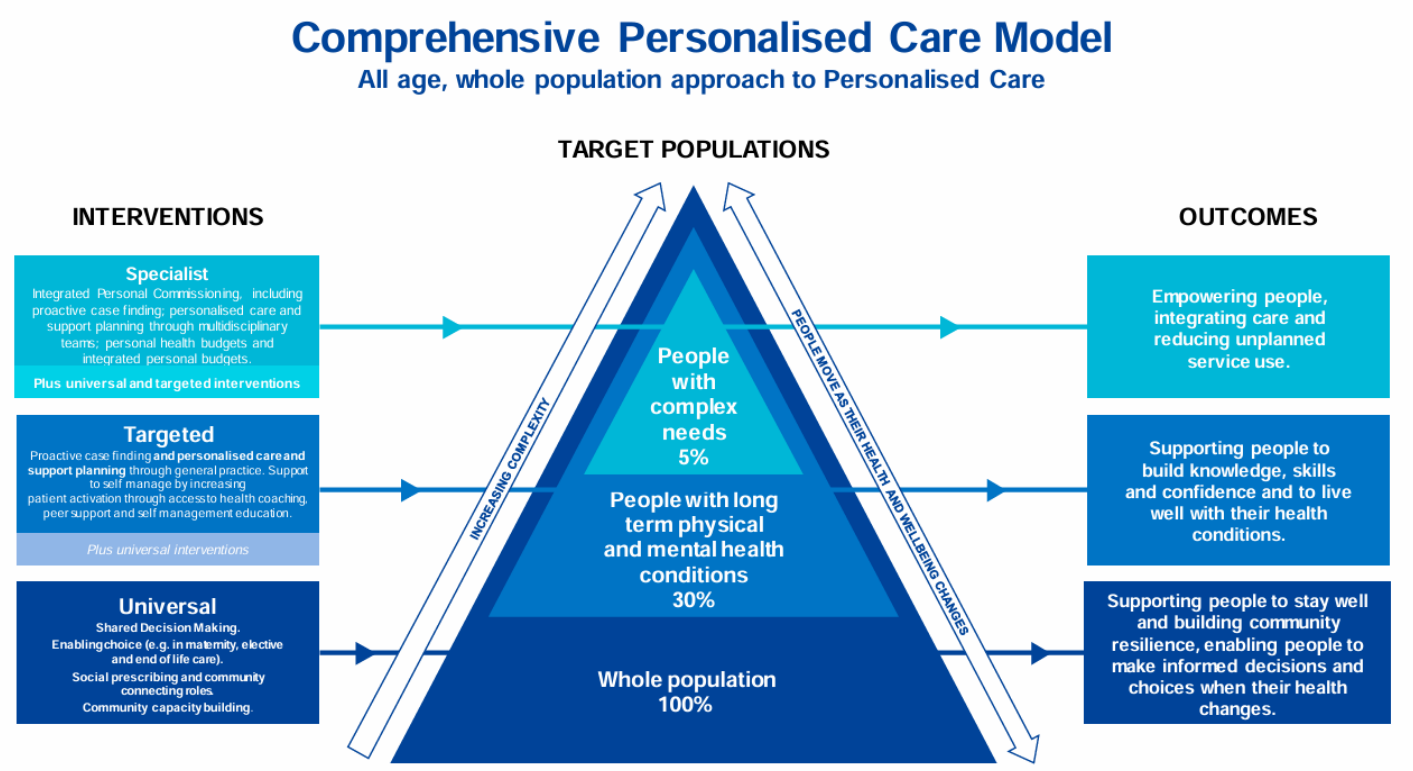


Figure 1: from Comprehensive Model of Personalised Care, NHS England [3, p.17])

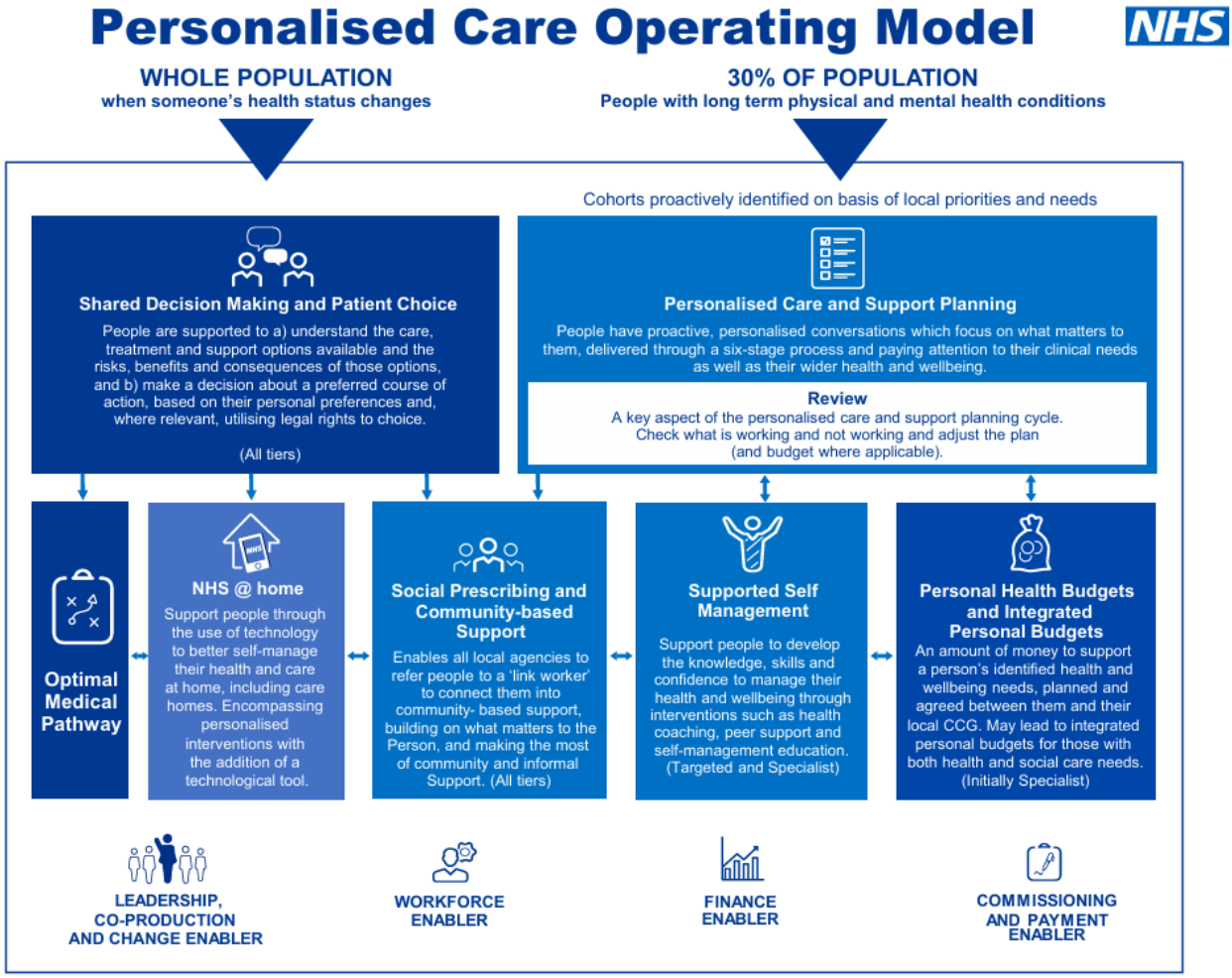


Figure 2: from Personalised Care Operating Model, NHS England [3, p.27 , 4]

The Comprehensive Model of Personalised Care was adopted as the underpinning model of care for the NHS by the NHS England and Improvement board in January 2019.

Personalised Care is now expected to be business as usual and is referenced in the 10 Year Health Plan for England [5] and the Neighbourhood Health Framework [1]. Both of these plans intend to deliver the three shifts from hospital to community, disease to prevention and analogue to digital. The Comprehensive Model of Personalised Care is an enabler for this, with the Personalised Care roles forming an integral part of how it will be delivered.

However, a review of how services are funded will be required.

Funding shifts to resource neighbourhood health

Neighbourhood Health is a priority for the NHS [5]. However, there is no new money to implement it or allow for double running costs. Therefore, existing funding needs to shift to enable it to happen.

Like all ICBs, West and North London and their Local Authority partners will have to change the proportion of total spend which is allocated to primary and community, public health and social care relative to spending on acute and emergency care. The Nuffield Trust report [6] *'Where does the NHS money go?'* shows that over the last 10 years there has been a significant growth in the total percentage of health spend on acute and ambulance services.

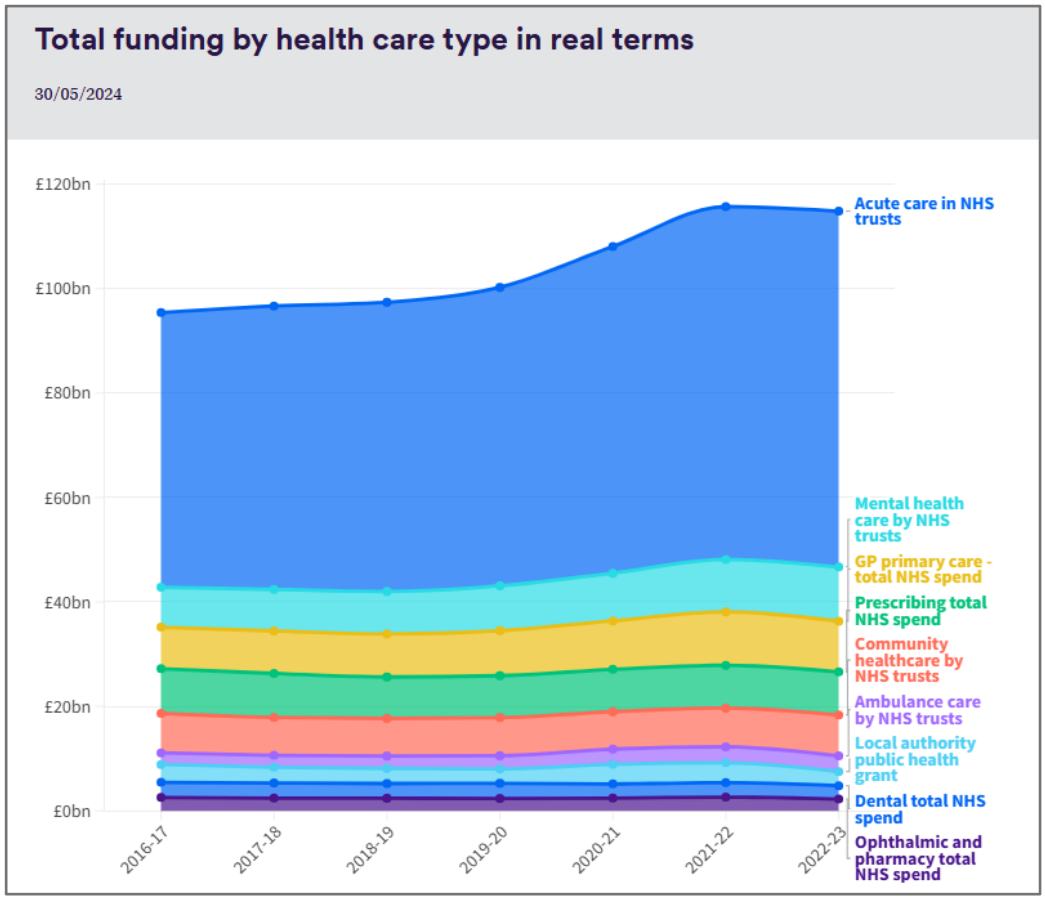


Figure 3: from Where does the NHS money go? | Nuffield Trust [6]

The 10 Year Health Plan for England states, "*At its core, the neighbourhood health service will embody our new preventative principle that care should happen as locally as it can: digitally by default, in a patient's home if possible, in a neighbourhood health centre when needed, in a hospital if necessary. To make this possible we will:*

- *shift the pattern of health spending. Over the course of this Plan, the share of expenditure on hospital care will fall, with proportionally greater investment in out of-hospital care.*
- *This is not just a long-term ambition. We will also deliver this shift in investment over the next 3 to 4 years as local areas build and expand their neighbourhood health services."* [7, p.3]

This funding shift will allow the ICB to ensure that there are sufficient resources to fund the right skill mix of roles within the areas' Integrated Neighbourhood Teams (INT). The right skill mix within an INT will be essential to support the people identified in the Neighbourhood Health Framework as priority groups within the community:

- people with frailty
- care home residents
- housebound patients
- those receiving end of life care
- those with:
    - CVD
    - diabetes
    - chronic obstructive pulmonary disease (COPD)
    - dementia
    - mental health conditions
    - children and young people
- any other cohort identified by local areas

West and North London ICB will need to work with their NHS provider partners to consider how to balance simultaneous delivery of in-year returns (in terms of reduced emergency admissions, acute bed days used and resources absorbed by outpatient long-term condition support), with embedding their neighbourhood health infrastructure. To achieve this, it is likely they will need to use flexibilities such as Section 75 pooled budgets to create novel risk and gains sharing arrangements with all providers across the system to transition resources, as well as health care responsibilities, from hospital to the community.

