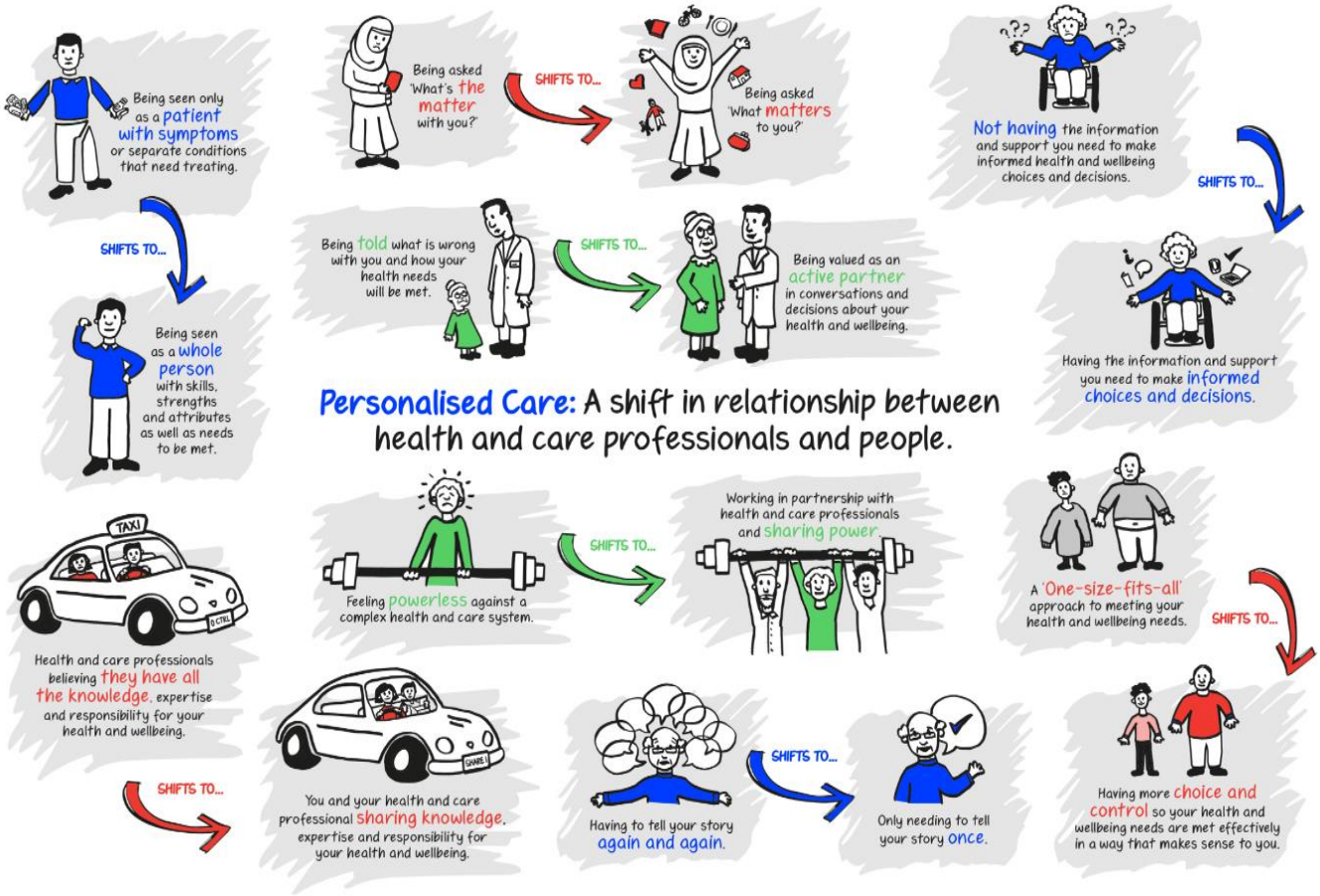
Coventry and Warwickshire
Integrated Care System

Coventry and Warwickshire Personalisation Strategy 2022-2024



This illustration was developed by the Personalised Care Strategic Coproduction group

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Contents

Foreword

The NHS Long Term Plan *describes Personalised Care as one of the five major practical changes needed to achieve a new Integrated Care service model for the 21st Century.*

That is why personalisation is an essential element of our Integrated Care Strategy.

Our Personalisation Strategy is focussed on creating the conditions and commitment to enable Personalised Care to become embedded, thrive and ultimately become "business as usual" as our local integrated health and care System evolves and matures.

Through our Personalisation Strategy we will seek to promote and develop a passion for personalised care across our workforce and to reflect Personalised Care in our integrated care pathways and commissioned services.

Our Personalisation Strategy will act as a vehicle through which we will pursue, with determination and focus, clearly defined personalisation ambitions - across System, Place, PCNs and individual organisations.

The Strategy will act as a 'call to action to embrace personalisation', because personalisation means people have more choice and control over the way their care is planned and delivered based on "what matters to them" and their individual diverse strengths, needs and preferences.

Personalisation ***must be*** *a cornerstone of our Local Integrated Care Strategy to ensure we deliver care that is meaningful and valued by those that access and receive support, and because personalisation is* ***so integral*** *to tackling health inequalities.*

Jenni Northcote, Senior Responsible Officer (SRO) for the Coventry and Warwickshire Integrated Care System's Personalisation Programme

