NHS England London

How the London Region can enable the Left Shift

Commissioning digitally-enabled, coordinated, and systematic support for self-care

Version: 0.1
Date: 08/01/2026

This document will be reviewed and re-released to reflect new and emerging evidence as appropriate. This London guide is designed to complement and not replace local guidance and professional judgement. It will be updated to align with other national and regional guidance once published.

Introduction

The ‘Why’ behind the Proposed Change

The NHS is fundamentally reactive but wants to change

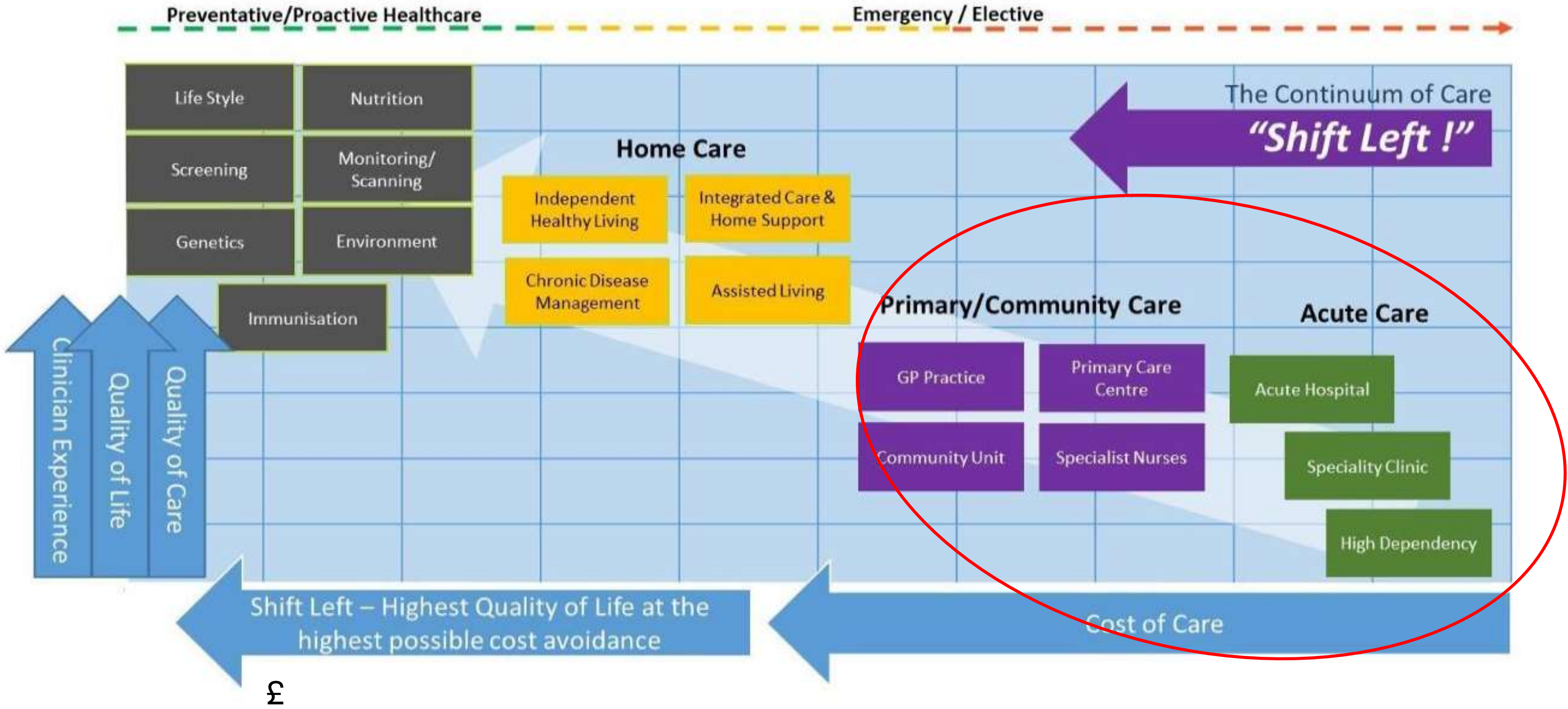
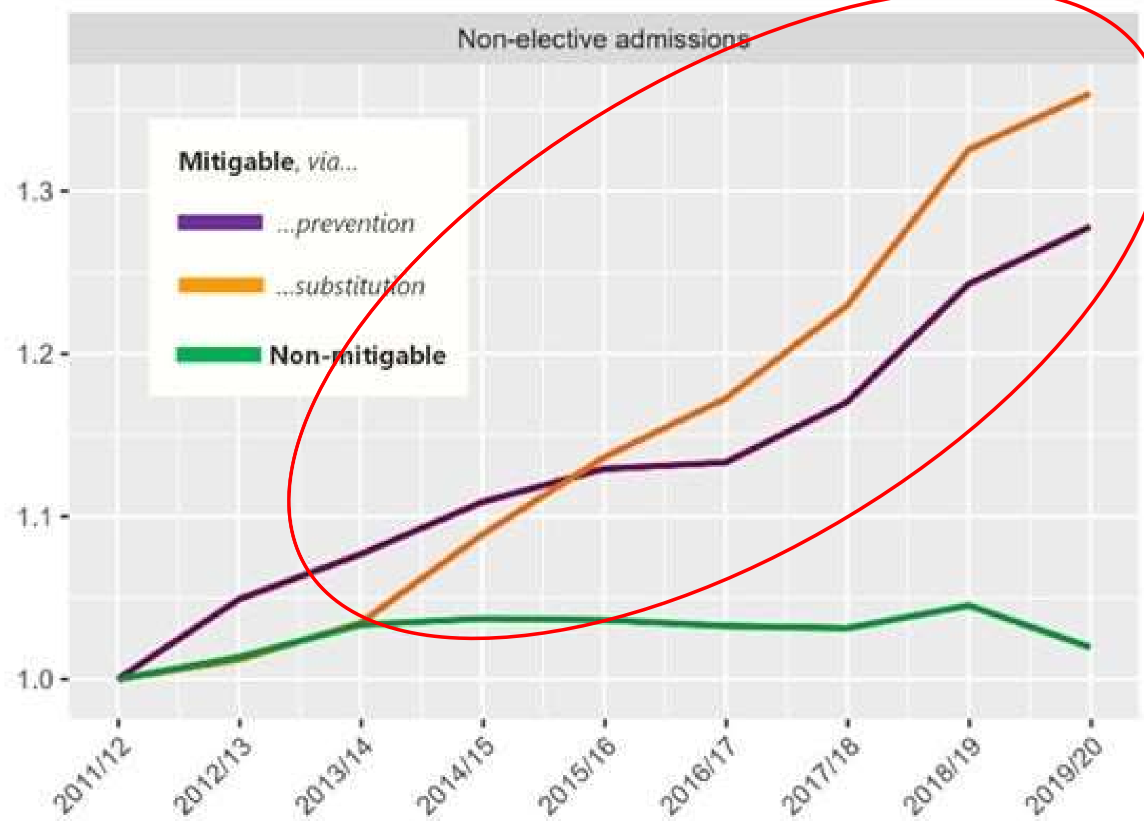


Figure 1 Stay Left, Shift Left – source M Curley

https://www.stgeorgeshouse.org/wp-content/uploads/2024/11/The-Digital-Transition-for-Healthcare-Curley-Stay-Left-Shift-Left-v1.0f-IVI.pdf