Realistically this will be manageable by focusing first on the greatest avoidable pressure on acute demand. If both the Comprehensive Model of Personalised Care and the Personalised Care roles are explicitly included in the modelling, it will aid understanding of the cost benefit to the system.

For example, if High Intensity Users of emergency care pathways are supported differently, including by alternative roles, their attendances can significantly reduce. These are a group of people seeking help from the health system, where traditional support provided does not meet their needs. Alternative support is required, such as that provided by the Personalised Care roles.

What are the Personalised Care roles?

On their own, traditional health and care roles are not the most productive way to make Personalised Care work.

To ensure that GPs, pharmacists, practice and district nurses most effectively utilise their clinical expertise, the additional roles were created to compliment and support traditional clinical roles. These are known as the ‘Personalised Care Roles’.

In 2019, the ARRS Social prescribing link worker role was included in the Primary Care Network DES contract. This was followed by Health and wellbeing coaches and Care coordinators in 2020.

Taken together these roles are known as the Personalised Care Additional Roles Reimbursement Scheme (ARRS) roles. The Social prescribing link worker role is mandated with the others being employed according to local need.

While each role of the Personalised Care ARRS role has a different focus and function (see figure 4 below) overall they aim to:

- provide personalised and holistic support beyond medical care
- enable proactive, preventative care
- address health inequalities, including digital inclusion
- improve people’s connections with their wider communities

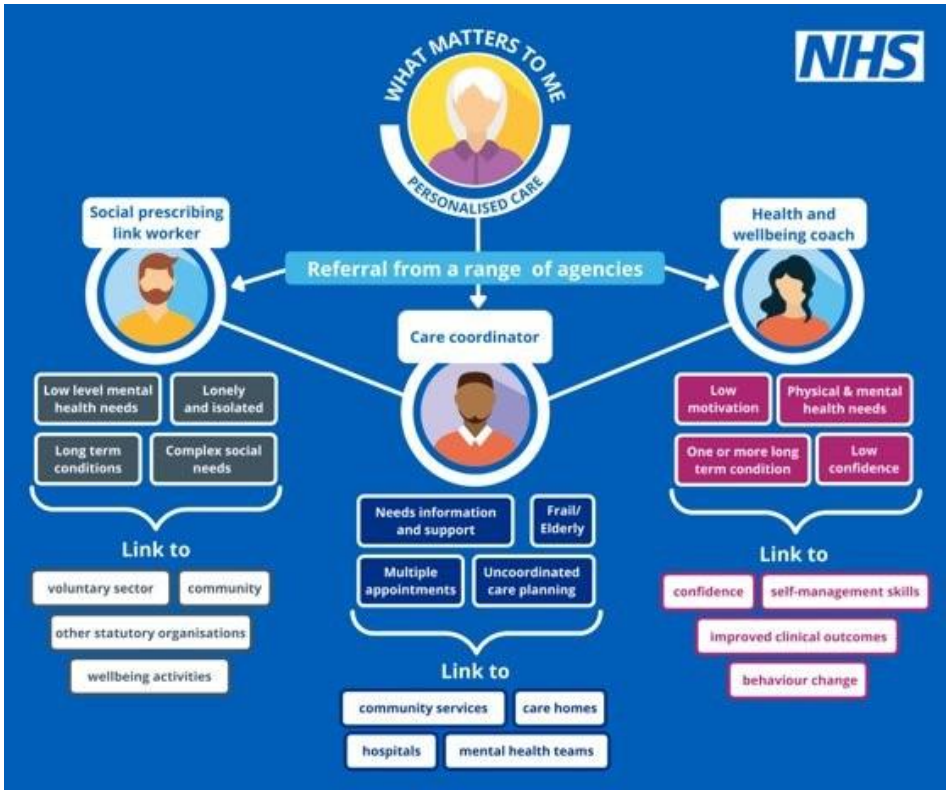


Figure 4: from Arrs roles - Personalised Care Institute [8]

The Personalised Care Institute defines the three roles as follows [8]:

Social prescribing link workers connect people to community-based support, including activities and services that meet practical, social and emotional needs that affect their health and wellbeing. This includes connecting people to services for example housing, financial and welfare advice. Social prescribing link workers work collaboratively across the health and care system, targeting populations with greatest need and risk of health inequalities. They collaborate with partners to identify gaps in provision and support community offers to be accessible and sustainable.

Health and wellbeing coaches support people to increase their ability to self-manage, motivation levels and commitment to change their lifestyle. They are experts in behaviour change and focus on improving health related outcomes by working with people to set personalised goals and change their behaviours. They work with people with physical and/or mental health conditions and those at risk of developing them.

Care coordinators help to co-ordinate and navigate care across the health and care system, helping people make the right connections, with the right teams at the right time. They can support people to become more active in their own health and care and are skilled in assessing people's changing needs. Care coordinators are effective in bringing together multidisciplinary teams to support people's complex health and care needs.

There are opportunities for these roles within Neighbourhood Health as the following infographic outlines:

How personalised care roles support the Neighbourhood Health Framework

Issues people face	Neighbourhood Health Priorities	How the Personalised Care roles can help
Increasing health issues including: • Frailty • Cardiovascular disease • Diabetes • Chronic Obstructive • Pulmonary Disease • Dementia • Mental health issues **Fragmented care for:** • Children and young people • People at end of life • Housebound • Care home residents	**Goal 1** High Priority cohorts Help people with mid to severe frailty, in a care home or housebound, to stay healthier, manage escalating conditions and maintain greater independence for longer Better diagnosis and treatment for people with long-term conditions, particularly people with CVD, diabetes, COPD, mental health conditions and dementia	**Care coordination:** • Proactively identify people with long term conditions or at end of life, particularly those experiencing health inequalities • Encouraging the uptake of screening and vaccinations, particularly where this is historically low **Health and wellbeing coaching:** • Enabling lifestyle change and self-efficacy to support self-management of conditions **Social prescribing:** • Addresses social determinates of health which impact people's health • Link people to community support that improves wellbeing and promotes independence • Liaise with the VCSE sector and statutory organisations and facilitate development of local community support
Difficulty accessing same day GP appointments for clinically urgent conditions **Long waits for routine GP appointments**	**Goal 2** **Improve access to General Practice:** • Same day access for clinically urgent appointments • Faster access for routine GP care	More capacity is freed up for clinically urgent and routine GP care through taking a preventative and personalised approach to people with identified needs, where care is coordinated and people are linked with community support organisations Fewer appointments are taken up with people consulting with a GP for non-medical needs
Complicated outpatient care	**Goal 3** **Improve experience of planned care including:** • Better coordination of outpatient activity across multiple specialities for patients in high-priority cohorts	Care coordination and care navigation which takes a holistic view of people's needs and helps to coordinate outpatient (and other health-related) activity
Increased ED attendance and admissions	**Goal 4** **Better Urgent and Emergency Care performance** • Reduction in ED attendances and admissions • Better coordination of discharge processes across health and care services	This is a consequence of people being better supported to manage their conditions in the community
Poor patient and staff satisfaction	**Goal 5** **Improve patient and staff satisfaction**	What matters to individuals is considered through personalised care and support planning. They can better self-manage their conditions, and they are supported within their local communities.

Personalised care roles help to deliver better health outcomes, improve access to care and strengthen communities

The impact of Personalised Care roles

Approximately one in five GP appointments are for non-medical issues [9].

In North West London many of the Personalised Care roles use the Joy app for social prescribing or health and wellbeing services record the 'client needs' These may be multiple and overlapping.

41% of referrals are for finances, loneliness and isolation or housing problems.

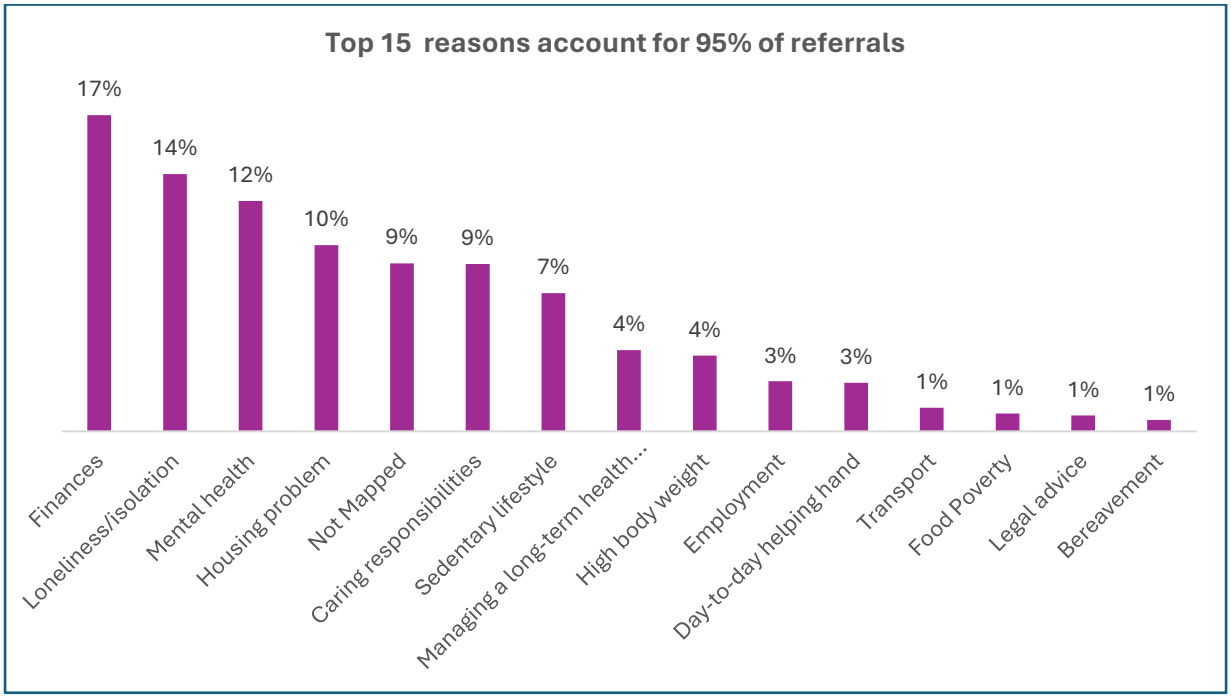


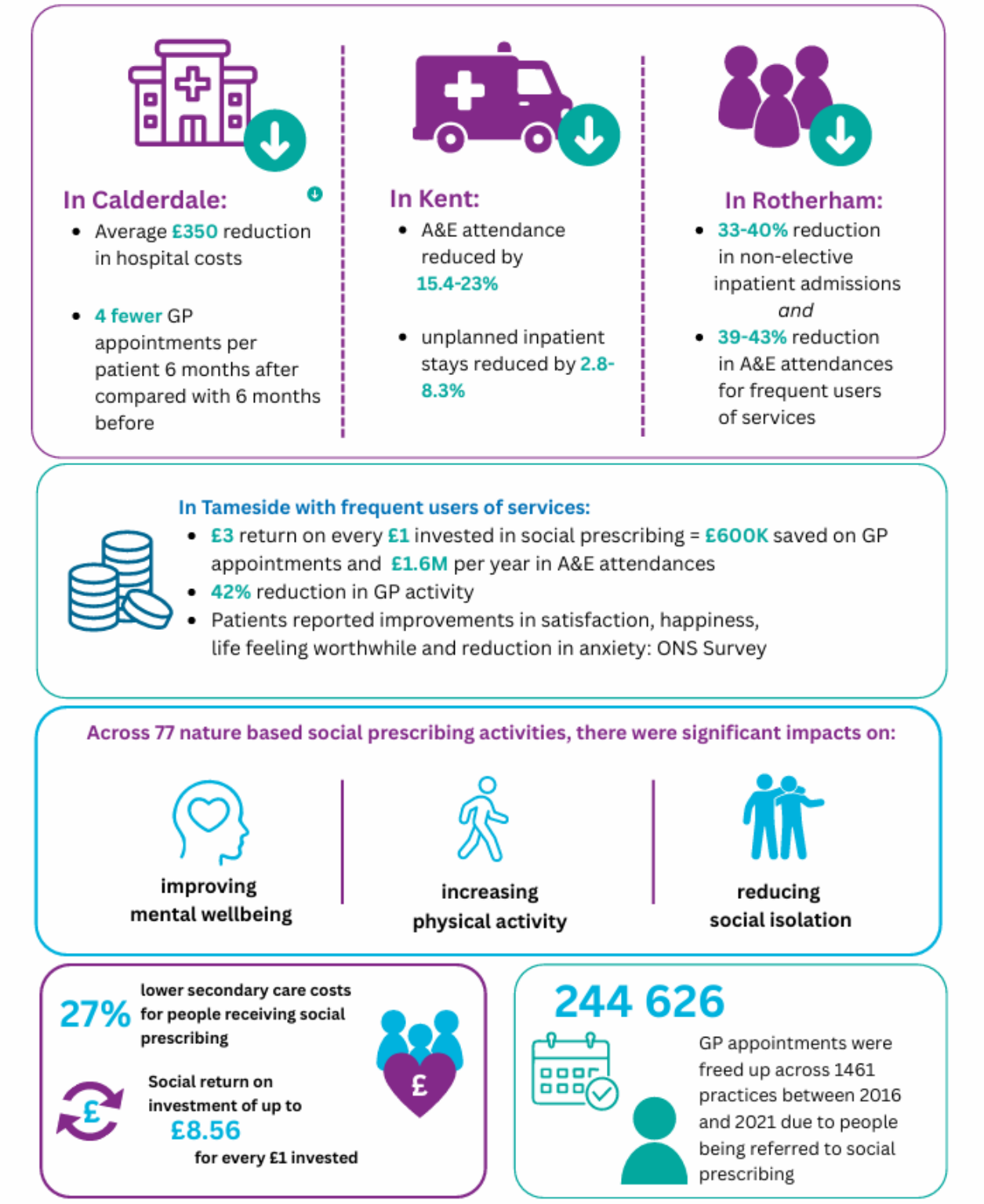
Figure 5: From the Digital First Joy Dashboard developed by North West London ICB

There is a growing body of evidence around the benefits of the Personalised Care ARRS roles in practice, particularly for social prescribing and health coaching. This is despite a lack of standardisation in what is being measured, the difficulty of measuring long term outcomes, the complexity of the roles and the environments in which they operate [10,11].