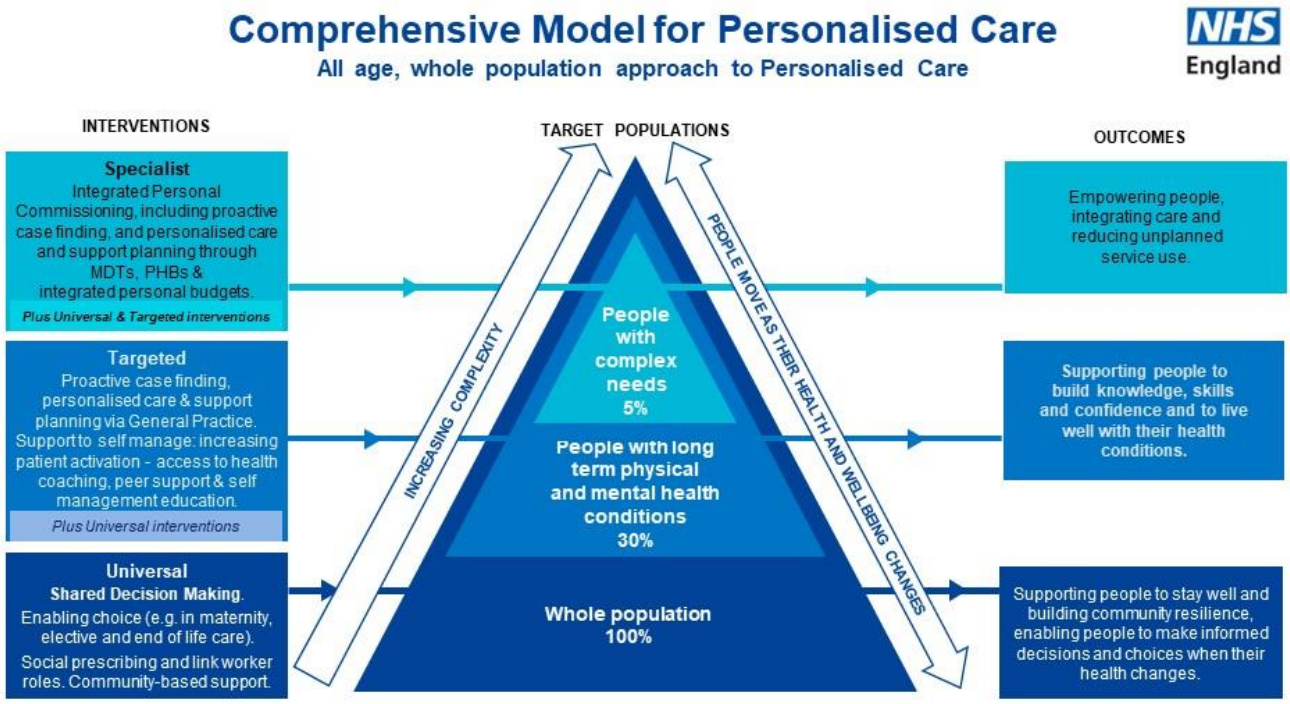
Personalised Care – an introduction to what it is, and our strategic approach

This document sets out our strategy for embedding Personalised Care across the Coventry and Warwickshire Integrated Care System (ICS). It provides the framework for how we transform the way we work to deliver the NHS Long Term Plan (LTP) ambitions for personalisation.

Personalised Care takes a whole System approach, integrating services including health, social care, public health and wider services around what's important to the individual. It has a long history in social care where it is commonly called personalisation. In the NHS, new approaches and disciplines have been developed to form a new model called Personalised Care which at its best complements and enhances the way personalisation works in social care.

It is based on a universal model developed by NHS England and referred to as "The Comprehensive Model for Personalised Care". It is an all-age, whole population approach to Personalised Care.

A short animation explaining the Model can be found here: [Comprehensive Model of Personalised Care (short version) - YouTube]



Personalised Care requires a new way of working in the NHS, in which people have more options, better support and properly joined-up care at the right time. Most importantly, it means that people get an equal voice in planning the care they receive, and get support to manage their health and wellbeing, rather than just receiving treatment when they get ill.

It means a new relationship between people, professionals and the health and care System, shifting power and ensuring that people feel informed, have a voice, and are connected to each other and their communities.

Principles of Personalised Care:

- It starts with the principle of "what matters to you" as opposed to "what's the matter with you?"
- It's about shared power and collaboration between people, families, and health professionals.
- It enables people to have choice and control over their lives.
- It moves people from being passive recipients of services to active citizens.
- It is about getting a life, not a service.

The six components of Personalised Care

Within the Comprehensive Model, there are six key components, which are central to embedding Personalised Care. These are:

1. **Shared decision-making** - equal partnerships and better conversations about what matters to patients, in the context of their whole life.
2. **Enabling choice** – have choice over your treatment and the services you can access.
3. **Social prescribing** – connecting people to their communities and non-medical support.
4. **Support for self-management** – health coaching, self-management education and peer support.
5. **Personalised care and support plans** – the opportunity for people with long term conditions to co-create their own plan.
6. **Personal health budgets** – giving people with the most complex needs direct control over their care.

Shared Decision Making (SDM)	People are supported to understand their care, treatment, and the support options available - and the risks, benefits, and consequences of those options - so they can make an informed decision about their preferred course of action. Shared decision making is appropriate when someone needs to make a decision about treatment when there is more than one option available (including no-treatment options). Staff in patient-facing roles can be trained in SDM, and patients/people prepared for this shared conversation.
Personalised Care and support planning (PCSP)	Personalised Care and support planning is the process that enables someone with care and support needs to have a structured conversation about **what matters to them**, what they can do to manage their health, and what support they need from formal and informal services. The process results in a plan which sets out their health and wellbeing goals, and how they will be achieved. The ambition is for everyone with a long-term condition to have the opportunity to co-create their own plan.
Enabling Choice	In many cases there is a legal right to choose where you have your NHS treatment. By 2020, NHS England wanted everyone treated by the NHS to be able to say: ✓ I have discussed with my GP or healthcare professional the different options available to me. ✓ I was given the opportunity to choose a suitable alternative provider. ✓ Information to help me make my decisions was available and accessible for me. ✓ I was given sufficient time to consider what was right for me.[1]
Social Prescribing and community-based support	Enables local agencies to refer people to a link worker to connect them to community-based support, building on what matters to the person as identified through the shared decision making conversation. Social prescribers provide an important 'bridge' between services, the local community and voluntary sector, individuals, and mutual aid groups. They spend time talking to people and finding out **what matters to them** and how they want to interact with and participate in their local communities.
Supported self-management	Helping people with long term conditions to increase their knowledge, skills, and confidence to better manage their health and wellbeing. Through a process known as '***patient activation'***, increasing the knowledge, skills, and confidence a person has in managing their own health and care through systematically putting in place interventions such as health coaching, self-management education, and peer support.
Personal Health Budgets (PHB)	An amount of money to support a person's identified health and wellbeing needs, planned and agreed between them and their local ICS. This isn't new money, but a different way of spending health funding to meet the needs of an individual. Personal health budgets give people with long term conditions and disabilities more choice and control over the money spent on them and the support they receive.