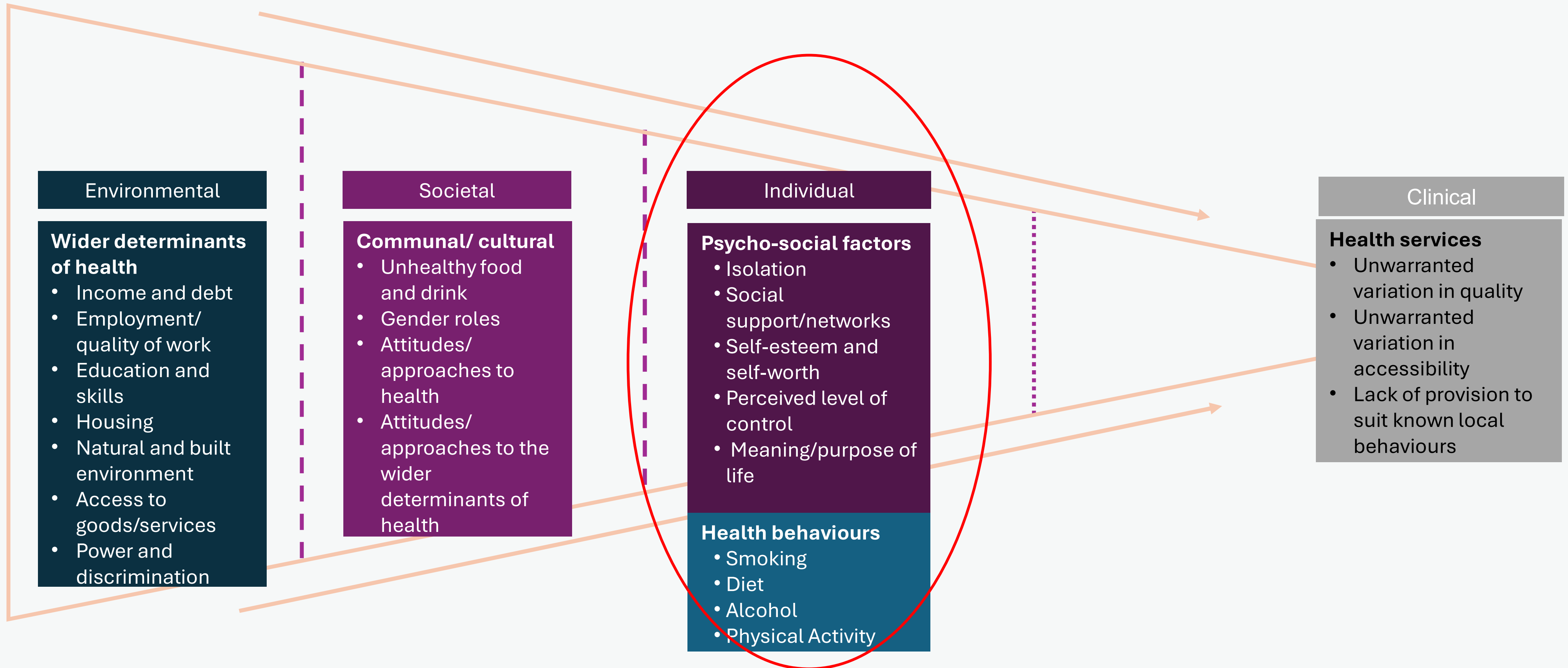
Where do you start the Shift Left?



https://integratedcarejournal.com/shifting-care-in-birmingham-and-solihull/

Demand is driven by forces outside healthcare

The **'Funnel of inequalities'** model shows **how different factors concatenate to drive ill-health**. It also shows the approximate impact of these factors on health outcomes and inequalities of access, experience and outcomes. **Healthcare services** are estimated to **contribute 20%** to people's health **outcomes*** **



*-https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health
McGinnis, J.M., Williams-Russo, P. and Knickman, J.R. (2002) The case for more active policy attention to health promotion. Health Affairs 21 (2) pp.78-93.
Canadian Institute of Advanced Research, Health Canada, Population and Public Health Branch. AB/NWT 2002, quoted in Kuznetsova, D. (2012) Healthy places: Councils leading on public health. London: New Local Government Network. Available from New Local Government Network website
Bunker, J.P., Frazier, H.S. and Mosteller, F. (1995) The role of medical care in determining health: Creating an inventory of benefits. In, Society and Health ed Amick III et al. New York: Oxford University Press. Pp 305-341.
** Institute for Clinical Systems Improvement https://www.icsi.org/wp-content/uploads/2019/08/1.SolvingComplexProblems_BeyondClinicalWalls.pdf

People's management ability drives their behaviours, outcomes and service usage*

The concept can be quantified by the Patient Activation Measure (PAM) by a score (0-100) and a Level (1-4). People's ability to manage their health can be characterised by PAM Level.

Patient Activation	Characteristics
Level 1	Individuals tend to **feel overwhelmed** by managing their own health or health conditions and may not: feel able to take an active role in their care; understand what they can do to manage their condition; take their medication; attend preventative appointments; see the link between healthy behaviours, and managing their condition.
Level 2	Individuals **may be able to manage** some aspects of their health (for example, take their medication and attend appointments) **but still struggle** in some aspects of their care
Level 3	Individuals appear to be **taking action**, for example setting goals for their health or creating a care plan with clinicians, but may still lack the confidence and skill to maintain these
Level 4	Individuals **have adopted behaviours** and practices **to manage their condition**, such as good medication adherence, care planning or self-monitoring. Patients occasionally still need extra support, e.g. to recover from a relapse, or when life stressors make it difficult to maintain their practices

Research indicates that between **25-40%** of a given population will have the lower Activation Levels 1-2**, and they will drive a disproportionate amount of service usage and have the worst health outcomes. We see this reflected in the Islington Health Foundation study and in NCL's risk stratified population.

Patient Activation levels in Islington in 2018 Health Foundation study***

Population Patient Activation Breakdown	
Level 1	22%
Level 2	19%
Level 3	46%
Level 4	13%

41%

NCL Risk Stratified Hypertensive population

Hypertension (HTN)	Head count	% of HTN population
High Risk + Complexity	1,977	1.09
High Risk	21,323	11.72
Medium Risk	38,498	21.16
Low Risk	120,108	66.03
Total	181,906	

34%

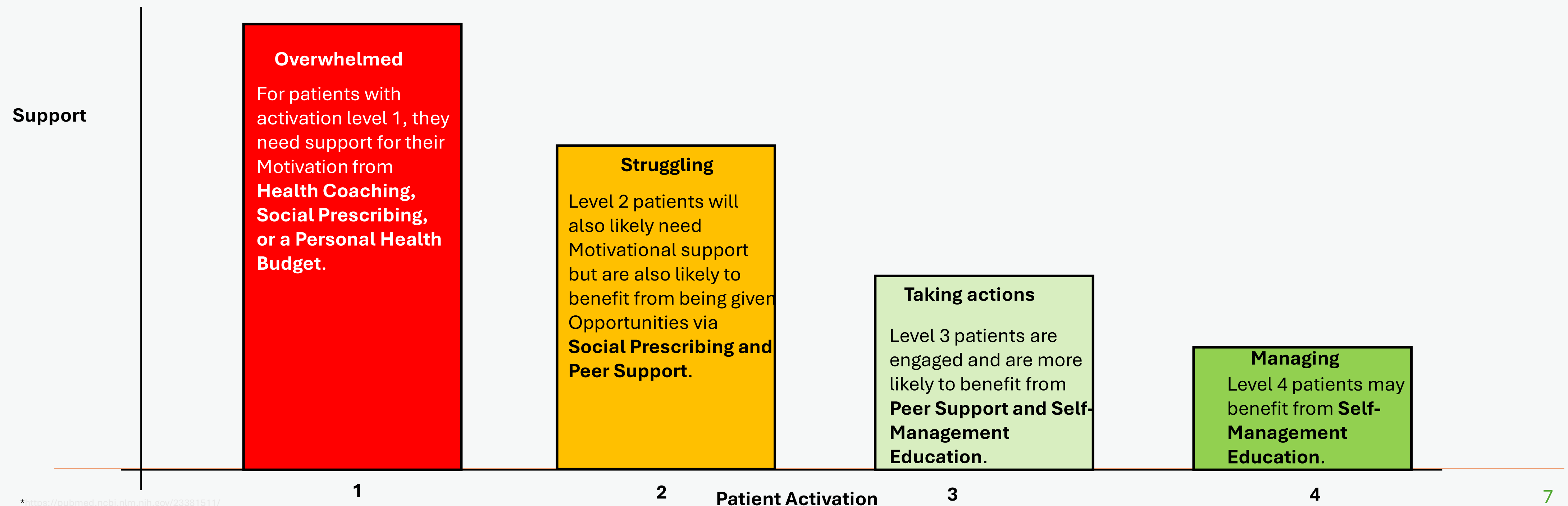
*Greene J, Hibbard JH, Sacks R, Overton V, Parrotta CD. When patient activation levels change, health outcomes and costs change, too. Health Aff. 2015;34(3):431–7. https://doi.org/10.1377/hlthaff.2014.0452.