National and local evidence shows that at these services can:

- Reduce GP appointments and primary care activity overall [9]
- Reduce ED attendances and admissions
- Increase people's ability to manage their own condition (patient activation)
- Impact people's sense of wellbeing
- Produce a return on investment of between £3 and £9 for every £1 invested in social prescribing [12,13].

Social Prescribing: Evidence of Impact



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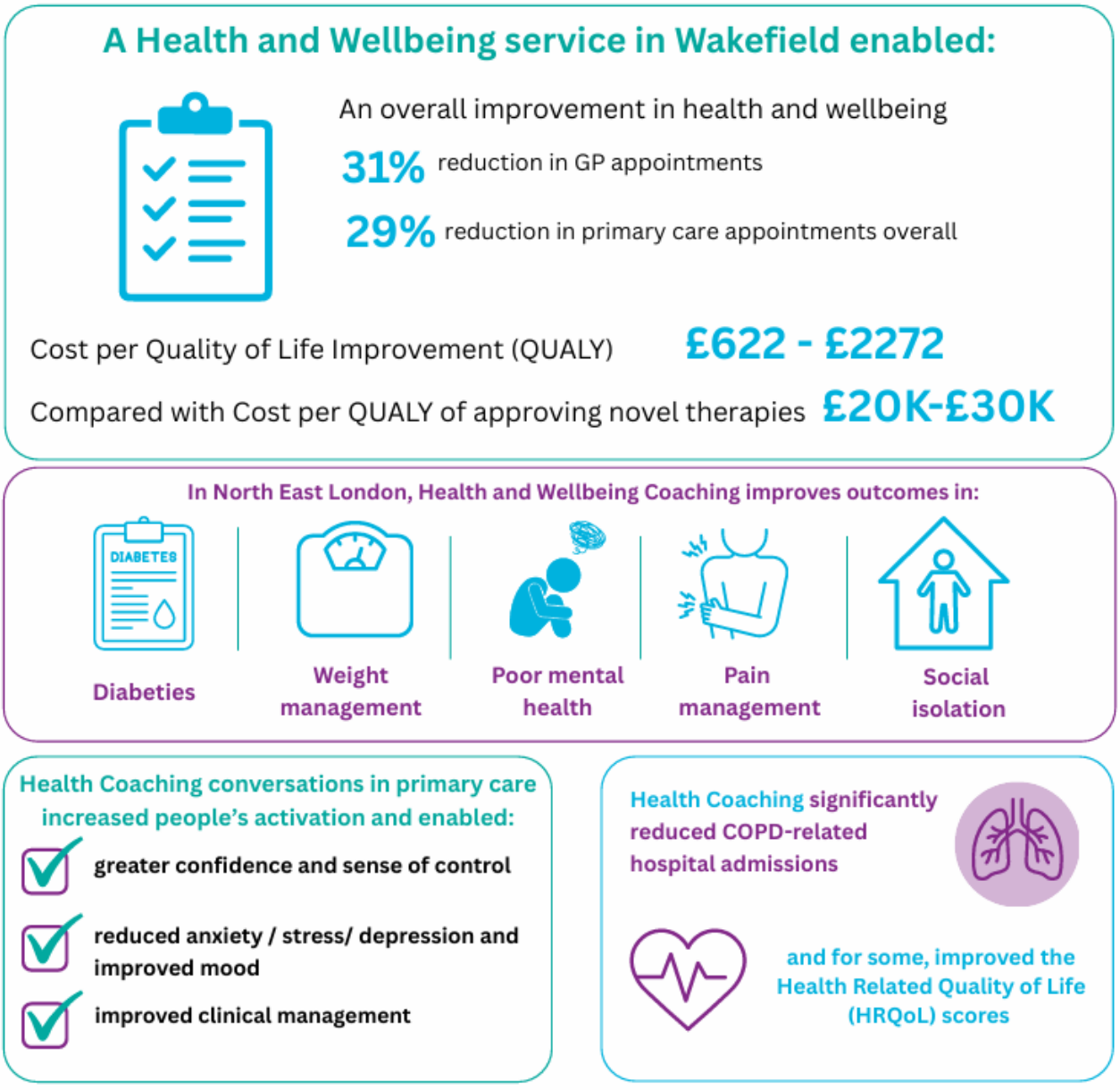
- Wilding, A., et al., *Have social prescribing referrals reduced appointment pressures on primary care? Evidence from Electronic Healthcare Records.* British Journal of General Practice, 2025. **75**(suppl 1): p. bjgp25X741633.

Health and Wellbeing Coaching: Evidence of Impact



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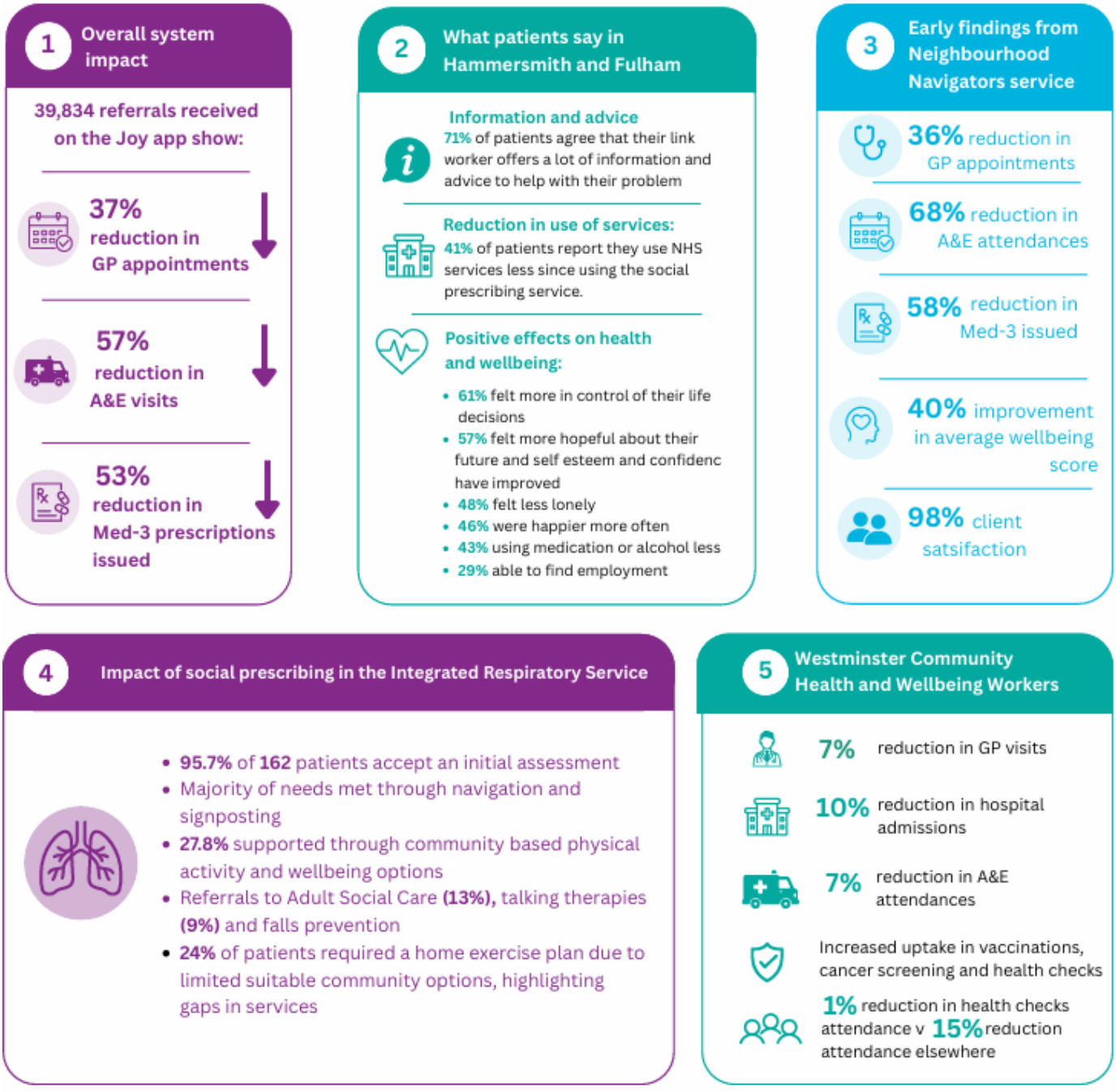
- Henry, K., A. El-Osta, and K. Leedham-Green, *Health coaching for people with long-term conditions and multimorbidity: a mixed methods prospective service evaluation of Structured Agenda-free Coaching Conversations (StACC) in UK primary care.* BMC Public Health, 2025. **25**(1): p. 2365.
- Griffin, R., *Making a difference, an evaluation of health and Wellbeing Coaches in North East London* 2022, Kings College London.

Local evidence is equally as compelling:



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- Zdesar, I., *Demonstrating Impact of Neighbourhood Navigation*. 2026, West London General Practice Plenary.
- Junghans Minton, C., *Transforming Primary Care Through Community Health and Wellbeing Workers in Westminster*. 2025, National Association of Primary Care

2. A stocktake of Personalised Care roles in North West London

Personalised Care roles canhelp to create stronger communities and reduce health inequalities - key parts of the Long-Term Plan and Neighbourhood Health Framework. In West and North London, there is an opportunity to embed the Personalised Care roles within neighbourhoods, however this will require thinking beyond the ARRS roles and taking a systemic approach.

In undertaking the stocktake and creating recommendations we have combined evidence from stakeholder interviews and data from across North West London with the broader literature around the impact of Personalised Care roles and our own knowledge as the Coalition for Personalised Care.

The stocktake focuses on what is currently happening across North West London. Because this commission predated the merger, this report focuses on the eight boroughs of North West London, specifically Westminster, Kensington and Chelsea, Ealing, Brent, Hammersmith and Fulham, Harrow, Hounslow, Hillingdon, formerly North West London ICB.

The West and North London context

In April 2026 North West London ICB merged with North Central London ICB to create the largest ICB in the country now known as West and North London ICB.

The new ICB serves a population of over 4.5 million people. It consists of 13 boroughs and 53 neighbourhoods, with significant diversity in demographics, levels of deprivation, ethnicity and other socio-economic characteristics.

The gap in healthy life expectancy across West and North London boroughs was 7.2 years in 2022 – i.e. residents in Islington experienced poor health on average 7.2 years before those in Kensington and Chelsea. At neighbourhood level this is even greater, with a 17 years gap between South Southall (55.1 years) and Kensington and Chelsea (72.1 years) [14].