[1] The NHS Choice Framework: what choices are available to me in the NHS? - GOV.UK (www.gov.uk) – *for the 2020 update on the Choice Framework*

Why personalised care is important

There is a moral, ethical, and legal imperative for Personalised Care[2]:

1. People/patients want their preferences understood, respected, and acted on - a moral/ethical imperative.
2. Evidence-based healthcare = evidence + clinical expertise + individual patient preferences.
3. Medico-legal imperative – patient 'as decider' saw changes in Tort law following the Montgomery ruling in 2015[3].
4. Patients overestimate treatment benefits and underestimate potential harms (as can clinicians) – something Personalised Care addresses.
5. Treating the **whole** person optimises healthcare values so reducing health inequalities by focussing on what matters to people, taking account of their circumstances, challenges and assets, and giving everyone the opportunity to lead a healthy life - no matter where they live or who they are.
6. Reduces demand - people who lack confidence to manage their health and wellbeing see their GP 10 times more than the average every year. With health coaching and a holistic approach, health care utilisation reduces, and outcomes improve.
7. The workforce finds it more rewarding, improving staff retention rates, productivity, sickness incidence, and staff wellbeing.

"Isn't everyone doing this anyway?"

Not consistently- there's plenty of room for improvement!

In 2022 record numbers of patients said:

44.6% want more involvement in their healthcare decisions

New patient survey data[4] reveals that patients want to be more involved in their healthcare decisions. A survey completed by 719,137 people in 2022, found that a record 44.6% of patients want more involvement than they currently have in their healthcare decisions.

Furthermore, the proportion who felt they were "not at all" involved is up from 7.1% to 10.1% - another record.

We know that[5]:

- More than 40% of people weren't as involved as they wanted to be in decisions.
- 59% felt they didn't have enough support to manage their condition.
- 60% felt that they didn't adequately discuss what was important to them to manage their condition.
- 40% didn't feel they had a fully agreed plan to manage their condition.

We will review the Patient Reported Experience Measures (PREM) available for each of our Trusts to identify patient feedback on how involved they feel in the treatment they receive.

[2] Quote Aimee Robson, Deputy Director of PC, NHS England
[3] Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (supremecourt.uk)
[4] Survey and Reports (gp-patient.co.uk)
[5] *Source: Information from the NHS England GP Patient survey 2019.*

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J's story: a Patient's journey

Moving from 'what's the matter with you?' to 'what matters to you'

At 27 years old, J enjoyed walking and rambling, often went camping, and loved to dance. That same year, she found herself in excruciating pain, and was diagnosed with a bulging L4/L5 disc. In 2022, 9 years on, she had rarely walked, suffering pain when walking even short distances. She missed many events because of the pain, affecting her son too, and her relationships and mental health had as she says, 'been massively affected'. She had worked only sporadically.

> "The pain programme spent most of the time teaching me to accept what I cannot do. I was never inspired about the future and was never shown there was a possibility that my condition could improve. I never felt truly listened to in all the years I have back pain and it has put my life on hold, I felt hopeless and my anxiety has got a lot worse."

The traditional intervention:
J was prescribed many types of painkillers, which had side effects including stomach ulcers, steroid injections and nerve ablation. Clinical staff were reluctant to touch her because of the potential for causing pain and provided printouts of exercises which she was unable to do, which made her feel guilty.

The Personalised approach adopted in Coventry:

- **Description**: an individually tailored, psychologically informed physiotherapist-led intervention, specifically developed to target the biopsychosocial complexity of persistent lower back pain.
- **Patient selection:** J is one of a cohort of Coventry patients identified with persistent lower back pain. Of that cohort, the wider determinants of health also feature: 80% are from mid or highly deprived areas, and a high percentage of the cohort have mental health disorders (>50%), a history of smoking (>50%), and other metabolic disorders (~25%).
- **Rationale**: as well as the debilitating physical, mental and financial issues caused to individuals, lower back pain is a primary cause of disability, and has huge economic consequences. Patients with persistent lower back pain are high users of primary care, with ***an average of 32 contacts per year.***
- **Activities undertaken**: an initial holistic 90-minute assessment that is physiotherapist-led. The results of the initial assessment may lead to a personalised journey with wide multi-disciplinary support where indicated (including for e.g., medical, psychology, social prescriber, clinical pharmacists, health, and wellbeing practitioner).

The impact on J's life:

"From my first session, I was optimistic about the future. He did not tell me what I could or could not do. He has shown me what I can do. He is patient and understanding. The thing that has stood out the most is he has made it clear that the limitations I have placed on myself are a normal reaction to painful episodes.

He spent a lot of time demonstrating ways of moving and helped me compare my old ways with the new ways and

> *"I am already walking more, standing up from a chair easily without pain and getting more housework done.*
>
> *I even danced last weekend for the first time in nine years.*
>
> ***I feel that this holistic approach may be the thing that allows me to finally get my life back."***

the effect that had on my breathing, tension and pain. Having tangible comparisons has greatly assisted me. For the first time, I was able to control my pain. This was not something being done to me by somebody else or medications to mask the pain. He has already taught me that it is not one thing that causes me pain but a combination of things which all relate to each other."

J's Patient Reported Outcome Measurements:

In just two weeks, J's own assessments of her improvements taking this Personalised approach to her health and care were astounding:

19/05/2022	
Disability:	20/24
Pain rating:	9/10
Fear:	28/30
Pain catastrophising:	30/52
Self-efficacy:	17/60
General health:	75%
Risk:	7/9
Distress, Anxiety, stress & depression: (really high)	144

27/05/2022	
Disability:	7/24
Pain rating:	3/10
Fear:	9/30
Pain catastrophising:	6/52
Self-efficacy:	52/60
General health:	90%
Risk:	3/9
Distress, Anxiety, stress & depression: (normal)	34

Note: J's story is from work undertaken by the MSK team at UHCW working with Coventry Central PCN, as part of the Coventry & Warwickshire ICS Population Health Management Programme.

We are pleased to be supporting the Population Health Management Programme – to have the opportunity to embed personalised care in the interventions planned with people.

Key policy drivers

The NHS Long Term Plan[6] describes Personalised Care as one of the five major practical changes needed to achieve the new NHS service model for the 21st Century, delivered over the next five years. It states that Personalised Care will become "business as usual" across the health and care System. Personalised Care means people have more choice and control over the way their care is planned and delivered based on "what matters to them" and their individual diverse strengths, needs and preferences.

The key commitments and actions by 23/24:

a) Personalised Care will benefit up to 2.5 million people, giving them the same choice and control over their mental and physical health that they have come to expect in other aspects of their lives.
b) Over 1,000 social prescribing link workers will be in place, with over 900,000 people referred to social prescribing.
c) Expansion of supported self-management to increase knowledge, confidence and skills for people with long term conditions.
d) 750,000 people will have Personalised Care and support plans to manage their long-term health conditions.
e) 200,000 people will have personal health budgets, enabling them to control their own care.
f) The workforce is trained and supported to use Personalised Care approaches in day-to-day practice.
g) Delivery of the six components across the NHS and the wider health and care system.