** Hibbard JH, Cunningham PJ (2008) 'How engaged are consumers in their health and health care, and why does it matter?', Health System Change Research Briefs, (8) 1–9

***p7, https://www.health.org.uk/sites/default/files/Reducing-Emergency-Admissions-long-term-conditions-briefing.pdf

This has implications for managing population health

Patient Activation can be helped to improve*, and this is most effective when support is **tailored to different Patient Activation levels.** This way sustainable improvements can be made to patients' health and wellbeing over time. The **lower the Patient Activation, the more (and more intense) holistic support patients need** to manage their health and wellbeing.**



* https://pubmed.ncbi.nlm.nih.gov/23381511/

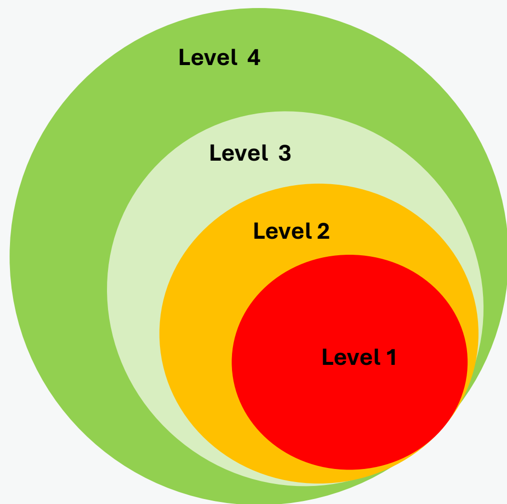
** https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/supporting-people-manage-health-patient-activation-may14.pdf, p11

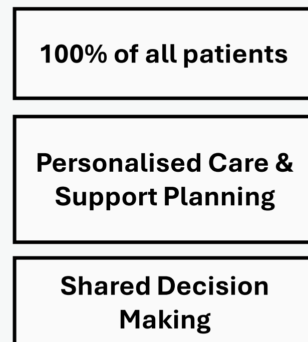
We can develop a support offer to meet that need

Personalised Care interventions broadly align to the **COM-B model of change**. Where a complex interaction of **Capability, Opportunity** and **Motivation** combine to drive Behaviour. The **most fundamental** of those factors is **Motivation**, and that is the primary cause of low Patient Activation.

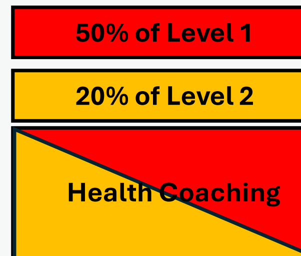
The diagram below shows a systematic supported self-management pathway. **Personalised Care and Support Planning discovers what matters to the patient,** and then **provides them with a suitable intervention**.

For modelling purposes we have estimated the support requirements of patient cohorts aligned to the different Patient Activation Levels. E.g. 100% of Level 1 need motivational support from Health Coaching or Social Prescribing but 20% of that group may benefit from a Personal Health Budget.