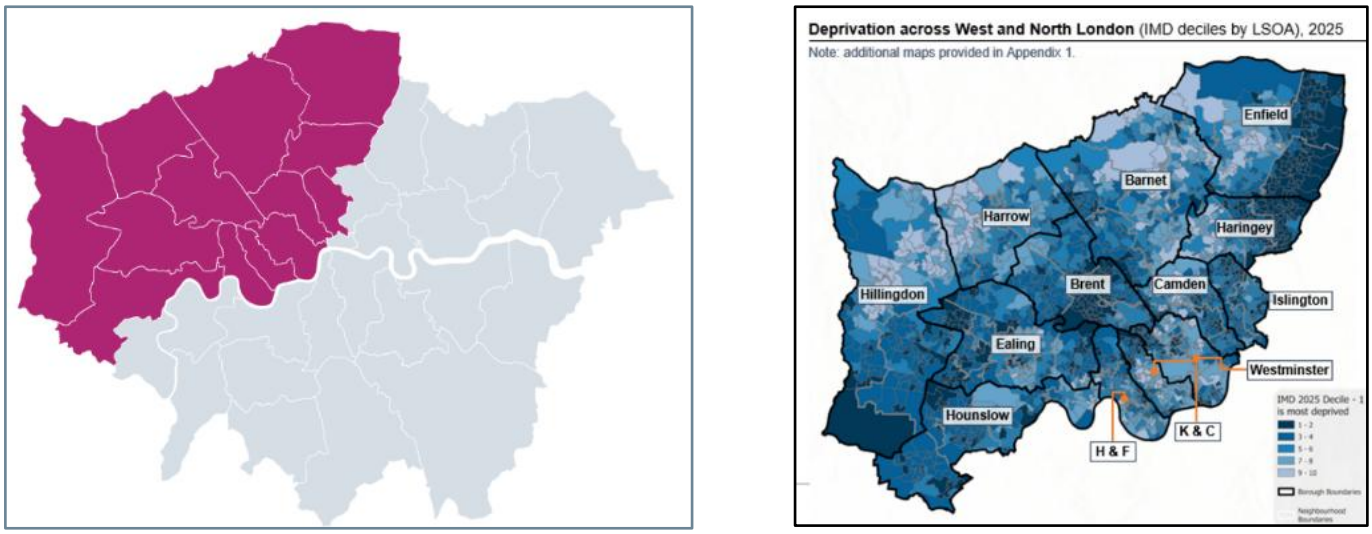


Figure 6: Maps of North and West London ICB area and IMD deciles by LSOA 2025

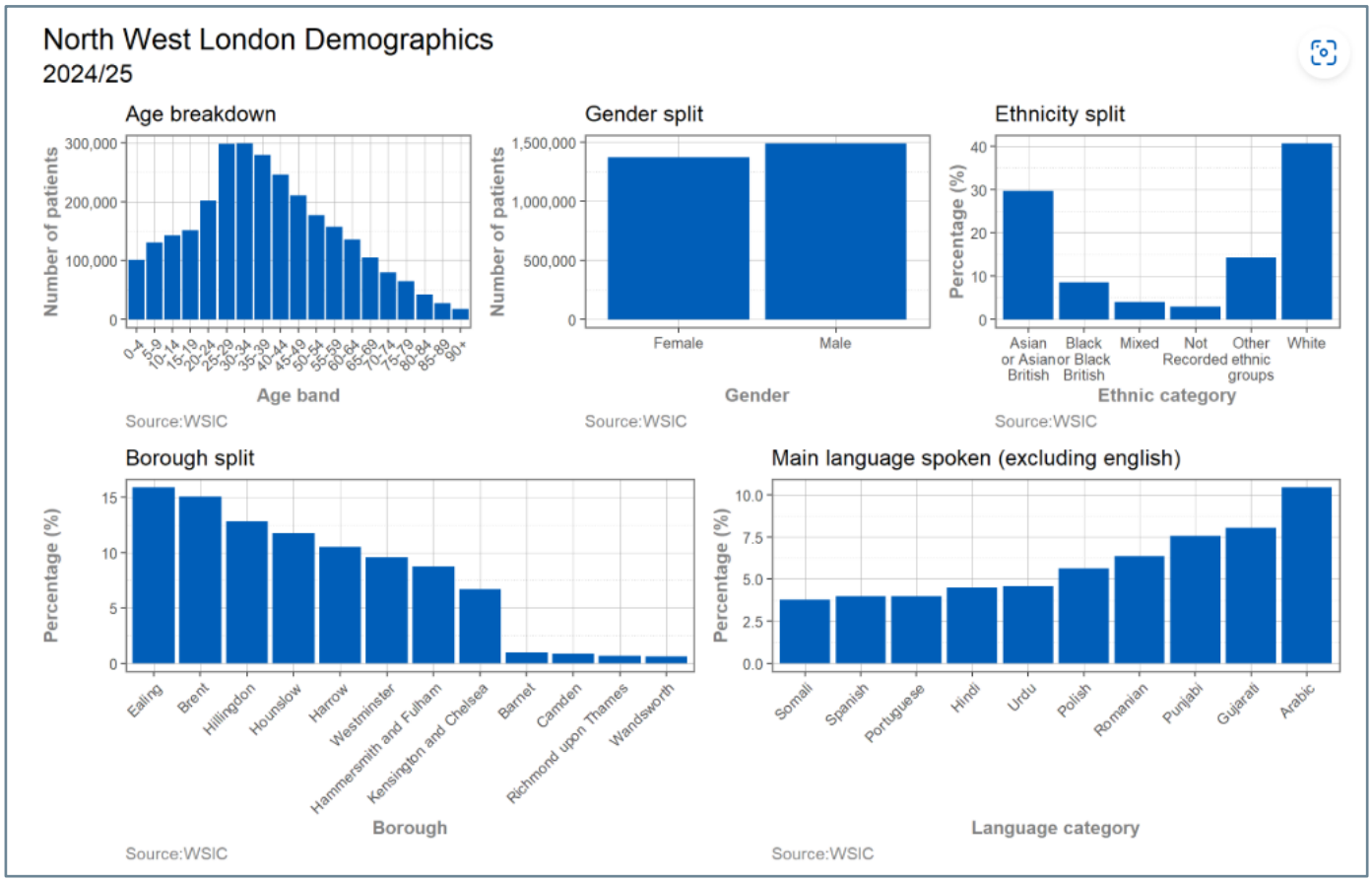
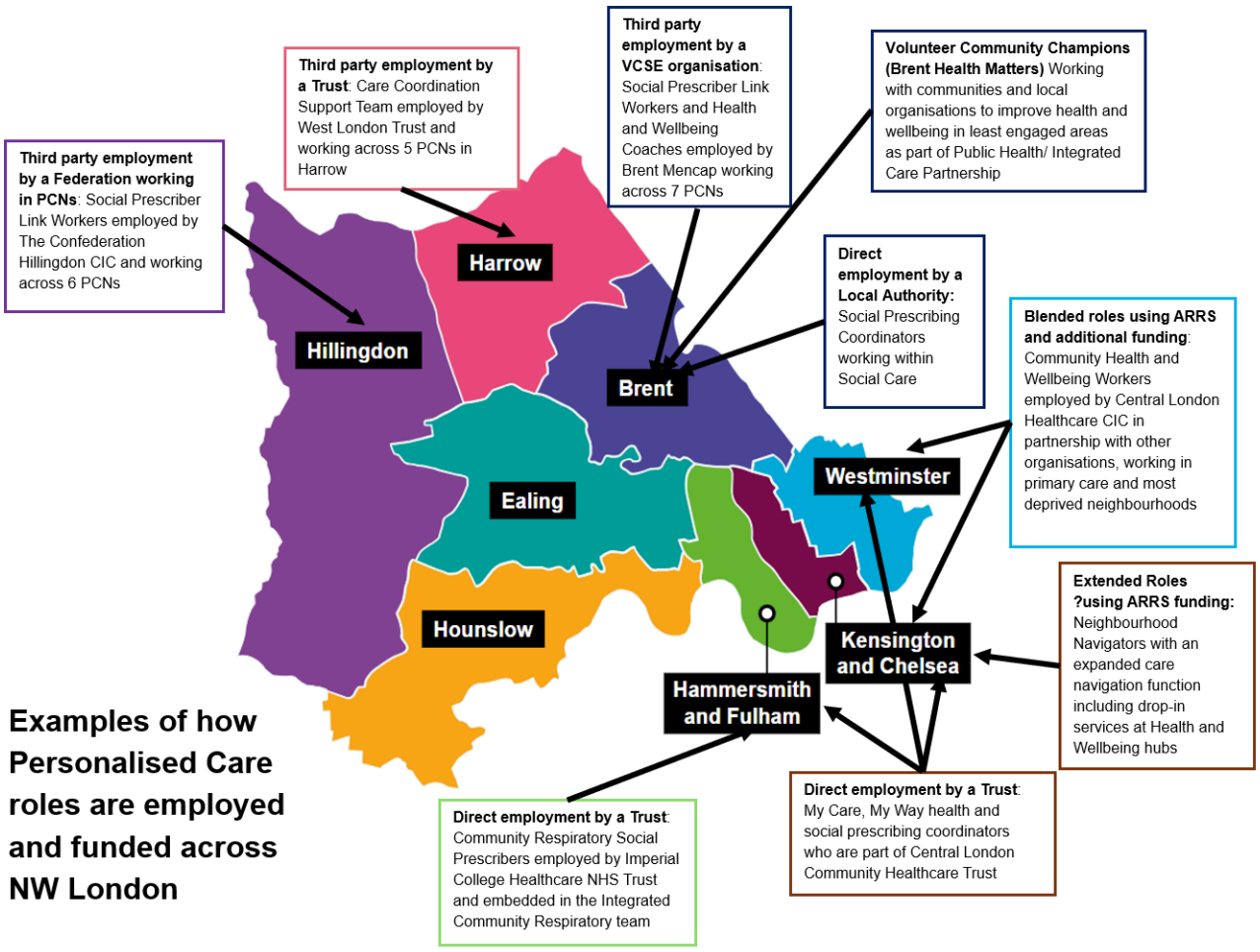


Figure 7: Demographics from North West London Integrated Needs Assessment [15]

Trends in employment

a. A variety of roles and employment models

The figure below gives some examples of the different kinds of roles and employment models in North-West London.



As in other areas of the country [16], the variety in role descriptions, employment models and names leads to confusion for all parties.

"I could be delivering a service in Central London and be called a Community Health and Wellbeing Worker (CHWW). I could be delivering the same in West London and be calling it something else. If you look at the Care coordinators in West London and you look at the CHWWs, they do exactly the same thing." (Commissioner)

There is also variation in what staff in similar roles do [17]. In NWL, some social prescribers predominately signpost to other services, whereas others 'buddy' patients and accompany them to activities to help build confidence and foster engagement. Some staff spend time in community hubs, building relationships with voluntary sector organisations, whereas others are home or practice based.

Employment terms vary and referrers may not understand who they are referring to.

“Many members of the primary care team are unfamiliar with the nuances of the different roles. GPs just about understand a social prescriber’s role now that they have been in place for some time. They probably do not understand what a health coach can do or cannot do. Most think a care coordinator is ‘just another receptionist/administrator who chases up things’.” (GP.)

The lack of a shared language about what the roles do and deliver is more than a communication issue: the Neighbourhood Health Framework itself calls for *"a fundamental reimagining of the roles, skills and ways of working across health and social care"* [1]. Without a common understanding of function and competency across boroughs, it will be difficult for neighbourhoods to design INT skill mixes that make full and consistent use of the Personalised Care workforce, or to compare and scale what is working from one neighbourhood to another.

At ICB level, focusing on the function and the expected outcomes of the roles could also enable greater understanding and a common language around Personalised Care roles. This would again create more consistent understanding of the roles, regardless of the local priorities and needs in individual neighbourhoods which determine how teams are configured.

“We want to celebrate the kind of diverse nature of these Personalised Care roles and the strength of all of them, and we'll be better off with them all working together rather than creating any sort of division or anything.” (Commissioner)

b. Falling numbers of Personalised Care ARRS roles

A breakdown of ARRS funded roles per borough is given in Appendix 3. It has not been possible to gain a comprehensive picture of the numbers of all the Personalised Care roles across North West London due to the complexity of funding and roles.

There appears to be a reduction in the number of roles employed through ARRS funding.

- In 2025/26 there has been an overall 12.5% decrease in FTE numbers of ARRS funded Personalised Care roles in North West London.
- Specifically, in 2025/26 Social prescribing links workers FTE has decreased by 28% and Health and wellbeing coaches by 16%. Care coordinators have increased by 1% in this time.
- However, some Personalised Care roles, such as Social prescribing co-ordinators in Brent Council, or neighbourhood navigators in Kensington and Chelsea are funded through other sources and are not included in these figures.

This trend runs counter to the direction required by the Neighbourhood Health Framework, which depends on a blended staffing model where non-urgent demand is managed by the most appropriate professional rather than a GP. Over the same period, several more clinical ARRS roles have held steady or grown (Appendix 3), meaning the balance of the primary care workforce is shifting away from, not towards, the mix the Framework anticipates. Because Personalised Care roles are the primary mechanism for diverting non-medical demand away from GP appointments, this divergence between clinical and non-clinical ARRS investment poses a direct risk to the 90% same-day access target and to the wider ambition of shifting activity from hospital to community and from disease to prevention.

Reasons for the decrease identified by stakeholders include:

- The non-clinical nature of the roles and their impact mean GPs and practices may not see an immediate difference in their day-to-day business

"PCNs feel that the clinical pharmacists are adding more value for money because they help "generate income" from QOF/ Enhanced service targets whereas Personalised Care roles help direct patients away from using up GP appointments for non-therapeutic issues." (GP)

- With limited ARRS funding, there is often a choice between Personalised Care roles and more clinical patient focussed roles. Where there is a directive to employ more expensive clinical roles which take up a larger proportion of the budget, there is less capacity for the lower banded roles.

"But the social prescribers, you can't tick-box them because of the nature of the work that they do. So then practices have gone, well, I can employ GPAs or rebadge my HCAs as GPAs. …what they've reduced down, say, the social prescribers down to the bare minimum, maybe one or two. to cover the DES requirement contract." (Personalised Care manager)

- Some of the more traditional Personalised Care ARRS roles may be cut in favour of blended roles which carry out a similar function.