NHS Primary Care DES contract[7] sets out the ambitions for personalising healthcare services in Primary Care.

NHS Core20Plus5 – approach to reducing health inequalities[8]**:** Core20Plus5 is a national NHS England approach to support the reduction of health inequalities at both national and System level. The approach defines a target population cohort – the Core20Plus - and identifies "5" clinical areas requiring accelerated improvement.

Coventry and Warwickshire Integrated Care Strategy – Personalised Care is identified as a strategic focus area, summarised in Appendix B.

NHSE Anticipatory Care framework - Personalised Care is a key component of the new framework.

[6] NHS Long Term Plan » Online version of the NHS Long Term Plan
[7] NHS England » Network Contract DES
[8] NHS England » Core20PLUS5 – An approach to reducing health inequalities

The Coventry and Warwickshire ICS Personalisation programme

The Coventry and Warwickshire Personalisation programme is currently hosted by George Eliot Hospital NHS Trust, on behalf of the ICS. A memorandum of understanding underpins the programme of work which is focused on the following:

Our Ambitions are to:

- Achieve better experiences and health outcomes for people by embedding the six components of the Comprehensive Model for Personalised Care across our System, Place and Neighbourhoods.
- Reduce health inequalities by focussing on what matters to people, and taking account of their circumstances, challenges, and assets, enabling everyone the opportunity to lead a healthy life, no matter where they live or who they are.

Our Approach is to:

- Start with strengths: celebrate good practice where Personalised Care is already embedded into customer and service pathways.
- Embed the philosophy and culture of the Comprehensive Model for Personalised Care in existing programmes and areas of focus for the System, in priority cohorts, and with Place partnerships. This involves major transformative shifts – changing the way health and care staff work alongside people to deliver more Personalised Care and improve care outcomes.
- Seek to avoid setting up siloed work streams and new programmes of work where possible.
- Endeavour to avoid duplicating and enlarging infrastructure where we can deliver through others as part of an embedded culture and the 'every contact counts' approach. This will provide a better opportunity for sustainable delivery.
- To achieve this, we will raise awareness, identify opportunities, share and celebrate good practice, and track impact and benefits to create momentum and movement with:

    - ❑ each of our Trusts: SWFT, GEH, UHCW and CWPT
    - ❑ each of our Place partnerships
    - ❑ Primary Care
    - ❑ our people/patients, supporting them to be ready to engage with shared decision-making conversations
    - ❑ our Social Care partners, to achieve further integration
    - ❑ our local health inequalities programme.

We will:

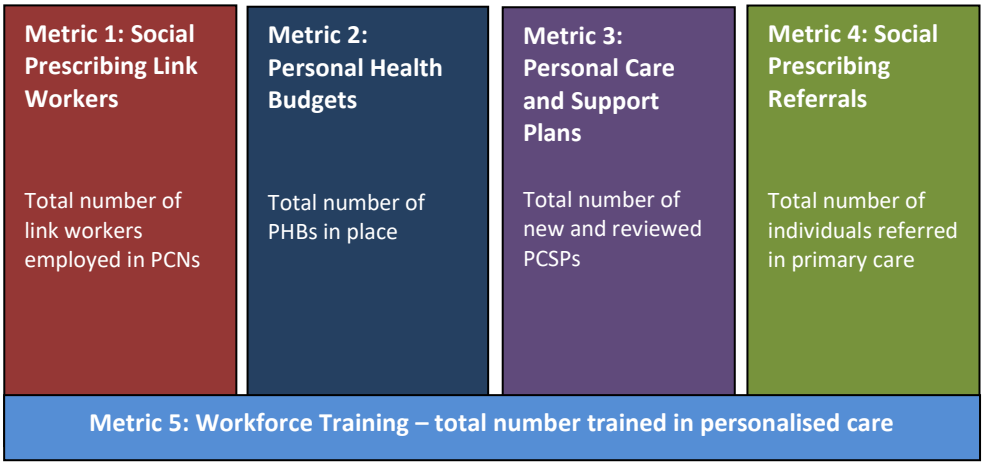
- ✓ Support Service Leads to identify opportunities to embed Personalised Care approaches in Trust services and pathways.
- ✓ Support our workforce with training in Personalised Care through eLearning and reflective practice sessions.
- ✓ Support Primary Care ARRs roles with a peer support network.
- ✓ Support our people and patients to share "what matters to them" in their health and care interactions – helping them navigate their health and care journey.

- ✓ Evaluate the impact for people/patients, staff and our System.
- ✓ Continue to promote the use of new technologies such as Proactive Care @Home to support our people at home and in care homes using self-directed support.
- ✓ Continue to adopt innovative models of care that can support a highly integrated and personalised experience of care – such as the PHM improvement programme with PCNs.
- ✓ Develop specific expansion areas such as the Children and Young People (SEND), and Homeless people in Warwick District, as funding emerges.

NHSE contract KPIs to deliver by March 2024 - metrics

NHSE has awarded the Coventry and Warwickshire ICS a contract to deliver the Personalisation programme until March 2024, with a number of KPIs:

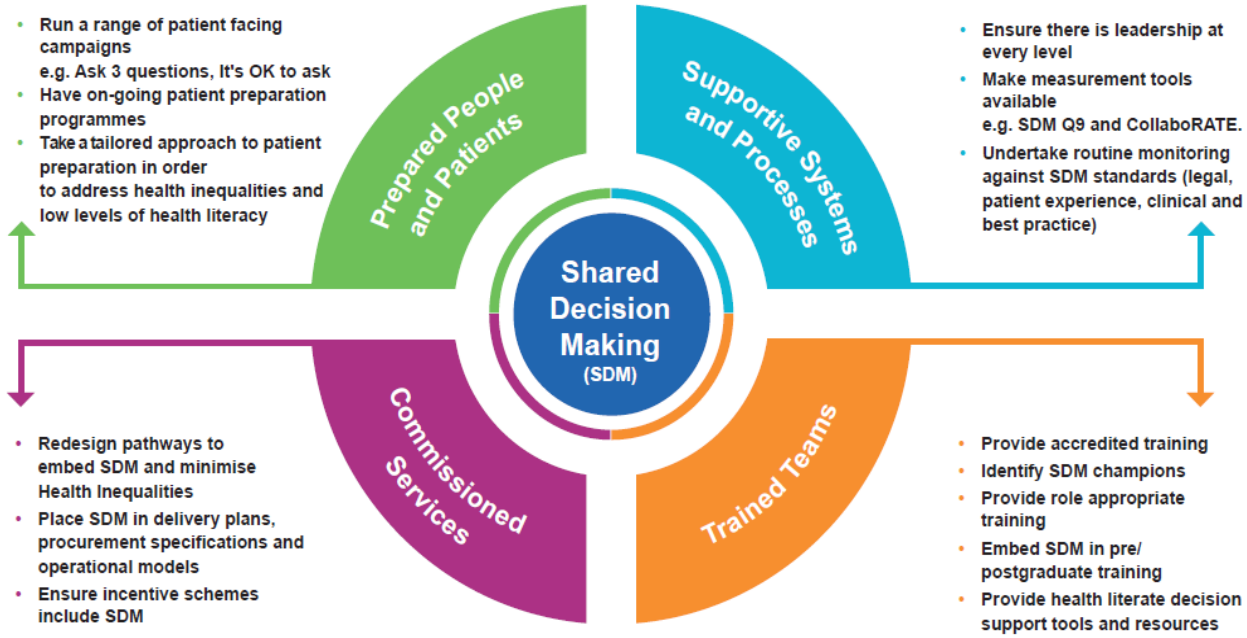
- Increased uptake of personal health budgets.
- Numbers of social prescribers employed in PCNs.
- Increase in referrals to social prescribing.
- Increased use of Personalised Care and support plans.
- Workforce training in Personalised Care module(s).
- Embedding Personalised Care with C&YP (SEND) pathway.
- Embedding Personalised Care with “plus” group - homeless people in Warwick District.



Embedding Personalised Care across Coventry and Warwickshire ICS – what does this mean?

A key starting point will be to focus on shared decision making – and drawing on the NHS England shared decision making implementation framework, outlined below.

Shared Decision Making – What Good Looks Like:



Workforce training - trained teams

We will promote the eLearning modules in Shared Decision Making and Personalised Care and support planning via the Personalised Care Institute[9] with all staff in patient-facing roles; and support this with workshops and webinars for staff to further develop their knowledge, skills and understanding of personalised care.

Preparing people and patients

We will work with partners to adopt a prepared patient resource (see Appendix C for example) to support and enable their people/patients to be confident in engaging in a shared decision making conversation during their health and care appointment.

[9] Your learning options (personalisedcareinstitute.org.uk)

How will we achieve this?

Working with each of our Trusts:

- We will work with service leads to help identify opportunities to embed the six components of the Personalised Care model into services and pathways – ensuring patients receive improved health outcomes.
- We aim to strengthen Personalised Care and support plans for patients where appropriate, and for staff with a patient-facing role to have a shared decision making conversation.
- We will support workforce training in Personalised Care via the Personalised Care Institute (PCI), supporting patient-facing roles to undertake shared decision making and other modules as appropriate.
- We will roll out a Prepared People and Patient campaign to help patients prepare for their appointments – optimising opportunities for this to be personalised to them.

Example of Trust work currently in progress:

- ✓ *Across all four Trusts – we are working with MSK physiotherapists to identify opportunities to embed Personalised Care: reviewing the role of community social prescribing to support patients and clinicians, researching the barriers for patients accessing therapies when referred (including health inequalities), and providing additional training for the workforce in motivational interviewing and shared decision making.*

Working with Primary Care:

The NHS Primary Care DES contract[10] sets out the ambitions for personalising healthcare services in Primary Care: "*Further expansion of social prescribing to a locally defined cohort which is unable or unlikely to access care through established routes; supporting digitised care; supporting planning for care home residents; workforce training in key components such as: shared decision making and Personalised Care and support plans.*"

There is an important role for Primary Care in personalising healthcare services and working across the Primary Care sector to support the changes. To this end, requirements around personalisation are outlined in the LTP and the new DES contract. Consequently, we will:

Example of Primary Care work currently in progress:

- ✓ *We are providing reimbursement to PCN staff who wish to undertake the Personalised Care training.*
- ✓ *We are supporting 5 PCNs to embed personalised care as part of the Population Health Management Programme - they have segmented their patient lists into specific cohorts of patients.*

- Work with Primary Care to support embedding the six components of the Personalised Care model into services – ensuring patients receive improved health outcomes through services personalised to them.

[10] NHS England » Network Contract DES

- Work in partnership with the Primary Care Collaborative to ensure we are aware of the opportunities to support and embed personalisation across Primary Care.
- Support PCNs who are fulfilling the Network DES contract requirements for Personalised Care to undertake Personalised Care training and embedding the use of Personalised Care and support plans with patients.
- Support referrals to social prescribing in PCNs and the community.
- Help to identify opportunities to increase the uptake of personal health budgets.
- Support a local peer support network, to enable good practice to be shared, and facilitate available support for staff.

Example of Place work currently in progress:

- ✓ *In Warwickshire North we are supporting the Proactive Care @ Home programme, which helps patients with a remote monitoring unit in a care home or at home. This is an opportunity to embed shared decision making, self-supported management, and ensure patients have a Personalised Care and support plan.*
- ✓ *See Mary's story of Personalised Care through the Proactive care at home initiative: Coventry & Warwickshire - patient view - Docobo*

Working with each of our four Place partnerships:

- We will work with each of the Place partnerships to help identify where the opportunities are to embed Personalised Care into existing local priorities.
- We will support staff to undertake Personalised Care training.
- We will promote the Prepared People/Patient campaign.
- We will provide advice and guidance to Place partnerships on how to embed personalised care, so it becomes business as usual.

Working with our local Health Inequalities programme

Evidence shows how Personalised Care can contribute to reducing health inequalities. Personalised Care takes account of people's different backgrounds and preferences, with people from lower socio-economic groups benefitting the most.

- *"Most individual long-term conditions are more common in people from lower socioeconomic backgrounds, and multiple conditions are disproportionately concentrated in these groups. The evidence shows that levels of knowledge, skills and confidence to manage their health tend to be lower for people with lower incomes and lower levels of education. When people are supported to increase their knowledge, skills and confidence they benefit from better health outcomes, improved experiences of care and*

Example of Health Inequalities work currently in progress:

- ✓ *Using NHSE expansion funding we will be working with one of the C&W "Plus" groups from Core20PLUS – transient communities - to show how embedding Personalised Care delivers better outcomes for the patient, the System, and the staff supporting individuals.*

fewer unplanned admissions. People in lower socioeconomic groups can therefore benefit the most from Personalised Care, as it focuses on people with lower knowledge, skills and confidence, and better supports people with multiple long-term conditions as part of the 'specialist' tier of interventions in the Comprehensive Model." [11]

The new Integrated Care System (ICS) provides an opportunity for personalisation to be embedded in how health and care services are delivered – we will work with System partners to ensure Personalised Care aspirations are integrated into appropriate work streams and priorities, engaging with partners across all sectors.