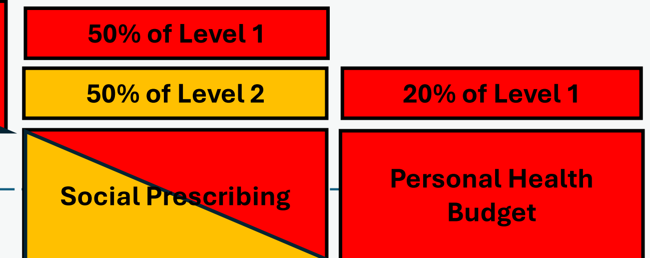




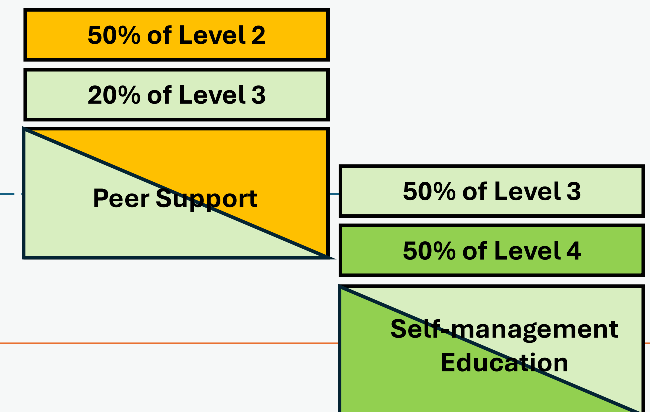
Motivation



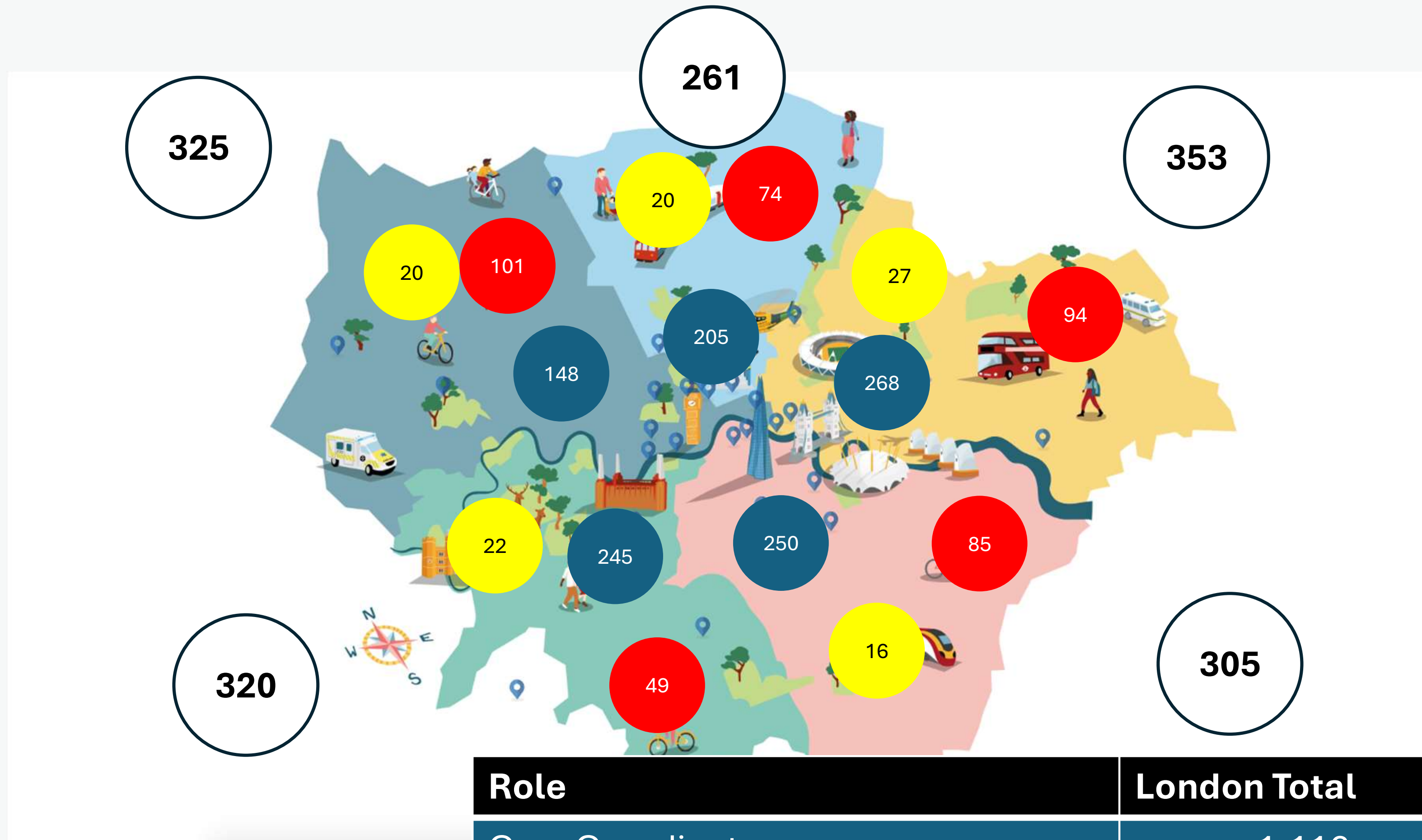
Opportunity



Capability



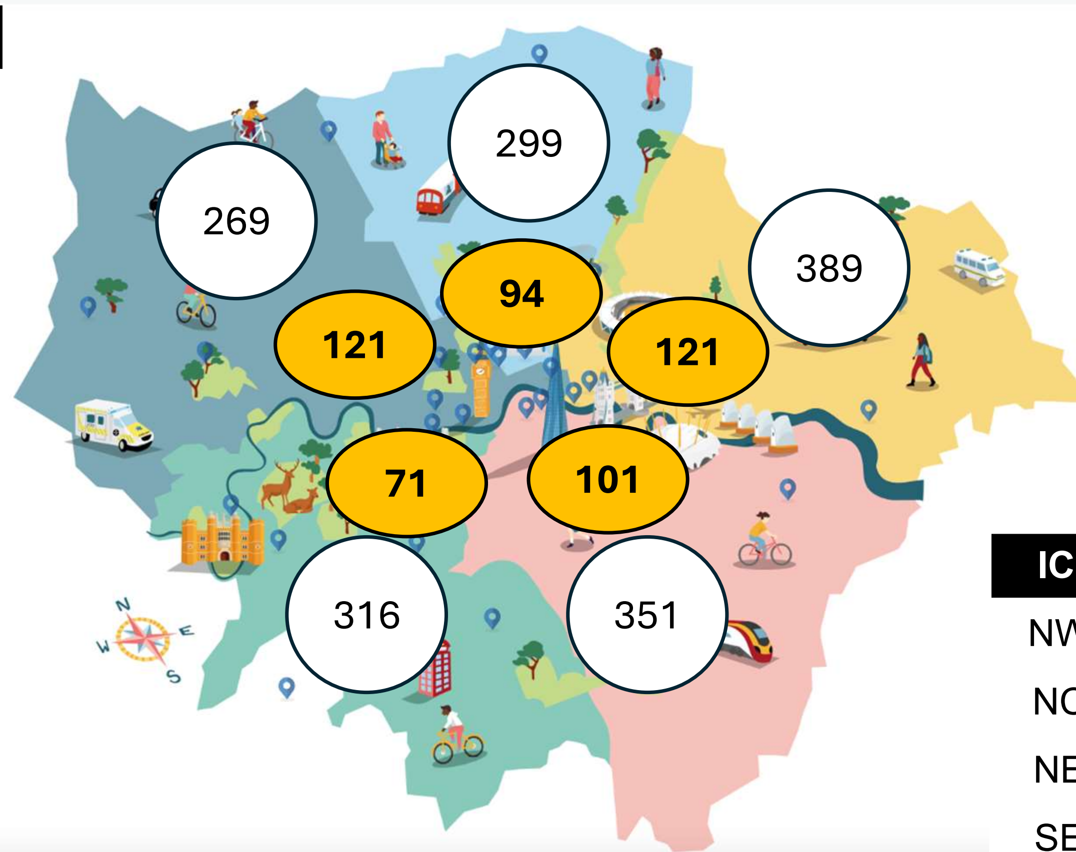
So how do we stack up in London? (01/12/25)



Role	London Total
Care Coordinator	1,116
Social Prescribing Link Worker	403
Health & Wellbeing Coach	105

But we are far from the Capacity required to address the Need

ICB	Pop	Need
NWL	2.4m	240k
NCL	1.8m	180k
NEL	2.0m	200k
SEL	2.0m	200k
SWL	1.5m	150k

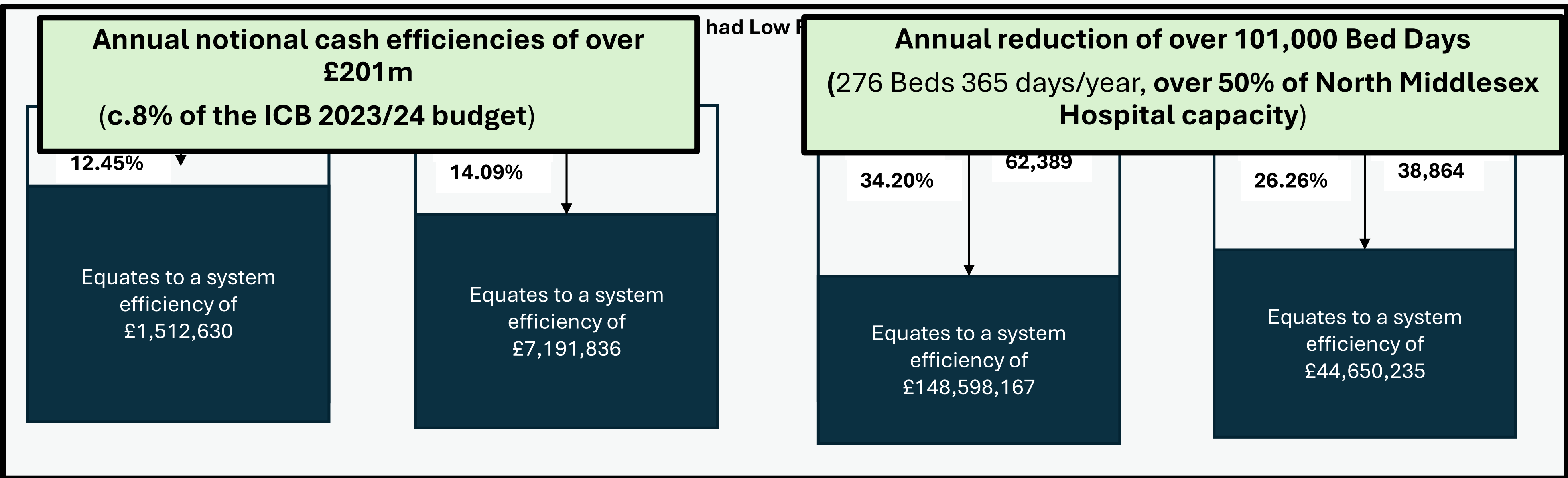


ICB	Roles req	%
NWL	1,200	**10.1**
NCL	900	**10.4**
NEL	1,000	**12.1**
SEL	1,000	**10.1**
SWL	750	**9.5**

If the Need were substantially met, the impact would be significant

A Business Case for Personalised Care in London looked at NCL's Hypertensive (HTN) cohort and showed that there was a **strong correlation between people's quantified ability to manage, their health outcomes and their service usage**. Namely, those that can manage least well have the worst outcomes and the highest levels of service usage. That demand stemming from this need was significant.