"There can be a role that can be of flavour of the month with these roles, which can really be detrimental to the motivation of others…" (Commissioner)

But some areas are bucking the trend:

"The practices we work with, we've actually increased our numbers. So, we went from having, five or six and seven. I think they realised the importance of it. And we've actually gained the number of social prescribers we had rather than reduce them. So, I think they're all at a point where they do understand the value of the roles". (Personalised Care Manager)

Having a clear understanding of the cost benefit of the roles locally will help with decision making (see recommendation 3).

c. Risk from upcoming contractual reform

Consultation is due to take place on new neighbourhood contracting models, including single- and multi-neighbourhood provider arrangements, alongside the existing primary care DES. These changes are likely to directly affect ARRS funding flows, including the funding that currently supports Personalised Care roles. This creates a risk that, at precisely the point when Neighbourhood Health implementation requires these roles to be embedded within INTs, the funding mechanism that sustains them may be in flux or reduced further. Given the workforce decline already evidenced in this stocktake, we consider funding continuity through this transition to be a significant risk to Neighbourhood Health delivery and recommend the ICB treats this as a priority area for the "value matrix" and strategic commissioning work set out in Recommendations 3 and 4.

Supporting Personalised Care staff

A national 2020 survey showed 29% of link workers considering resigning in the next year due to lack of support [18]. Three years later over half of 343 responders to a questionnaire had considered leaving their role in the past 6 months and just over one-quarter were thinking of doing so in the next 6 months. Lack of peer support, time for training and having supervision less than every two months were some of the factors associated with their thinking [19]. Supervision enables staff to feel more confident in ‘holding’ patients [20].

a. Training

The minimum role requirements for the Personalised Care ARRS roles within the PCN DES includes training accredited by the Personalised Care Institute (PCI), as outlined in appendix 4.

There is no standardised approach to training or CPD. The North West London Training Hub invested circa £550K over three years in PCI accredited Health Coaching training, with approximately 270 staff completing the training. The hub itself offers a variety of courses. Where a larger organisation employs Personalised Care ARRS staff, in-house updates and training may also be organised. But time for Personalised Care training may compete with other mandatory training required by individual organisations.

Training is often self-sourced, particularly for staff employed by individual PCNs and the PCN may need to finance the training.

“We kind of have to figure out where the training is, what the need is, but if we can find it and put enough of a case forward today, they usually help us out.” (Personalised Care Staff)

Being able to access training is important for people's motivation.

"Last year, there was an international trauma conference, four days. I thought this is highly unlikely, but the PCN CEO said 'yes'. Personally, those sorts of things really keep me fired. So, I do love my job and that really is what fires me up." (Personalised Care staff)

b. Supervision

Supervision can take several forms. The PCN DES expects ARRS staff to have access to a first point of contact for general advice and support. In addition, supervision is required as follows:

- Social prescribing link workers: monthly access to clinical supervision with a relevant health professional.
- Health and wellbeing coaches: formal individual and group coaching supervision from a suitably qualified or experienced individual'.
- Care coordinator: supervision provided by a member of staff with relevant competencies and ability to discuss patient related concerns with a GP [21].

Experiences of supervision vary:

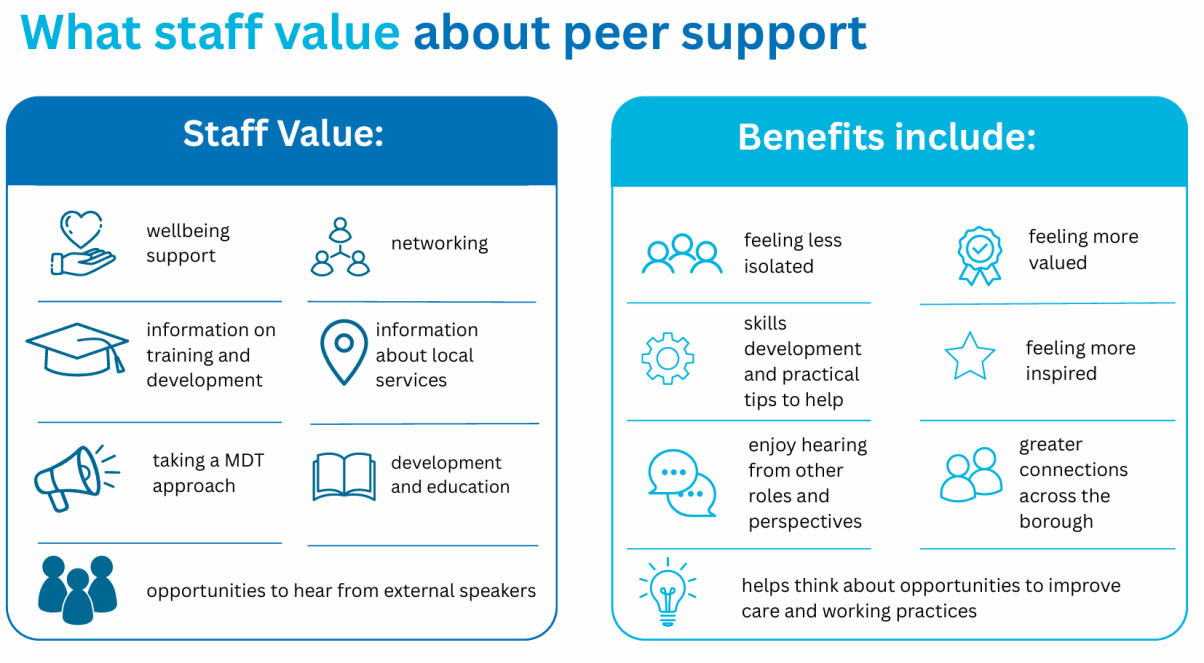
"When we first started, we'd get supervision every few months. Since that person left, we tried to maintain the clinical supervision with one of the partners which became more of 'tell me what you're doing'. But they don't really understand necessarily the process of coaching. And now we are currently on no supervision for anything." (Personalised Care staff)

"Sometimes it's patients we need to be discussing. If it is of concern, then every Thursday morning, I am linked into the surgery meetings I wouldn't say that's a very common, there's not a lot that I feel, I personally feel that I need to discuss or get support about. I'm very, I'm very much on my own with my work, but I feel I'm okay. I get on with it." (Personalised Care staff)

There are good examples in North West London where infrastructure has been put in place to enable management supervision and support. This works well in larger employing organisations where there are managers and people to act as a senior point of escalation, as well as weekly team meetings [22]. Accessible responsive supervision has helped with the implementation of the Community Health and Wellbeing Workers programme in Westminster [23].

Support for supervisors is also important. A new pilot Supervisor Peer Network aims to support ARRS staff who manage others. Meeting bi-monthly, it includes local input as well as teaching in topics such as team-based working, leadership vs management, compassionate leadership and career planning. However, consistent engagement with staff has been a challenge.

c. Peer support



ARRS roles in North West London have benefited from a variety of 'peer support' opportunities. These include:

- ICB-wide peer forums for the three Personalised Care roles and Personalisation Networking days.
- Local role-specific peer support networks e.g. a monthly social prescribing peer support network in Hillingdon with regular involvement from VCF
- SE organisations, training and case discussions.
- Borough specific multidisciplinary peer support networks, online and/or in person.
- As part of the Neighbourhood Health development work, a community of practice for 'navigation' roles (including Community Health and Wellbeing Workers, Community Navigators, voluntary sector coordinators and community champions alongside traditional ARRS roles) and wider community organisations.

The content is broadly similar across the different forums, including:

- Opportunities for networking with other attendees
- Providing clinical and operational updates
- Showcasing different ARRS roles
- Input from external speakers.
- The ICB-wide peer forums and navigator community of practice included 'marketplace' style stalls enabling community organisations to showcase their offer. This has improved awareness of what is available locally and built relationships between different roles and organisations.

However, not all areas have local peer support groups for the different roles, and attendance can be patchy. Where groups exist, staff may not be aware of them. The amount of support people receive to attend these events varies from organisation to organisation.

And like training, time attending external events means less time to work directly with patients.

“For attendance of 'peer support' networks, we are asked to take a day or half a day out of our annual training allowance, which is only 5-days per year. It therefore makes it quite difficult to attend - as I have to negotiate training with peer support.t” (Personalised Care staff)

“I am free to attend; I do sometimes have client work which takes precedence but that is a professional choice due to wishing to meet target or commitment to role.” (Personalised Care staff)

“During induction the [Peer support] meetings are not discussed. I was not sure what they were and thought they would be more for clinical staff.” (Personalised Care staff)

At a system level, there is also the risk that with funding uncertainty, organisational restructure and changing roles, the capacity and central funding to support these networks is no longer available.

d. Career progression

Considering development needs as part of supervision and enabling career progression opportunities encourages people to stay within the sector [19, 22]. This was highlighted at a recent North West London Personalisation day. Comments from Personalised Care staff included:

“I think there needs to be clear career progression for social prescribers - at present, there isn't much opportunity for growth.”

“I would like more discussion with senior management about career pathway training and development.”

“To have leaderships and CPD opportunities - as our clinical colleagues have”

“We've done this training about motivational interviewing and coaching and using those skills, Sometimes I feel I don't really get to use those skills because I'm kind of, I'm just signposting sometimes.”

Several career progression opportunities were identified by interviewees:

- Within larger employing organisations, there may be opportunities to ‘move up the ladder’ and become a coordinator or manager. Some have a policy of recruiting internally recognising this enables career progression for staff.
- The person specialises in a specific area e.g. pain management, housing or business.
- Use the role as a stepping stone into other similar roles for example becoming Nurse Associates, GPAs or explore project management and quality improvement.

There would also be opportunities to move into other parts of the health and care sector, for example going from a primary care ARRS role within a PCN to a more pathway specific role within a Trust, or a community-based role within a VCFSE organisation.

Managing relationships in a complex and varied system

Across our interviews, no single point of accountability for Personalised Care roles within neighbourhood-level governance was identified. Commissioners, PCN leads and Personalised Care staff described decisions about role numbers, funding and configuration being made independently at practice, PCN or borough level, without a designated senior owner able to represent Personalised Care within emerging INT discussions. This absence of a named accountable lead is a structural barrier to the "clear designated responsibility... with accountability sitting with the SRO" called for in Recommendation 1, and helps explain why, despite strong local evidence of impact, investment in these roles has not kept pace with investment in more clinical ARRS roles.

a. Working within primary care

Organisationally, the status of Personalised Care roles within primary care ranges from being ‘bolted on’ but not really part of the primary care organisation, to ‘fitting in’ and finally to ‘belonging’ as an integral part of the team [19, 24]

“Some practices will consider you as part of the core team. Name is on the door when you get there, it's great, you have a little chat. Other practices are not so much that way, where you go in and you're there every single week, and you're like, ‘well, where am I going?’. You're to the side, like an external thing.” (Personalised Care staff)

Integration *is* more likely where there is space for the staff member to be co-located in the building, ‘rubbing shoulders’ with other members of the primary care team, reminding them of their existence and enabling ‘corridor conversations’ to take place.

Feeling part of the team increases job satisfaction and retention and can improve communication with clinicians.

"Myself and only one other colleague cover 5 surgeries. Due to lack of space, we end up being based mainly in one of them. We do tend to get more referrals through the one we're based in because I guess we just get to know the GPs better." (Personalised Care staff)

b. Working within MDTs

Having a blended multi-disciplinary team is essential for Neighbourhood Health to work in practice.

The Personalised Care roles can make a valuable contribution to MDT working, with a 'whole person' emphasis. Some staff already take part in MDT meetings or feel they work as part of a multi-disciplinary team. Others are being included in discussions with health, care and VCFSE colleagues around the formation of INTs

However, feedback from staff is they would like to see more MDT working and the ability to attend MDT meetings where it would benefit the patient.

"We are having problems at the moment getting into MDT meetings. I've emailed practices to bring a patient to an MDT and I've been ignored." (Personalised Care staff)

"I'd like stronger connections between PCNs, charity services and local councils to help everyone included better understand functions and capacity of the services and what to expect from each other while maintaining a patient centred focus." (Personalised Care manager)

Ensuring the Personalised Care roles are included in discussions about integrated working will enable a greater understanding of where they fit within wider teams and enabler greater collaboration, making the most of each other's specific strengths.

c. Working with statutory and voluntary organisations.

In 2025/26, 811 different organisations across North West London were referred to or signposted to via the Joy app including:

- Statutory organisations such as adult social care and housing support, community health and mental health services or equipment services
- Falls prevention groups
- Arts centres, activity or exercise groups

- Support for carers
- Information and advice (particularly around housing or debt)
- Food banks
- Mental health support.

These VCFSE organisations and community initiatives play a part in reducing loneliness and social isolation and increasing social capacity through:

- Facilitating people to make connections by running regular activities/meetings
- Enabling them to feel part of a group or community
- Providing them with something to look forward to in their week
- Allowing them to draw support from others who had been through similar life experiences

Having a vibrant VCFSE sector is vital therefore to the success of the Personalised Care roles, in particular the social prescribing function [25]. Evidence from around the country shows that building good relationships with the voluntary sector contributes to the success of social prescribing [22, 26].

For staff in Personalised Care roles however, it can be time consuming keeping track of what is going on, particularly when funding is cut to services, or they change [22, 27, 28].