We will support the C&W Health Inequalities Programme to reduce health inequalities by focussing on what matters to people and takes account of their circumstances, challenges, and assets, enabling everyone the opportunity to lead a healthy life, no matter where they live or who they are.

Working with Social Care partners

Further integration provides an opportunity to enhance personalisation, choice and flexibility for people who draw on health and social care services – we will work with partners in Social Care to optimise opportunities to embed Personalised Care in local commissioned services.

[11] *Source:* NHS LTP – 2.5 Addressing Health Inequalities through *Personalised Care*

Key Enablers to support our ambitions

The type of System working required to deliver progress and change in Personalised Care means that we are mindful of other channels of activity with overlapping interests. The steering group will review the best ways to ensure this is achieved. There are some key enablers:

- **Develop the workforce and culture** to enhance awareness of what Personalised Care is and how to apply it in day-to-day interactions with patients. We will upskill practitioners to increase their skills and confidence in embedding Personalised Care with patients in day-to-day interactions, reframing conversations from "what's the matter with you?" to "what matters to you?"
- **Work in partnership with key partners and stakeholders** across Coventry and Warwickshire to agree priorities, tackle barriers, and implement opportunities to embed Personalised Care across the System.
- **Strategic leadership**: ensure there is robust strategic leadership in place across the System to facilitate the agreement of and support from partners and stakeholders to this strategic approach.
- **Co-production**: ensure co-production is embedded into our approach, drawing on people with lived experience and patient champions to advise, steer and inform our journey to embedding Personalised Care.
- **Commissioning, contracts, and finance** to support providers to deliver care in accordance with the Universal Personalised Care Model. Contracts may need to be reviewed to include elements of Personalised Care, as per Section 2M of the new NHS England Standard Contract[12]. For Local Authority-commissioned services, we will be keen to embed Personalised Care elements into contracts to include shared decision making, Personalised Care and support plans, and referrals. Bespoke advice and guidance on contracts will be given.
- **Digital change** to ensure we utilise digital solutions that can significantly enhance people's experiences, e.g. Proactive Care @ Home, the NHS App, PHB toolkit, NHS website – including self-referral services.
- **Population Health Management** (PHM): utilising PHM tools and approaches to segment patient cohorts and introduce new methods of supporting patients, drawing on a multi-disciplinary team approach, which takes into account the wider determinants of health for patients and communities.
- **Aligning with key strategic plans**: ensuring that personalisation is woven into other System activities as appropriate – ensuring that Personalised Care is embedded wherever there is an opportunity do so, such as in: the Health Inequalities strategy; Digital Transformation; Proactive care @ Home; Anticipatory Care planning.
- **Active patient-enabling**: developing and embedding a campaign for patient preparation, supporting self-care and optimising Making Every Contact Count (MECC).

[12] NHS England » NHS Standard Contract

Our delivery plan

Appendix A shows the delivery plan for the programme setting out the detail for:

- Managing the Coventry and Warwickshire ICS Personalisation programme.
- Delivering the NHS Long Term Plan key performance indicators.
- Delivering two partnership agreements.
- Delivering expansion funding.

Outcomes and Impact - what we aim to achieve for Patients, Staff and our System[13]

To identify what is important to our population, and to evidence where Personalised Care approaches are adopted and with what impact, we will work with our partners to adopt "I" statements such as these:

Patients:

- ✓ I feel involved with the decisions about my health and care, understanding the options, risk, and benefits.
- ✓ I feel the care I am receiving is based on "what matters to me" – making it personalised.
- ✓ I am able to access support for my health and wellbeing needs closer to home.
- ✓ I am confident that at every stage my health and care needs will be met.
- ✓ I have access to information and experts with early intervention to support me to manage my care and reduce the need for me to use hospital.
- ✓ I feel safe and confident that I can access support in the right care setting.
- ✓ I know that I am supported throughout my care journey.

Staff:

- ✓ I feel confident in holding shared decision-making conversations with patients.
- ✓ I am able to access supporting tools and training on Personalised Care.
- ✓ I understand the benefits of Personalised Care for my patient(s).
- ✓ I encourage patients to ask questions about their health and care needs.

System: these will vary depending on setting, but may include:

- ✓ Reductions in emergency admissions.
- ✓ Reductions in A&E attendances.
- ✓ Reductions in repeat visits to Primary Care.
- ✓ Reductions in bed days/improved process (MT).
- ✓ Increase in population able to self-manage health and wellbeing – reducing health inequalities.

[13] *Source: The Midlands Training Collaborative Personalised Care April 2022*

Governance and Resources

Governance and operational arrangements

- The Personalisation Steering Group provides oversight and steer to the Programme. It reports to the Population Health, Inequalities and Prevention Programme Board and provides a quarterly assurance report to the ICS.
- The SRO and Programme Manager have financial and management responsibility for delivering the contract with NHSE, and monitor performance against each of the NHSE targets to ensure contractual commitments with the NHSE contract are fulfilled.
- This strategy will form the basis of a series of engagement sessions with partners in Autumn/Winter 22 to engage with and work with key partners and stakeholders across the System, Place and Neighbourhoods.
- Risk is managed through the Steering Group with a risk register as part of the bi-monthly reporting.

Resourcing and costs

In 2022/23, the programme has received £235k funding. This will support the programme costs comprising:

- Programme staffing costs.
- Workforce training in Personalised Care.
- Supporting embedding Personalised Care across our ICS.

The embedding of Personalised Care cannot be fully achieved before March 2024 when the existing funding arrangements come to an end. Therefore, it will be necessary to seek funding from 1st April 2024 for ongoing programme resources to achieve a sustainable long-term plan for releasing resources to deliver Personalised Care.

Monitoring and Evaluation

The strategic plan and NHSE Memorandum of Understanding work programmes will be monitored and measured by the C&W Personalisation Steering Group and NHSE regional Personalised Care team.

An assurance report will be submitted to the Population Health, Inequalities and Prevention Programme Board & ICS.