Approx. **62,000 people** (34.1%) of that HTN cohort, who had sub-optimal outcomes **generated unmitigated demand of c.£200m of service activity**



An improvement in activation and health outcomes has a significant impact on service usage

A key insight from the Health Foundation study* was that the **difference in service usage even between people with Level 1 and Level 2 is significant**. These differences in usage are observed across all Points of Care (below)

Elective Care usage

Difference in Elective Admission vs PAM Level 1	
Level 1	
Level 2	**-16%**
Level 3	-23%
Level 4	-20%

Difference in Overnight Elective Admission LoS vs PAM Level 1	
Level 1	
Level 2	**-33%**
Level 3	-33%
Level 4	-41%

Difference in Outpatients attendance vs PAM Level 1	
Level 1	-
Level 2	**-10%**
Level 3	-13%
Level 4	-19%

Difference in Outpatients DNA vs PAM Level 1	
Level 1	-
Level 2	**-22%**
Level 3	-32%
Level 4	-28%

Urgent and Emergency Care usage

Difference in Emergency Admissions vs PAM Level 1	
Level 1	-
Level 2	**-29%**
Level 3	-34%
Level 4	-38%

Difference in 30 day emergency readmission vs PAM Level 1	
Level 1	-
Level 2	**-7%**
Level 3	-22%
Level 4	-32%

Difference in ED Attendance vs PAM Level 1	
Level 1	-
Level 2	**-24%**
Level 3	-27%
Level 4	-32%

Difference in ED Attendance w. Minor vs PAM Level 1	
Level 1	-
Level 2	**-9%**
Level 3	-23%
Level 4	-33%

Primary Care usage

Difference in GP Attendance vs PAM Level 1	
Level 1	-
Level 2	**-8%**
Level 3	-13%
Level 4	-18%

Difference in DNAs for GP appointments vs PAM Level 1	
Level 1	-
Level 2	**-9%**
Level 3	-15%
Level 4	-23%

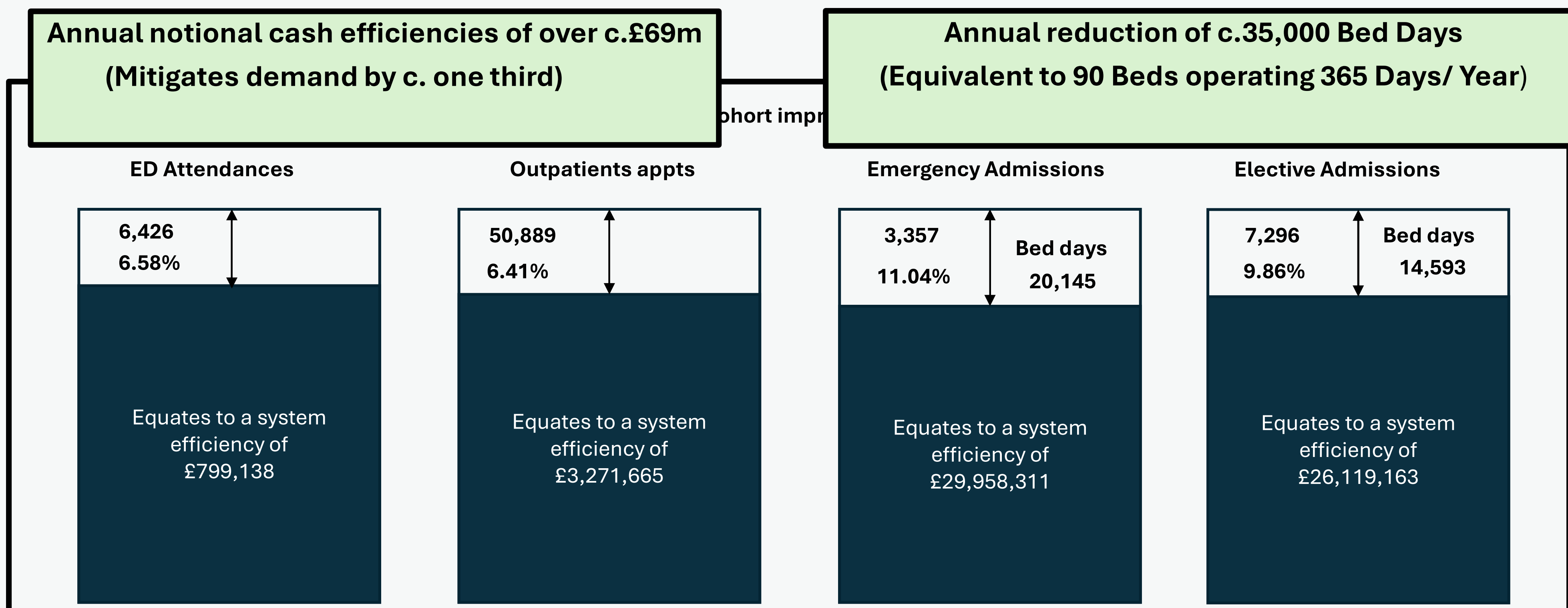
* https://www.health.org.uk/sites/default/files/Reducing-Emergency-Admissions-long-term-conditions-briefing.pdf

Improving activation would support population health and reduce pressure on services

The total NCL HTN population is c.181,000.

The patient cohort who struggle to maintain their BP within range (Medium Risk and above) number c.62,000.

The graphic below shows that if **80% of the prioritised group** could be supported to **improve their Patient Activation** from 1 to 2, or from 2 to 3, the efficiency would be:

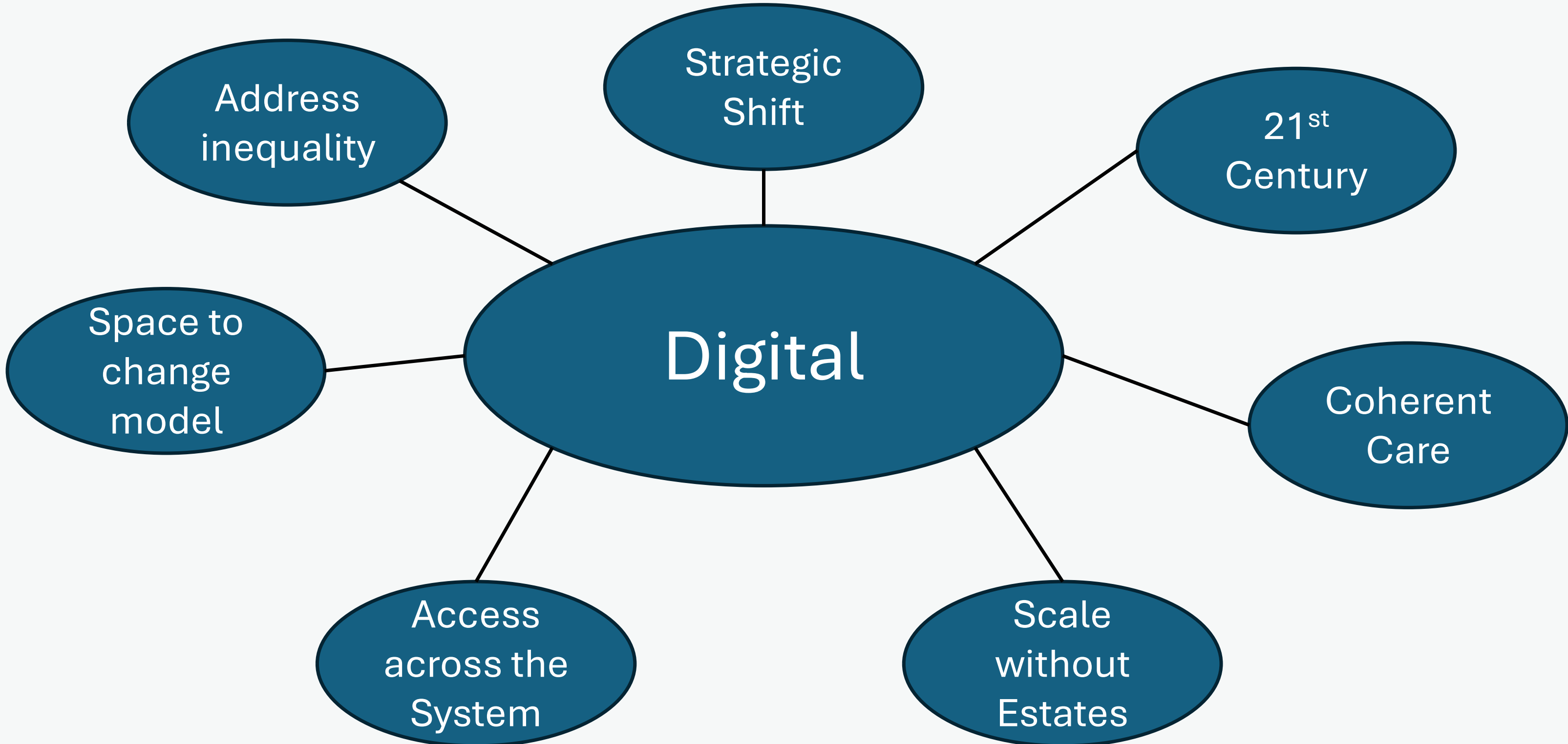


What should happen?

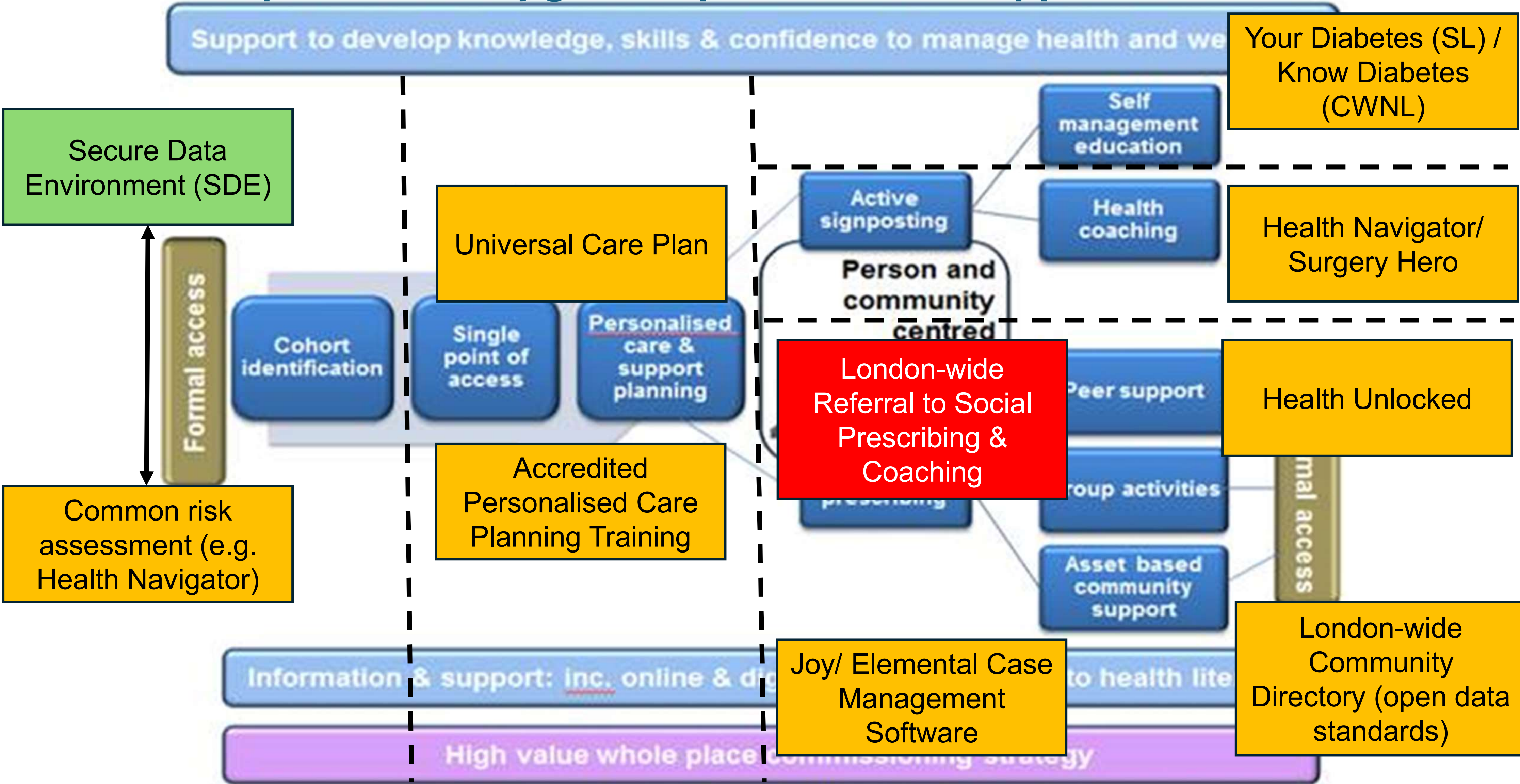
The Change Itself

There is clearly a commissioning gap, but how can it be addressed?

Motivational support isn't just the responsibility of the NHS. We can and should **map local provision** from Local Authorities and the VCSE. But the capacity to make up the shortfall will not all be found there. And where it is found **there will be significant unwarranted variation** across the city, as it will be **hyper-local and uncoordinated** with healthcare services.



We have the pieces of the jigsaw in place to offer support at scale



How do we Shift Left?

Putting Ideas into Practice

So how do we take this idea forward?

Use the SDE to identify a cohort with poor Hypertension management/ those at high risk of a Cardiovascular event, and choose a pilot ICB.

Build capacity in the pilot area for Motivational support – the fundamental element of behaviour change, and where we can have the greatest impact – and follow on from creating a UCP to a coaching intervention.

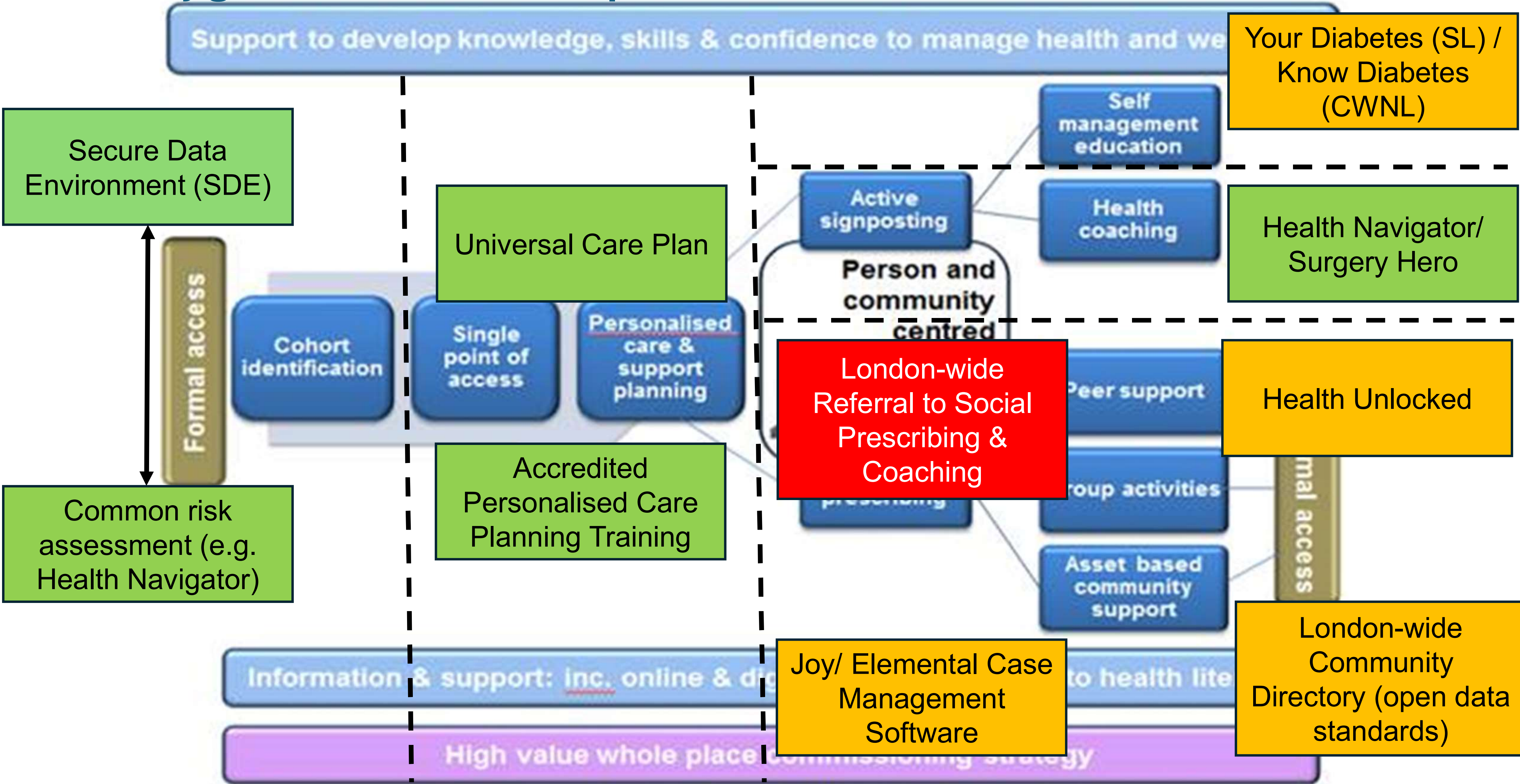
Proactively target them with outreach from workforce trained in Personalised Care and Support Planning, and develop a UCP