> *"Completing a single referral takes quite some time when services to which service users are being referred are not taking referrals or have changed their referral criteria without informing our team." (Personalised Care manager)*

Reductions in statutory and voluntary sector capacity also increases waiting lists:

> *"With the whole neighbourhood thing and working with the voluntary sector, we are trying to always find all what's available. And there's always things are starting and ending and cuts and challenges." (Personalised Care staff)*

> *"One charity, I think had a 60% funding cut last year. So that had a huge knock-on effect. Things like they did home visits to people who are housebound. They would do home visits to help complete forms. That is no longer the case. Another charity does home visits now for that as well, but they're just overloaded, so their waiting list is huge." (Personalised Care staff)*

Examples of good practice in North West London to be continued and built on include:

- Individual staff link with local VCFSE organisations in their area e.g. attending the community hub
- Inviting VCFSE organisations to team meetings as well as providing training for their staff on specific themes e.g. housing and homelessness

- In Hillingdon, the social prescribing manager has set up a community of practice for the voluntary sector, community and social care organisations to get to know them and improve communication.

d. Managing inappropriate referrals

Data from the Joy app shows that between 2021 and 2026, 6.3% of referrals were declined by the service, and 6.8% of the clients either declined or were a 'no show'.

3.4% of 48,000 referrals were declined as inappropriate, with 1.9% 'declined other', and 1% declined duplicate referrals.

As with other areas, staff increasingly find themselves 'holding' patients who are waiting for other assessments, or who have more severe mental health issues alongside their social needs [22]

"There are bits around like how much they do with social services referrals, housing and finance and the level of support they give. Quite a few social prescribers are asked … to do the social services referral. But it should be a halfway house. So that's kind of the scope of practice problems that crop up." (Personalised Care manager)

It helps to have clear referral guidelines for GPs explaining what a service will and will not take.

"There is a huge pressure for social prescribers to work with patients with high level mental health, alcohol or substance misuse, suicide … Social prescribers are worried about pushing back. We are actively working on streamlining the processes for social prescribers so they're not feeling uncomfortable with saying the SOP is currently being updated." (Personalised Care manager)

Demonstrating value

a. Evidence matters

Value has been demonstrated where staff have had data to back up their impact. An example is where care coordinators evidence how many patients have attended screening or vaccinations, or numbers of universal care plans are produced.

"We did stuff around KPIs, which was quite onerous to begin with, it was not popular … But I think getting that objective data, them being embedded there, helped kind of get the trust in the team. (Personalised Care roles manager)

A robust data set (Recommendation 9) would provide better evidence for funding decisions, commissioning and understanding what works so successful models

could be scaled across the system. It is also useful at individual level for service improvement, identifying unmet need and highlighting system gaps.

"Another thing that we're doing in terms of proactive social prescribing. In my last report, I identified that we get low referrals for LTD patients, and we know that maybe they're not as good as maybe reaching out and asking for support or certain ethnic backgrounds. We can't really tell the practices what to do, but we make recommendations." (Personalised Care roles manager)

b. Outcome measures

Developing measures to reflect impact is notoriously difficult [28, 29]. Prevention is particularly hard to measure because it is trying to quantify something that has not happened. However, it is possible to use information on, for example, reduction in activity or increased wellbeing scores to assess the outcomes of an intervention.

Measures collected by some services or pilots include numbers of GP appointments, A&E attendances and Med-3 prescriptions issued before and after a referral, and patient satisfaction with the service.

Several different wellbeing measures have been used over time, including the Patient Activation Measure, Measuring your Concerns and Wellbeing, Warwick-Edinburgh Mental Wellbeing Scale, PHQ-4, and ONS Wellbeing Measure.

Several newly established services are developing their own wellbeing index or identifying additional metrics to better capture wellbeing and preventative impact.

"It's not tangible very often, the results we have. I've had patients who decline my input initially and then three months later they called and they said, okay, now I'm ready. How do we capture that somebody went from crying during the first visit to being constantly smiling and these things. So, I tend to record qualitatively. In terms of what I do record is barriers that I identify, the goals, referrals that we made, signposting that we made." (Personalised Care staff)

The North West London 'Whole Systems Integrated Care' (WSIC) dashboard is a linked dataset across health and social care, which can be used for direct patient care, case finding and managing patients requiring proactive care. Developed as part of Integrated Care, recommended outcome measures include measurement of personal and social goals and prevention [30].

c. Processes for collecting data:

In North West London, staff associated with 335 practices have used the Joy app which provides a data set for these patients. The Joy app includes the ability to accept referrals, track progress of individual cases and refer onwards to community services. There is also an insights dashboard where data is collated.

“The best thing about Joy is it manages your caseload. So, you can see where people are, you can have your waiting list, you can put someone on hold depending on what it is that you're doing. You can directly refer into the local groups and activities”. (Personalised Care staff)

The system integrates with EMIS and SystmOne clinical systems. For non-primary care organisations, Joy Connect Universal enables referrals but, currently, only with full integration, Information governance within an employing Trust has also been a barrier.

Not all the Personalised Care roles use Joy; other services use spreadsheets or clinical systems such as EMIS to refer patients and gather data on activity and impact.

This variation is often due to organisational preference (for example, a service was set up before the Joy App became available and alternative referral pathways in the clinical system are already well established) or information governance barriers.

“So within the borough, 2 PCNs don't use the Joy app. One uses the Joy app just for caseload but works off EMIS, and another PCN uses EMIS solely. For other PCNs, you use Joy correctly. So that's one of the issues because it's not uniform.” (Personalised Care manager)

Variation in what data is collected and how it is gathered makes it very difficult to get a clear picture of referrals, outcomes and workforce numbers. Establishing a common dataset which could be included across all services (with additional local variation where required) would make it much simpler to demonstrate activity and impact (Recommendation 9).

This inconsistency has a direct bearing on Neighbourhood Health delivery, not only on service-level evaluation. Without a common dataset, West and North London ICB will not be able to demonstrate neighbourhood-level progress against the Framework's own goals — for example, the contribution of Personalised Care roles to reducing ED attendance (Goal 4) or improving patient and staff satisfaction (Goal 5) cannot currently be evidenced consistently across boroughs. This limits the ICB's ability to target investment towards the roles and models proven to work locally, and to report progress to NHS England against Neighbourhood Health milestones.

3. Recommendations

Delivering the Neighbourhood Health target of 90% of clinically urgent appointments being seen on the same day requires a blended staffing team and for non-urgent demand to be seen by the most appropriate person, not necessarily the GP.

People with clinically urgent needs will be more likely to attend ED. Vaccination and screening opportunities will be missed, and the health inequality gap will grow wider across populations.

A reversion to primary and community care being reliant solely on medicines prescribing or referral to clinical pathways will increase prescribing costs, secondary care referrals and reactive care. This would limit GPs' ability to provide holistic care and support for people within their local population.

The recommendations below focus on how the Personalised Care roles, as outlined in this stocktake report, can continue to thrive in a changing healthcare landscape, in particularly within the context of Neighbourhood Health.

Recommendations 1, 2, 5, 6 and 9 below share a common deadline of March 2027, aligned to the Neighbourhood Health Framework's target of 90% same-day access for clinically urgent appointments. They are not independent actions but form a single coordinated delivery plan: embedding Personalised Care roles within neighbourhood governance (Rec 1) depends on a shared model of care (Rec 2), clear competencies (Rec 5), a comprehensive map of current provision (Rec 6) and consistent outcome data (Rec 9) all being in place together.

Recommendation 1: Ensure Personalised Care roles are embedded within local delivery frameworks as part of the Neighbourhood Health Programme

As demonstrated in this report, Personalised Care roles are vital to the delivery of the Neighbourhood Health strategy.

A strategic commissioning approach which includes these roles within the Neighbourhood MDT skill mix should be shaped and costed across the ICB in collaboration with primary and community care partners and providers.

This will help in achieving the 90% access for clinically urgent patients by March 2027 through diverting non-urgent demand away from GPs, alongside enhancing patient and staff satisfaction metrics.

The following will be required:

- Clear designated responsibility within West and North London ICB's neighbourhood programme for these roles, with accountability sitting with the SRO.
- Ensuring representatives of each of the Personalised Care roles are included in discussions at programme and neighbourhood level, raising awareness of what is available and build the necessary trust and relationships required to work across organisations and boundaries.
- Development of a clear competency framework (recommendation 5).
- Continued investment in workforce development and retention through training, supervision and peer support (recommendation 6).
- Local leadership and 'champions' who support through clarifying expectations and helping roles become established and 'span boundaries' [23].

Who and by when: ICB and partners by March 2027

Recommendation 2: Use the Comprehensive Model of Personalised Care as the underpinning model of care for neighbourhoods

The Comprehensive Model of Personalised Care is the underpinning model of care for the NHS. We recommend that you use its Operating Model to shape conversations around future delivery of all healthcare and support by INTs. Using this evidence-based model will provide a framework and consistent structured approach, which individual neighbourhoods can then tailor to suit delivery for local priority groups of people, utilising the unique variety of broad community support options available in each neighbourhood.

As well as supporting the Neighbourhood Health Framework, this will contribute towards early implementation of key deliverables within the 10-Year Health Plan for England:

"Support people to be active participants in their own care by ensuring people with complex needs have an agreed care plan by 2027, at least double the number of people are offered a Personal Health Budget by 2028 to 2029, offer 1 million people a Personal Health Budget by 2030, and ensure it is a universal offer for all who would benefit by 2035" [5]

Neighbourhoods should ensure that use of the Comprehensive Model of Personalised Care, and Personalised Care roles are represented, in the discussions about the makeup of INTs.

Who and by when: ICBs and partners by March 2027

Recommendation 3: Understand the cost benefit of Personalised Care roles

We recommend the ICB creates a 'value matrix' which outlines the relative costs and cost benefit of different health and care roles. This will help neighbourhoods carry out a workforce analysis and understand the cost benefit of the Personalised Care roles within the neighbourhood context and new contracting models.

Consultation will be taking place on new contractual options for neighbourhoods, including single and multi-neighbourhood provider models alongside the established primary care DES. This is likely to have a direct impact on funding flows for the ARRS roles.

As already discussed, ARRS funding for Personalised Care is being squeezed as other ARRS staff are employed from the same limited funding pot. The ARRS scheme funding alone is insufficient to resource INTs to the degree needed to deliver the Neighbourhood Health Framework goals.

Some Personalised Care roles are alternatively funded through the Innovation for Health Inequalities Programme (InHIP) monies, Local Authority funds, programme funding through the ICB or grant funding within the voluntary sector. In recent years, some of these traditional funding flows have been disrupted, for example reduction of grants for VCF

SE organisations.

As the Neighbourhood Health Framework is pointing towards a genuine partnership across local authorities, voluntary and community sector organisations and the NHS, understanding the funding framework for the Personalised Care support roles is important. Taking a 'helicopter view' of all the funding resources available for Personalised Care roles in a neighbourhood will give a sense of the total spend.

The time taken for a health coaching appointment or a personalised care and support planning appointment can sound expensive to people because the underlying cultural norm is the cost of a 10-minute GP appointment. A provisional model developed by the National Academy for Social Prescribing estimates a potential average NHS benefit of £418 per patient per year, including GP and primary care savings of £108 per patient per year [31, 32].

Who and by when: ICB by March 2027

Recommendation 4: Include Personalised Care within strategic commissioning intentions for pathways

Personalised Care can support early intervention, prevention and secondary prevention, with services coordinated around the individual. The ICB's strategic commissioning intentions set the local direction and resources, and there is an opportunity to ensure Personalised Care functions are part of these plans. This applies especially for long-term conditions, children and young people, frailty and end of life care.

Commissioning can include:

- Using Personalised Care roles for proactive case finding, self-management, developing personalised care and support roles and linking people to support in their communities.
- Including KPIs around improved health and wellbeing and numbers of personalised shareable care plans (see recommendation 9).
- Ensuring funding for Personalised Care roles is weighted towards areas with higher deprivation. This weighting would also support delivery of national Core20PLUS5 health inequalities priorities, given the strong association evidenced in this stocktake (Appendix 2) between deprivation, higher long-term condition prevalence, and the top reasons for referral into Personalised Care services (finances, housing and loneliness/isolation). Protecting and targeting investment in Personalised Care roles specifically –rather than clinical ARRS roles generally – is likely to have a disproportionately positive impact in the highest-deprivation neighbourhoods identified in the Integrated Needs Assessment.
- Enabling funding flows to support a broader range of sustainable community support options to be available within the community provided by VCFSE and micro-provider organisation.
- Ensuring there is funding delegated to local neighbourhood teams for use by Personalised Care roles for low cost or one-off Personal Health Budgets to help ensure a broader range of community support options can be micro-commissioned to support individuals personalised care and support plans. This will align with the 10-year health plan expansion of personal health budgets.
- Consider inclusion of a function within the Neighbourhood Health teams to support community strengthening, ensuring communities are enabled and empowered to engage in co-production.

Understanding the cost benefits and functions of the roles (recommendations 3 and 5) will support their wider commissioning.

Who and by when: ICB and providers ongoing

Recommendation 5: Develop clear competencies frameworks for Personalised Care roles

The Neighbourhood Health Framework states that *"The shift to neighbourhood health will entail a fundamental reimagining of the roles, skills and ways of working across health and social care over the next decade."* [1]

Taken together, the Personalised Care roles provide a number of functions with associated competencies.

Within a neighbourhood setting, who undertakes these functions may differ from individual to individual, team to team and neighbourhood to neighbourhood depending on context.