Appendices

Appendix A: C&W Delivery plan

Key work stream		Measurements for 22/23	Enablers
1.NHSE Long Term Plan: • Increase the uptake of Personal Health Budgets (PHB) • Support the number of FTE social prescribing links workers employed • Increase uptake of Personal Care and Support Plans (PCSP) • Increase referrals to social prescribing • Increase the number of patient-facing staff trained in Personalised Cared		2,874 54FTE 8,809 26,431 660	Workforce training Leadership Co-production Partnership working Strategic leadership
Area of focus	Activity	Indicators of success	
With each of our four Trusts	Working with each of our Trusts: identify opportunities to embed Personalised Care into key services and pathways as an improvement measure. Agree prioritisation of services. Support each of the service leads with the embedding process. Promote the workforce training offer to staff – to increase their skills and confidence to apply	✓ Workforce trained in Personalised Care. ✓ Increase in use of Personalised Care and support plans for patients. ✓ Increase in referrals to social prescribing. ✓ Increase uptake in personal health budgets. ✓ Increase in supported self-management advice for patients.	

	Personalised Care approaches in their day-to-day interactions with patients, focussing on “what matters to you?” rather than “what’s wrong with you?”. Adopt a Prepared People/Patient campaign in services and pathways to support the embedding process. Preparing our people/patients to understand the care, treatment and support options available, and the risks, benefits and consequences of those options so they can make an informed decision about a preferred course of action. Align with the CQUIN for shared decision making where appropriate. Share good practice across Trusts.	
With Primary Care	Working with Primary Care to embed Personalised Care into patient care. Align support to help fulfil DES requirements for embedding Personalised Care. Support workforce training in Personalised Care. Commission provider to facilitate a peer support network for ARRs roles and support dissemination of information on Personalised Care.	✓ Workforce trained in Personalised Care. ✓ Increase in use of Personalised Care and support plans for patients. ✓ Increase in referrals to social prescribing. ✓ Increase uptake in personal health budgets. ✓ Increase in supported self-management advice for patients.

	Adopt a Prepared People/Patient campaign to support shared decision making in PCNs.	
With each of our four Place partnerships	Identify a key priority work stream where Personalised Care can be embedded. Support workforce training.	✓ Workforce trained in Personalised Care. ✓ Increase in use of Personalised Care and support plans for patients. ✓ Increase in referrals to social prescribing. ✓ Increased uptake in personal health budgets. ✓ Increase in supported self-management advice for patients.
Reducing health inequalities	Identify key areas where Personalised Care can be embedded into services and pathways with partners from HI working group. Support workforce training. Pilot some innovation programmes to evidence the impact and share the learning across System partners.	✓ Workforce trained in Personalised Care. ✓ Increase in use of Personalised Care and support plans for patients. ✓ Increase in referrals to social prescribing. ✓ Increased uptake in personal health budgets. ✓ Increase in supported self-management advice for patients.
Work with adult social care	Building on the existing personalisation agenda in adult social care, work with partners to support further integration which provides an opportunity to enhance personalisation, choice and flexibility for people who draw on health and adult social care services – we will work with partners in adult social care to optimise opportunities to embed Personalised Care in commissioned services.	✓ Workforce trained in Personalised Care. ✓ Increase in use of Personalised Care and support plans for patients. ✓ Increase in referrals to social prescribing. ✓ Increased uptake in personal health budgets. ✓ Increase in supported self-management advice for patients.
2. Workforce training Provide workforce training	**Measurement 22/23:** 660 clinical staff trained.	**Enablers** Workforce training Strategic leadership

offer to staff in patient-facing roles		Partnership working Co-production Commissioning
Area of focus	**Activity**	**Indicators of success**
Workforce training	**Workforce training:** To successfully deliver Personalised Care, we will train and equip staff involved in the delivery of people's care to identify self-care needs and take a flexible holistic approach to people's needs - with an emphasis on prevention, encompassing person-centred approaches. This requires a workforce which is trained, supported, and equipped to deliver a preventative and person-centred approach.	✓ Increased uptake of staff undertaking Personalised Care training via the PCI website. ✓ Reflective practice workshops offered to staff to support their knowledge, skills application and understanding of Personalised Care.
3. Partnership Agreement(s) 3a) Population Health Management (PHM) 3b) Proactive Care @ Home (Docobo)	**Measurements 22/23:** • Increase uptake of PCSP. • Increase referrals to social prescribers. • Increase uptake of PHB. • Increase number of patients who receive supported self-management (SSM).	**Enablers:** Workforce training Strategic leadership Partnership working Co-production Digital PHM

Area of focus	**Activity**	**Indicators of success**
Partnership agreement: PHM	**Embedding Personalised Care into PHM Programmes @ Place**: Support the pilot programme in Warks North to embed Personalised Care in their interventions with patients in Primary Care. Continue to adopt innovative models of care that can support a highly integrated and personalised experience of care through the PHM improvement programme with PCNs.	✓ Workforce trained in Personalised Care. ✓ Increase in use of Personalised Care and support plans for patients. ✓ Increase in referrals to social prescribing. ✓ Increased uptake in personal health budgets. ✓ Increase in supported self-management advice for patients.
Partnership agreement: Proactive Care @ Home	Embedding Personalised Care into proactive Care @ Home (Docobo) Continue to promote the use of new technologies such as Proactive Care @Home to support our people at home and in care homes using self-directed support.	
4. Expansion funding areas: 4a) C&YP (SEND) 4b) Health Inequalities	**Measurements 22/23:** • Increase uptake of PCSP • Increase referrals to social prescribers • Increase uptake of PHB • Increase number of patients who are supported self-management (SSM)	**Enablers** Workforce training Strategic leadership Partnership working Co-production Digital

		PHM
Area of focus	**Activity**	**Indicators of success**
Expansion area: C&YP service and pathways	Support the Clinical Lead to embed Personalised Care into SEND C&YP service and pathways.	✓ Workforce trained in Personalised Care. ✓ Increase in use of Personalised Care and support plans for patients. ✓ Increase in referrals to social prescribing. ✓ Increase in supported self-management advice for patients.
Expansion area: Health Inequality and Transient communities	Support the Clinical Lead to embed Personalised Care with an identified cohort from the C&W transient groups (homeless people).	✓ Workforce trained in Personalised Care. ✓ Increase in use of Personalised Care and support plans for patients. ✓ Increase in referrals to social prescribing. ✓ Increase in supported self-management advice for patients.