If the patient warrants further holistic support, connect them as appropriate locally, where possible

Evaluate the impact on health outcomes and service usage.

Explore the costs and benefits of this approach in each ICB, and examine what a pan-regional commission and complete NHS App integration could achieve in terms of economies of scale, usability, uptake and culture change.

How the jigsaw will look in the pilot



Before we get to delivery there are two fundamental challenges to address

Culture. The NHS is set up to be clinical and reactive. It does not traditionally consider the psycho-social elements of patients lives. A Prevention strategy demands that it does, as fundamentally it equates to supporting behaviour change.

We also need to develop a way of working where bio-clinical becomes bio-psychosocial: where the holistic support elements fit seamlessly with more traditional clinical interventions.

This change will require the setting of new expectations for clinicians, managers and patients. That needs a worked up Neighbourhood vision, tailored communications and engagement, as well as training.

Funding. The development of digital infrastructure, of workforce capacity and capability will not be free. At a regional scale, the likely cost of workforce capacity required will run into £100Ms. This is a small % of the overall healthcare economy, but the funding is already allocated and services are over capacity.

To make this feasible, the programme needs a pump-prime phase to get started and demonstrate impact. From there, a more substantive case can be made about reallocating resources from reactive services to a proactive approach to make it sustainable and develop it further.

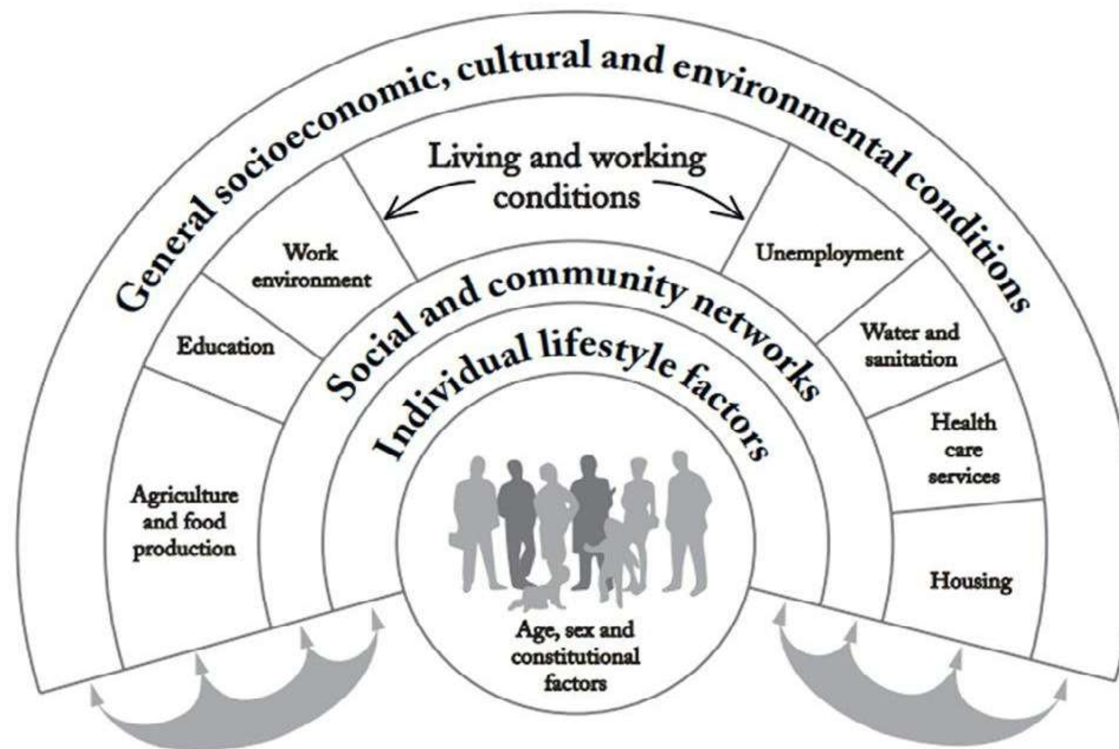
NOTES

Pers Care role numbers

Sum of Whole Time Equivalent (WTE)	Column Labels									
Row Labels	01/04/2025	01/05/2025	01/06/2025	01/07/2025	01/08/2025	01/09/2025	01/10/2025	01/11/2025	01/12/2025	01/01/2026
NHS NORTH CENTRAL LONDON ICB - 93C										
Care Coordinator	182	183	178	194	205	219	245	202	204	181
Health and Wellbeing Coach	14	12	11	11	12	13	16	53	19	17
Social Prescribing Link Worker	75	77	75	73	76	73	90	74	74	68
NHS NORTH EAST LONDON ICB - A3A8R										
Care Coordinator	323	349	344	335	323	287	284	288	270	184
Health and Wellbeing Coach	37	32	29	33	30	31	37	27	27	16
Social Prescribing Link Worker	125	138	134	122	122	116	110	99	95	68
NHS NORTH WEST LONDON ICB - W2U3Z										
Care Coordinator	184	190	172	164	147	152	142	144	148	91
Health and Wellbeing Coach	64	69	62	51	49	47	39	39	19	11
Social Prescribing Link Worker	149	148	114	120	110	118	146	151	101	45
NHS SOUTH EAST LONDON ICB - 72Q										
Care Coordinator	276	300	269	292	281	278	266	252	251	192
Health and Wellbeing Coach	32	24	25	34	25	24	22	17	16	7
Social Prescribing Link Worker	100	91	102	100	93	89	91	86	86	62
NHS SOUTH WEST LONDON ICB - 36L										
Care Coordinator	300	275	275	263	253	253	243	269	246	75
Health and Wellbeing Coach	25	27	25	25	28	22	21	22	21	11
Social Prescribing Link Worker	64	69	62	61	57	57	55	48	50	11