We recommend that the ICB develops a clear competencies framework linked to these functions. It should include:

- The skills required for competencies within all of the roles.
- Required training and supervision.
- Routes for career progression such as blended roles or specialisation within the role.

NHS England has outlined competencies for each of the three ARRS roles, which could be used as a basis for a joined-up competency framework. These include:

- Social prescribing link workers: competencies to engage and connect, enable and support, enable community development, safe and effective practice [33].
- Care coordinators: Personalised Care, relationships, communication and continuous learning [34] .
- Health and wellbeing coaches: Professional health and wellbeing coach competencies, communication and enabling in a health coaching context, knowledge of models and frameworks, group work skills to support self-management and group approaches [35.]

Within these conversations about skill mix it is important to also consider what other support would be beneficial and how the Personalised Care roles might be used as connectors to help people access that support. For instance, access to social welfare legal advice.

Through focusing on the functions within the Personalised Care roles neighbourhoods can enable local flexibility but consistent outcomes. This would also enable blended roles and greater potential of career progression.

As Neighbourhood Health develops, the competency framework could support multi-agency working and blended funding or varied organisational hosting of roles (depending on how the ICB uses future contractual options at neighbourhood level).

Who and by when: West and North London training hub by March 2027

Recommendation 6: Develop a comprehensive map of where Personalised Care roles are

It has not been possible within this stocktake to provide a complete picture of all the Personalised Care roles. Across the ICB both duplication and gaps will exist.

Previous work has been carried out by the training hub in North and West London. We recommend that this work continues across the whole ICB as part of the neighbourhood programme.

The competency framework (Recommendation 5) should be used to

- map what functions are already happening and working well across health, care and the voluntary sector
- understand where the gaps are in providing a comprehensive approach to Personalised Care at neighbourhood level.

Using a population health management approach and engaging all the partners in the neighbourhood will then allow contextualisation of these functions with regard to the health needs of the population and appropriate tailoring of the specific roles they employ.

Who and by when: West and North London Training hub by March 2027

Recommendation 7: Invest in ICB-wide training, supervision and peer support for all Personalised Care roles

We recommend that West and North London ICB invests in supporting the Personalised Care roles through ensuring training, supervision and ICB-wide peer support opportunities, which will ultimately contribute to staff job satisfaction and retention.

- The ICB should work with PCNs and other employers to explore career progression opportunities such as specialisation, the move into associated roles or management.
- The expectation of releasing staff for training should be made more explicit across the ICB, and as with clinical roles, time for continuing professional development built into working time.
- Investment in peer support should continue across the newly formed West and North London ICB. Different boroughs have taken different approaches, so for the new offer, it would be good to understand what has worked well as well as having more consistent expectations around taking time out of the 'day job' to attend.

- There should be clear expectations within neighbourhood teams that supervision is included and who is responsible for this, as well as assurance mechanisms to ensure this happens. It is noted that some people struggle to access supervision. There could be a role within the peer support group to check with staff that they are getting the supervision support they need and being the point of contact if it isn't being provided.

Who and by when: ICB, West and North London Training Hub, PCN and other employers ongoing

Recommendation 8: Maximise the opportunities for digital enablement

There are many areas where further investment in digital could enhance Personalised Care roles. Our recommendations include

- Enable Personalised Care roles to be part of local workforce teams through dedicated IT.
- Continue to invest in interoperability including enabling visibility between health and social care.
- Spread and scale digital self-management education via the Personalised Care roles and incorporate it into a coherent pathway of supported self-management, for example, helping people use the NHS App or access the Universal Care Plan (UCP). This will create capacity in other parts of the health service, such as saving time ordering prescriptions via the app or sharing up to date information between services via the UCP.
- Use Population Health Management data and insights to proactively target people with poor health outcomes and likely low levels of patient activation for targeted support.
- Use workforce development to enable understanding of, and capability to deliver, personalised care and support planning to enable spreading and scaling of the UCP.
- Develop a follow on from the UCP to enable support from Personalised Care roles and/or virtual coaching services.
- Developing a digital referral process into SPLW, Health Coaches and Care coordinators from across all care settings. An opportunity could be to scale and spread use of the Joy app across services to streamline the referral process into services. This would also provide visibility of VCFSE and community organisations.

- Support community asset map providers to all move to Open Data standards to enable easy sharing and validation of information on local community groups and activities.
- Map virtual peer support offers for patients and incorporate them into a coherent pathway of supported self-management.
- Invest in digital tools such as recall systems for some administrative processes which could free up capacity for staff to connect with people and services who need it most.
- Commission e-wallet functionality and provide funding for multi-year period to create stability and enable use of one-off Personal Health Budgets to support access to digital equipment/ data, admissions avoidance, support for behaviour change led by Personalised Care roles, as well as discharge teams to expedite warranted discharge for patients on Pathway 0 and 1.
- Promote the awareness and understanding of Personalised Care roles to NHS workforce and management through regular digital communications.

Who and by when: ICB and providers ongoing

Recommendation 9: Develop a standard set of local metrics to demonstrate impact

The variation in how and what data is collected makes it difficult to understand the overall impact of the Personalised Care roles.

Guidance for evaluating Personalised Care outcomes recommends exploring four areas to help understand the impact of these roles [36].

They are:

- Health and Wellbeing
- Staff and patient experience
- Use of health and care services
- Value for money

The Joy app is used by a large number of PCNs for social prescribing and health and wellbeing coaching, however even within the one platform there is inconsistency in how it is used. In particular very few outcome measures are captured.

Alongside this, other services are using other platforms such as the clinical system (EMIS/SystmOne) or spreadsheets and/or developing their own outcome metrics. It is very difficult therefore to compare the relative impact of different services and understand what works best from an individual or staff perspective.

We recognise that this is a country-wide issue however having a basic set of local metrics that is written into all service specifications would enable a better understanding of what works, and the difference personalised care approaches make.

This includes:

- Agreeing a standard reporting framework and including this within the ICB performance monitoring for neighbourhood health.
- A defined and limited set of SNOMED codes to be consistently used within primary care settings.
- A patient reported outcome measure for example the Health Confidence Scale (see appendix 6).
- Using the value matrix to calculate the cost of services and savings.
- Number of personalised care and support plans held within UCP, supporting the Neighbourhood Health ambition of an additional 95% of people with complex needs having an agreed care plan by 2027.

Who and by when: ICB Neighbourhood programme by March 2027

List of useful resources

Policy Documents

Fit for the Future: 10 Year Health Plan for England: https://www.england.nhs.uk/long-term-plan/

Neighbourhood Health Framework: https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework

Primary Care Networks: Network Contract Directed Enhanced Services: NHS England » Primary Care Networks: Network Contract Directed Enhanced Service from April 2026

Personalised Care

Personalised Care NHS England Guidance: https://www.england.nhs.uk/personalisedcare/

Personalised Care ARRS roles: https://www.england.nhs.uk/gp/expanding-our-workforce/#personalised-care-care-coordinators-health-and-wellbeing-coaches-and-social-prescribing-link-workers

Personalised Care Institute and ARRS roles: Arrs roles - Personalised Care Institute

Workforce development frameworks

Social Prescribing: https://www.england.nhs.uk/publication/workforce-development-framework-social-prescribing-link-workers/

Health and wellbeing coaching: https://www.england.nhs.uk/publication/workforce-development-framework-health-and-wellbeing-coaches/

Care coordinators: https://www.england.nhs.uk/publication/workforce-development-framework-for-care-co-ordinators/

National Associations

Personalised Care Institute (hosted by Royal College of General Practitioners): https://www.personalisedcareinstitute.org.uk/

National Academy for Social Prescribing: https://socialprescribingacademy.org.uk/

UK and International Health Coaching Association: https://www.ukihca.com/

Glossary

Additional Roles Reimbursement Scheme (ARRS)

This scheme, which expanded the number of roles in primary care, was introduced in 2017. Primary care networks are able to claim for the salaries of these roles. Currently 17 roles are part of the scheme[37].

Integrated Care Board (ICB)

An ICB is a statutory organisation which brings together NHS and care organisations locally to improve population health and establish shared strategic priorities in the NHS. They are designed to support strategic commissioning in order to best meet local needs.

Integrated Neighbourhood Teams

These are local teams of different professions and partners who work together to support people, delivering assessment, care planning, co-ordination and follow-on support. The team's members vary from area to area based on the needs of the local populations and will be predominately based in primary and community settings.

Neighbourhood Health

This focus includes many different ideas, policies and approaches such as bringing together services across health, social care and the local community, a focus on prevention, personalised care and community-led approaches to care which is delivered closer to home and across a particular geography (neighbourhood) The Neighbourhood Health Framework was published in March 2026 [1].

Primary Care Network Directed Enhanced Service (PCN DES)

This is a contract which provides additional funding to GP practices who work together as Primary Care Networks. It supports national healthcare priorities and aims to improve co-ordinated and proactive care at a primary care level.

VCFSE organisations

These are Voluntary, Community, Faith and Social Enterprise Organisations who work within local communities to promote health, wellbeing and social cohesion.. Many have contracts to deliver health and care services on behalf of the NHS or Local Authority, while others are signposted to by Personalised Care staff. There are alliances of VCFSE organisations throughout England [38]

Appendices

Appendix 1: How the report was put together

This report draws on multiple sources of information:

- Eighteen semi-structured interviews were conducted between February and May 2026 with stakeholders from a wide range of backgrounds, roles and perspectives relating to the Personalised Care across North-West London. See below for full details
- Survey for staff working in personalised care, conducted at a Personalisation Day on 6 March. Staff were asked:
  - What do you celebrate about your role?
  - What frustrates you about your role?
  - How would you like your role to develop in the future?
- Existing presentations including detail about current services and some of their outcomes.
- Workforce data and a download of data from the Joy app with quantitative insights to compliment the qualitative findings.

Thematic analysis was carried out during April and May 2026. Each interview was analysed by two team members to give more objectivity and to ensure a more in-depth analysis. A full list of stakeholders is below. Anonymised quotes from interviews and other sources have been included in the report.

In addition, a literature search of relevant publicly available evidence and policy documents was carried out, the references used are listed at the end of the report.

Following analysis, recommendations were developed collaboratively by members of the research team and tested against existing evidence and policy.

Name	Role	Organisation/area
Blessings Ncube	Head of PCN Strategy and Development	Hounslow GP Consortium, West London NHS Trust.
Charlotte Miller	Health Equity team	NWL ICB
Denise O'Brien	Social Prescriber and SP Team Leader	Hillingdon
Helena Stokes	Programme Implementation Lead	Hounslow GP Consortium
Javina Sehgal & Jiggy Triveda-Gardner	Director of Primary Care	NWL ICB
Joe McGale	Assistant Director of Place	West London
Jonathan Ord	Workforce Pathway Lead	NW London Training Hub

Josh Norman	Health and wellbeing coach	Hammersmith and Fulham
Kalwant Sahota	Personalised Care Programme Lead	NWL
Katerina Skalicka	Social Prescriber - Community Respiratory	Imperial College Healthcare NHS Trust (Inner London boroughs)
Madvhi Joshi	Deputy Clinical Director, Harrow Collaborative PCN and a GP champion	NWL
Maggie Neale	Head of Primary Care Workforce	NWL ICB
Mehrnoush Bakhashz	Manager Personalisation	Brent Mencap
Michelle Conway	Social Prescribing Link Worker	Hammersmith and Fulham
Shelley Reynolds	Head of Health and Wellbeing	One Westminster
Tony Willis	Personalised Care GP Clinical Lead	NWL
Yoel Berhane	Senior Programme Manager – Public Health	Brent

Appendix 2: Priority health needs and referral reasons to Personalised Care roles.

The North West London Strategic Needs Assessment has identified local priority areas for each borough. These are outlined below alongside the top 5 reasons for referral for social prescribing and health coaching as recorded on the Joy app.