Appendix B: ICS summary of Personalisation from emerging ICS strategy 2022

System focus area	Embedding Personalised Care at System, Place, Neighbourhood and within individual organisations; empowering individuals to be active participants in their health and wellbeing in any health and care journey.
Vision statement for effective integration	Through our Personalisation strategy we will seek to promote and develop a passion for Personalised Care across our workforce, and to reflect Personalised Care in our integrated care pathways and commissioned services; whilst supporting individuals to be active prepared participants in any health and care journey. Our Personalisation strategy will act as a vehicle through which we will pursue, with determination and focus, clearly defined personalisation ambitions - across System, Place, PCNs and individual organisations. The strategy will act as a 'call to action to embrace personalisation', because personalisation means people have more choice and control over the way their care is planned and delivered based on "what matters to them" and their individual diverse strengths, needs and preferences. Personalisation **MUST BE** a cornerstone of our Local Integrated Care Strategy to deliver care that is meaningful and valued by those that access and receive support, and because personalisation is so integral for tackling health inequalities.
Where we are now?	The Coventry and Warwickshire Personalisation programme is currently hosted by George Eliot Hospital NHS Trust, which is leading the programme on behalf of the ICS. A memorandum of understanding underpins the programme of work which is focused on achieving the following: **Our ambitions:** 1. Achieve better experiences and health outcomes for people by embedding the six components of the UPC model across our System, Place and Neighbourhoods. 2. Reduce health inequalities by focussing on what matters to people, and takes account of their circumstances, challenges, and assets, giving everyone the opportunity to lead a healthy life, no matter where they live or who they are. **Our approach:** To embed the philosophy and culture of the universal Personalised Care model in existing programmes and areas of focus for the System and priority cohorts and with Place partnerships. We will seek to avoid setting up siloed work streams and new programmes of work where possible. We endeavour to avoid duplicating and enlarging infrastructure where we can, delivering through others as part of an embedded culture and 'every contact

count's approach. This will provide a better opportunity for sustainable delivery.
To achieve this, we will raise awareness, identify opportunities, share and celebrate good practice, and track impact and benefits to create momentum and movement with:

- ❑ Each of our Trusts: SWFT, GEH, UHCW and CWPT
- ❑ Each of our Place partnerships
- ❑ Primary Care
- ❑ Supporting our people/patients to be ready to engage with shared decision-making conversations
- ❑ Social care partners for further integration.

Further integration provides an opportunity to enhance personalisation, choice and flexibility for people who draw on health and adult social care services – we will work with partners in social care to optimise opportunities to embed Personalised Care in commissioned services.

We will:

- ✓ Support Service leads to identify opportunities to embed Personalised Care approaches in Trust services and pathways
- ✓ Support our workforce training in Personalised Care with e-learning and reflective practice sessions
- ✓ Support Primary Care ARRs roles with a peer support network
- ✓ Support our people and patients to share "what matters to them" in their health and care interactions – helping them navigate their health and care journeys.
- ✓ Evaluate the impact for people/patients, staff, and our System
- ✓ Continue to promote the use of new technologies such as Proactive Care @Home to support our people at home and in care homes using self-directed support
- ✓ Continue to adopt innovative models of care that can support a highly integrated and personalised experience of care – such as in the PHM programme with PCNs.

KPIs to deliver by March 2024:

- Increase in referrals to social prescribing
- Increase in uptake of personal health budgets
- Increased use of Personalised Care and support plans
- Workforce training in Personalised Care module(s)
- Numbers of social prescribers employed in PCNs
- Embedding Personalised Care with C&YP (SEND) pathway
- Embedding Personalised Care with "plus" group - homeless people in Warwick District.

Strategies:
National:
NHS LTP ambitions for Personalised Care, NHS DES contract for Primary Care

	Local: C&W Personalisation strategy, C&W Health Inequalities strategy C&W Anticipatory care framework
Key outcomes – what do we need to achieve to realise the vision?	**Outcomes & Impact - what we aim to achieve for Patients, Staff and our System:** To identify what is important to our population and to evidence Personalised Care approaches are adopted, we will work with our partners to evidence the impact of their approaches with the adoption of "I" statements such as: Patients: ✓ I feel involved with the decisions about my health and care, understanding the options, risk and benefits ✓ I feel the care I am receiving is based on "what matters to me" – making it personalised ✓ I am able to access support for my health and wellbeing needs closer to home ✓ I am confident that at every stage my health and care needs will be met ✓ I have access to information and experts with early intervention to support me to manage my care and reduce the need for me to use hospital ✓ I feel safe and confident that I can access support in the right care setting ✓ I know that I am supported throughout my care journey. Staff: ✓ I feel confident in holding shared decision-making conversations with patients ✓ I am able to access supporting tools and training on Personalised Care ✓ I understand the benefits of Personalised Care for my patient(s) ✓ I encourage patients to ask questions about their health and care needs. System: these will vary depending on setting, but may include: ✓ Reductions in emergency admissions ✓ Reductions in A&E attendances ✓ Reductions in repeat visits to Primary Care ✓ Reduction in bed days/improved process (MT) ✓ Increase in population able to self-manage health and wellbeing – reducing health inequalities. *Source: The Midlands Training Collaborative Personalised Care April 2022*

How will we do this?	**Key Enablers to support our ambitions:** The type of System working required to deliver progress and change on Personalised Care means that we are mindful of other channels of activity with overlapping interests. The steering group will review the best ways to ensure this is achieved. There are some key enablers: • Start with strengths: celebrate good practice where Personalised Care is already embedded into customer/service pathways • Develop the workforce and culture to enhance awareness of what Personalised Care is and how to apply in day-to-day interactions with patients • Strategic leadership to Personalised Care across our System in Place • Co-production • Commissioning contracts and finance • Digital change • Population Health Management • Aligning with key strategic plans – we are ensuring that personalisation is woven into other System activity as is appropriate – ensuring that Personalised Care is embedded wherever there is an opportunity do so. For example: Health Inequalities strategy, Digital transformation, Proactive care @ Home, Anticipatory Care planning for C&W • Active enabling campaign for prepared patient and supporting self-care and optimising MECC.
How will we measure success monitor progress and outcomes?	Detailed monitoring of the programme is undertaken by the Programme Board, with bi-monthly progress reports (including KPIs for key metrics) reported to NHSE and subject to regular scrutiny.

Appendix C: Example of a Prepared Patient resource

Acknowledgements

This strategy has been co-produced with members of the Coventry and Warwickshire Personalisation steering group and with colleagues from the NHSE Personalised Care regional team.

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