Health Equity and Prevention Improvement Programme

The Wider Determinants of Health



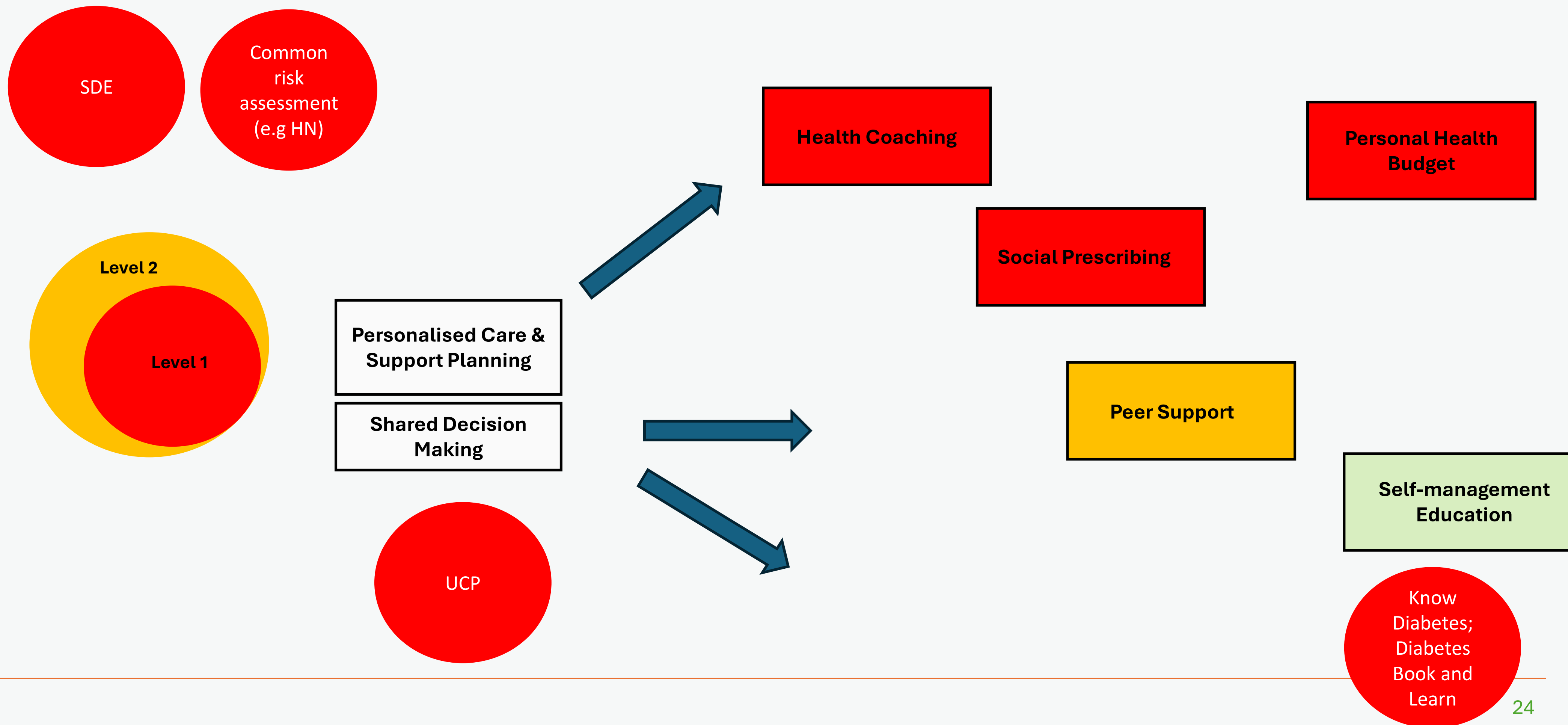
Reflecting on the origins of the words 'health' and 'care' helps to highlight the importance of the wider determinants.

To improve a person's health **we need to think about** their context, and **what 'makes them whole'**.

To do so, requires us to have **concern for their concerns**, **even if** those **don't seem** to be **relevant** to their bio-clinical **health outcomes**.

Dahlgren & Whitehead, https://www.euro.who.int/__data/assets/pdf_file/0018/103824/E89384.pdf

The key is digitising a platform to scale support. And we have a lot of pieces already in place, just not coordinated



The etymology of healthcare is significant

health (n.)

Old English hælþ **"wholeness, a being whole, sound or well,"** from Proto-Germanic *hailitho, from PIE *kailo- "whole, uninjured, of good omen" (source also of Old English hal "hale, whole;" Old Norse heill "healthy;" Old English halig, Old Norse helge "holy, sacred;" Old English hælan "to heal"). With Proto-Germanic abstract noun suffix *-itho (see -th (2)).

care (v.)

Old English carian, cearian **"be anxious or solicitous; grieve; feel concern or interest,"** from Proto-Germanic *karo- "lament," hence "grief, care" (source also of Old Saxon karon "to lament, to care, to sorrow, complain," Old High German charon "complain, lament," Gothic karon "be anxious"), said to be from PIE root *gar- "cry out, call, scream" (source also of Irish gairm "shout, cry, call;" see garrulous).

https://www.etymonline.com/word/health
https://www.etymonline.com/word/care

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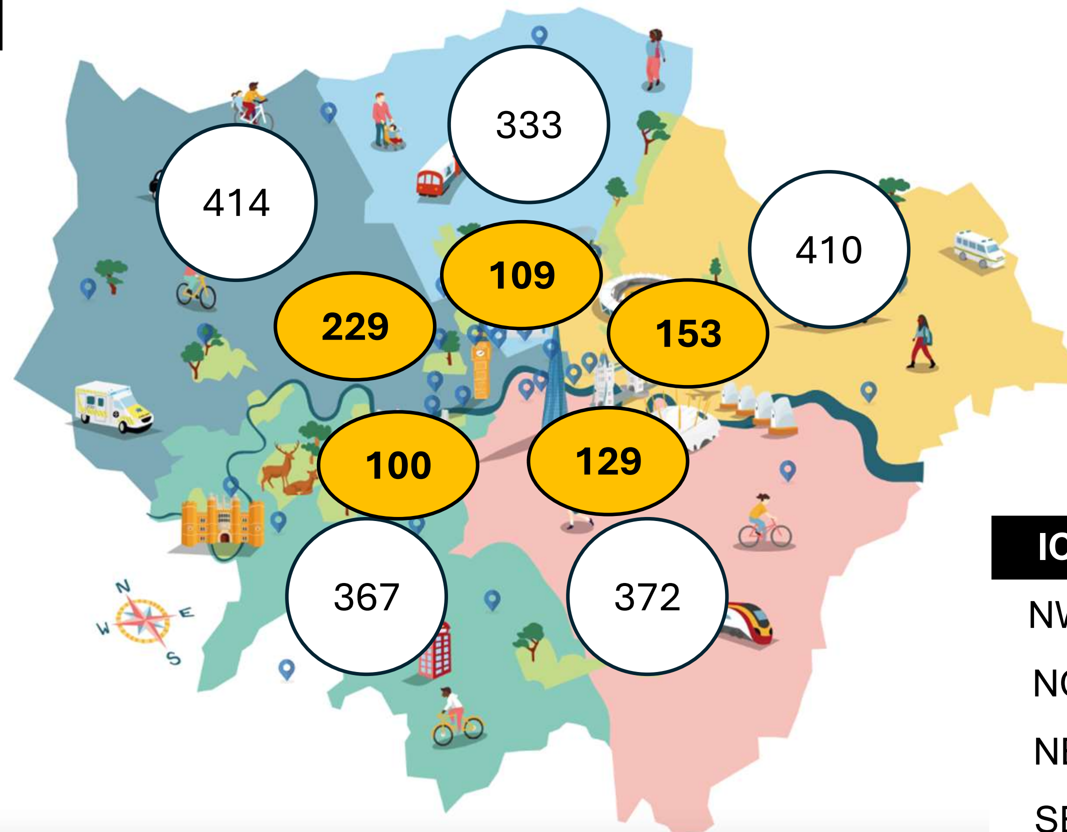

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