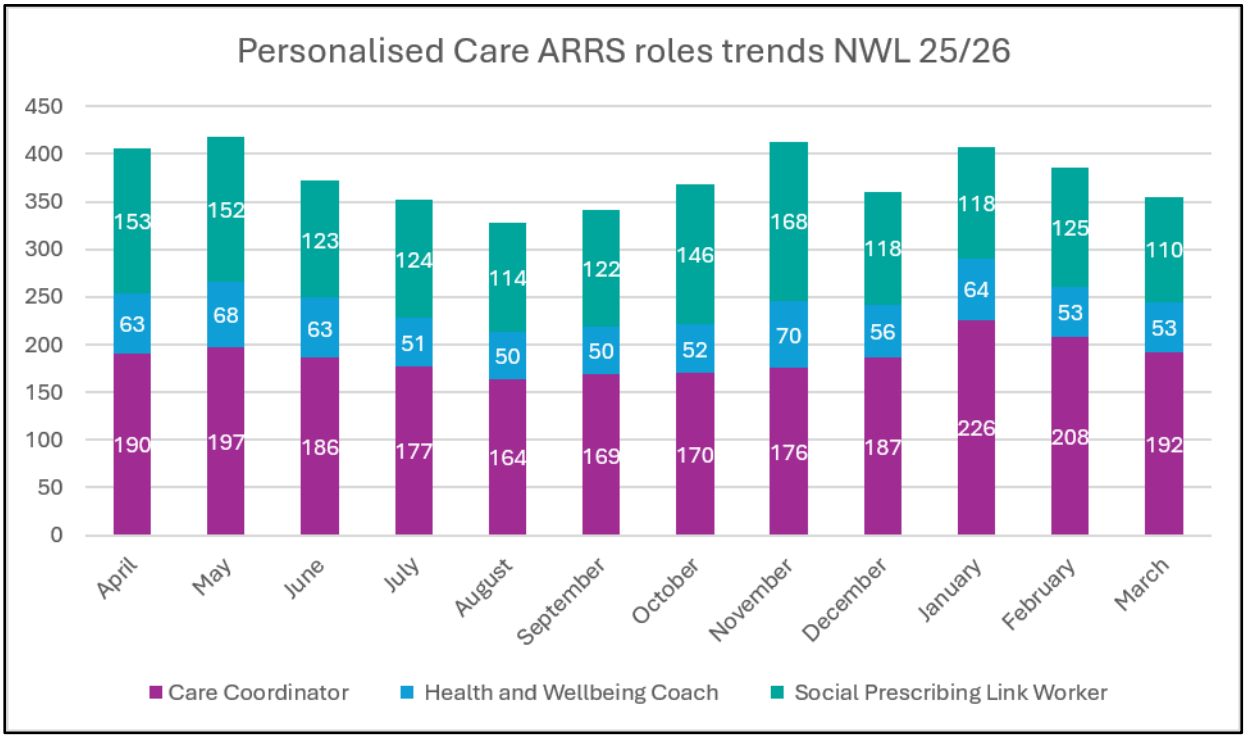
Borough	Rate relative to overall NWL measures.	Top 5 referral reasons to social prescribers/Health and wellbeing coaches via the Joy app
Westminster	Higher rate of healthy population Higher rate of Serious Mental Illness, cancer and depression	Sedentary lifestyle25% Loneliness/isolation 24% High body weight 19% Mental health 10% Not mapped 5%
Ealing	Larger proportion of healthy children and children with long term conditions Highest rates of physical activity, alcohol abuse and CHD	Mental health 21% Finances 17% Loneliness/isolation 11% Housing problem 10% Caring responsibilities 9%
Brent	Highest rates of hypertension, diabetes and chronic kidney disease Higher undiagnosed hypertension in Black and Asian ethnic groups and in the most deprived areas	Not mapped 22% Housing problem 14% Finances 10% Managing a long-term condition 9% sedentary lifestyle 9%
Kensington and Chelsea	Greater proportion of over 65s with LTCs but fewer over 18-64s Higher proportions of Serious Mental Illness and Depression, particularly in Core20 areas. COPD highlighted as an issue	Housing problem 24% Finances 23% lLoneliness/isolation 10% Sedentary lifestyle 7% Not mapped 6%
Hammersmith and Fullham	Generally healthier population Highest prevalence of cancer, COPD and depression	Not mapped 26% Housing problem 17% Finances 14% Loneliness/isolation 10% Caring Responsibilities 6%
Harrow	Generally older population with higher rates of long-term Conditions	Finances 19% Loneliness/isolation 15% Caring responsibilities 14% Not mapped 10% Mental health 9%
Hounslow	Population similar to average Higher rates of diabetes, obesity, CHD and hypertension	Finances 21% Loneliness/isolation 19% Mental health 12% Caring responsibilities 10% Sedentary lifestyle 9%

Hillingdon	Higher rates of smoking, lower rates of blood pressure checks and flu vaccinations. Greatest number of LTCs that are higher than NWL average	Finances 19% Mental health14% Loneliness/isolation 13% Caring responsibilities 10% Sedentary lifestyle 8%

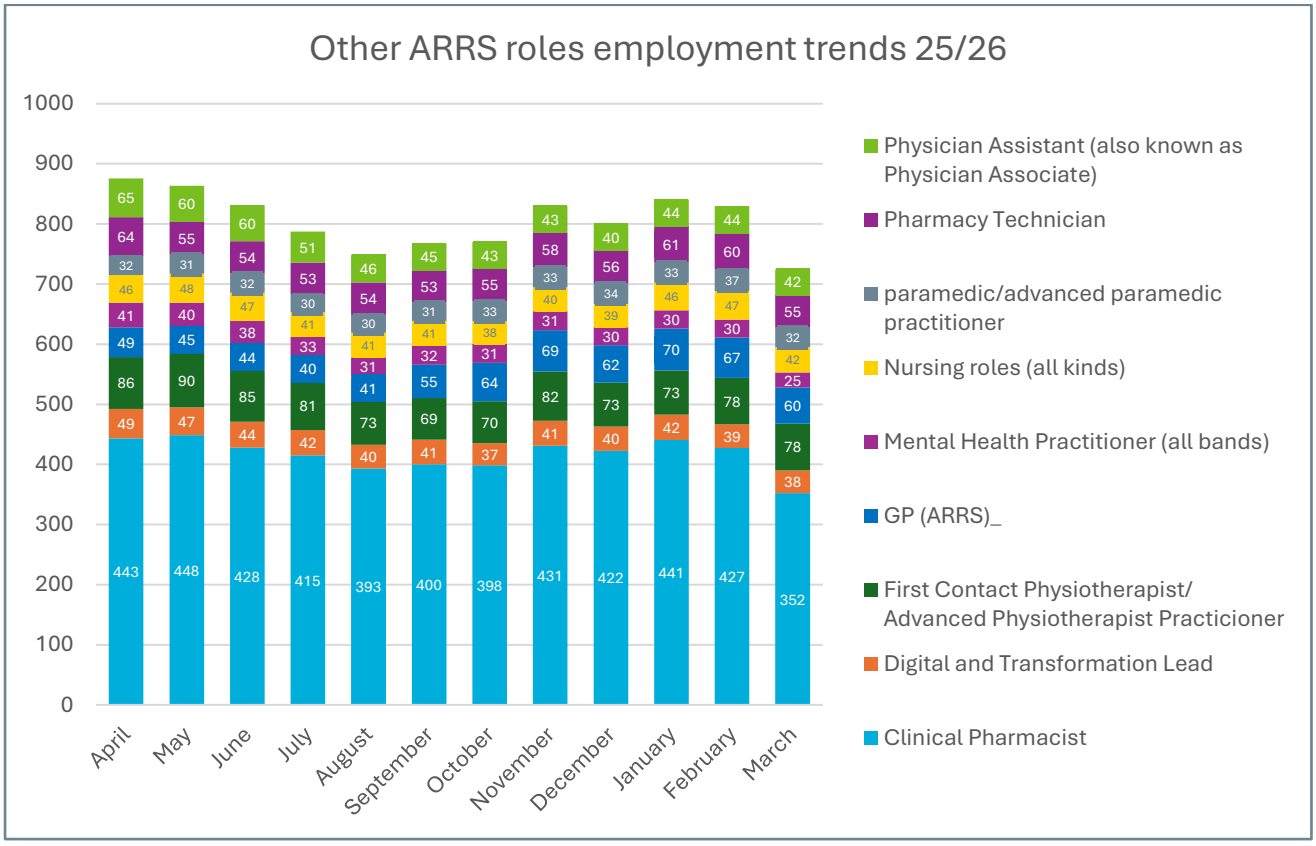
Appendix 3: Numbers of ARRS roles FTE across NWL

Place Name	Employee Role	April 2025	March 2026	FTE change
Brent	Care coordinator	4	11	+7
	Health and wellbeing coach	4		-4
	Social prescribing link worker	33	26	-7
Central London	Care coordinator	30	37	+4
	Health and wellbeing coach	36	39	+2
	Social prescribing link worker	12	9	-3
Ealing	Care coordinator	13	18	+5
	Health and wellbeing coach	1	1	0
	Social prescribing link worker	22	16	-6
H&F	Care coordinator	11	12	+1
	Health and wellbeing coach	8	7	-1
	Social prescribing link worker	20	14	-7
Harrow	Care coordinator	35	33	-2
	Health and wellbeing coach	1	1	0
	Social prescribing link worker	10	8	-2
Hillingdon	Care coordinator	37	47	+10
	Health and wellbeing coach	9	2	-7
	Social prescribing link worker	13	15	+2
Hounslow	Care coordinator	40	26	-14
	Health and wellbeing coach	2	2	0
	Social prescribing link worker	30	10	-20
West London	Care coordinator	20	8	-14
	Health and wellbeing coach	3	2	-1
	Social prescribing link worker	14	12	-2
		406	**355**	**-61**

This graph shows the figures for 25/26 in ARRS funded Personalised Care roles reported to the ICB, as of April 2026



The following graph shows employment trends for some more clinical ARRS roles in 25/26



Appendix 4: Examples of different roles and employment models

Many of the roles are employed directly by the PCN, working across one or more practices within a PCN, for example two Health and wellbeing Coaches in Hammersmith and Fulham Partnership PCN, or the two Central Hammersmith and Fulham PCN social prescribers.

Some PCNs use the ARRS funding to subcontract the employment to other organisations, such as the team of 17 social prescribers in Hillingdon who are employed by The Confederation Hillingdon CIC and work across 6 PCNs, the Brent Primary Care Social Prescribing team who are employed by Mencap or the Care Coordination Support Team working across 5 PCNs in Harrow but are employed by West London NHS Trust (this group also have some funding from the ICB).

Blended roles such as Community Health and Wellbeing Workers in Westminster and Chelsea are employed by Central London Healthcare CIC (in partnership with other organisations). They work within primary care and are funded as part of the ARRS programme. Neighbourhood Navigators in South Kensington and Chelsea also have an expanded care navigation function with GP practices including case load referrals and drop-in services at health and wellbeing hubs.

There are a number of social prescribing or care coordination roles in existence outside of primary care. Care Navigators have been working in Brent since 2016 as part of a multi-disciplinary Complex Patient Management Group. They have a social prescribing type role but provide longer term support for predominately complex housebound patients.

There is also a pilot project with social prescribing coordinators employed by Brent Local Authority and part of the Adult Social Care workforce. They provide support to people who may not go to GP or meet the threshold for social care support, but who could be signposted into the local community. They also train other social staff to take a ‘social prescribing approach’ in their work

The longstanding ‘My Care, My Way’ service in Kensington & Chelsea and some parts of Westminster is part of Central London Community Healthcare Trust, their Health and Social Prescribing Coordinators work alongside GP practices and voluntary sector organisations. They deliver care planning and care co-ordination to people aged 65+, living with frailty or those affected by the Grenfell fire.

Other non-primary care roles focus on specific pathways, such as the Respiratory Social Prescribers who are employed by Imperial College Healthcare NHS Trust and embedded in the Integrated Community Respiratory. The social prescriber supports people who do not currently meet the threshold for pulmonary rehabilitation or who experience barriers accessing it.

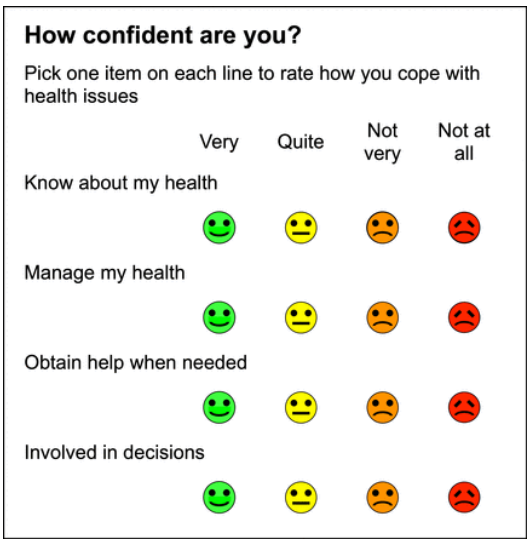
Appendix 5: PCI training and education standards [39]

Role	Minimum training requirement	Recommended training from PCI
Social prescribing link worker	• Mandatory HEE e-learning programme: Social Prescribing - Learning for Link Workers • Level 3 accredited training or apprenticeship from PCI approved list	• Personalised Care skills • Person-Centred Approaches • Personalised Care and Support Planning
Health and wellbeing coach	• Four-day PCI accredited health coaching training • Or Level 3 apprenticeship from PCI approved list	• Personalised Care and support planning • Shared decision making • Healthy Coach weight training
Care coordinator	• Two-day PCI accredited Care coordinator training • Or Level 3 apprenticeship from PCI approved list • Personalised Care and Support planning e-learning • Shared decision-making e-learning	• Healthy weight coach training • Person centred approaches

Appendix 6: The health confidence scale

20% of the North West London population have Cardio-Renal-Metabolic (CRM) conditions and constitute 70% of NWL admissions [40]. The proposed service across primary care moves from single disease silos to multidisciplinary, personalised care for people with overlapping conditions.

The service specification includes the Health Confidence scale [41, 42] as an outcome measure, and several interviewees recommended its widespread adoption as it is available in multiple languages, is codable in SNOMED and integrates with Accurx and SystmOne questionnaires.



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About the Coalition for Personalised Care

The Coalition for Personalised Care is a movement of people with lived experience of health care and their representative bodies, health providers, and commissioners.

We believe that what matters most is health care that is personalised and enables people to live the lives they want, and we are committed to ensuring that Personalised Care is an everyday reality for everyone using health and care services in England.

Find out more at www.coalitionforpersonalisedcare.org/