Coventry and Warwickshire
Integrated Care System

Leadership for Personalised Care

Toolkit and Checklist v0.1

January 2023

What is in this Toolkit?

- What Personalised Care is and why it matters
- The Universal Comprehensive Model
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What Personalised Care Is *and why it matters…*

- Personalised care represents a new relationship between people and professionals with “what matters to me” being at the heart.
- It is a central component of both the NHS Long Term Plan, and the Coventry & Warwickshire ICS Strategy.

We can, through personalised care:

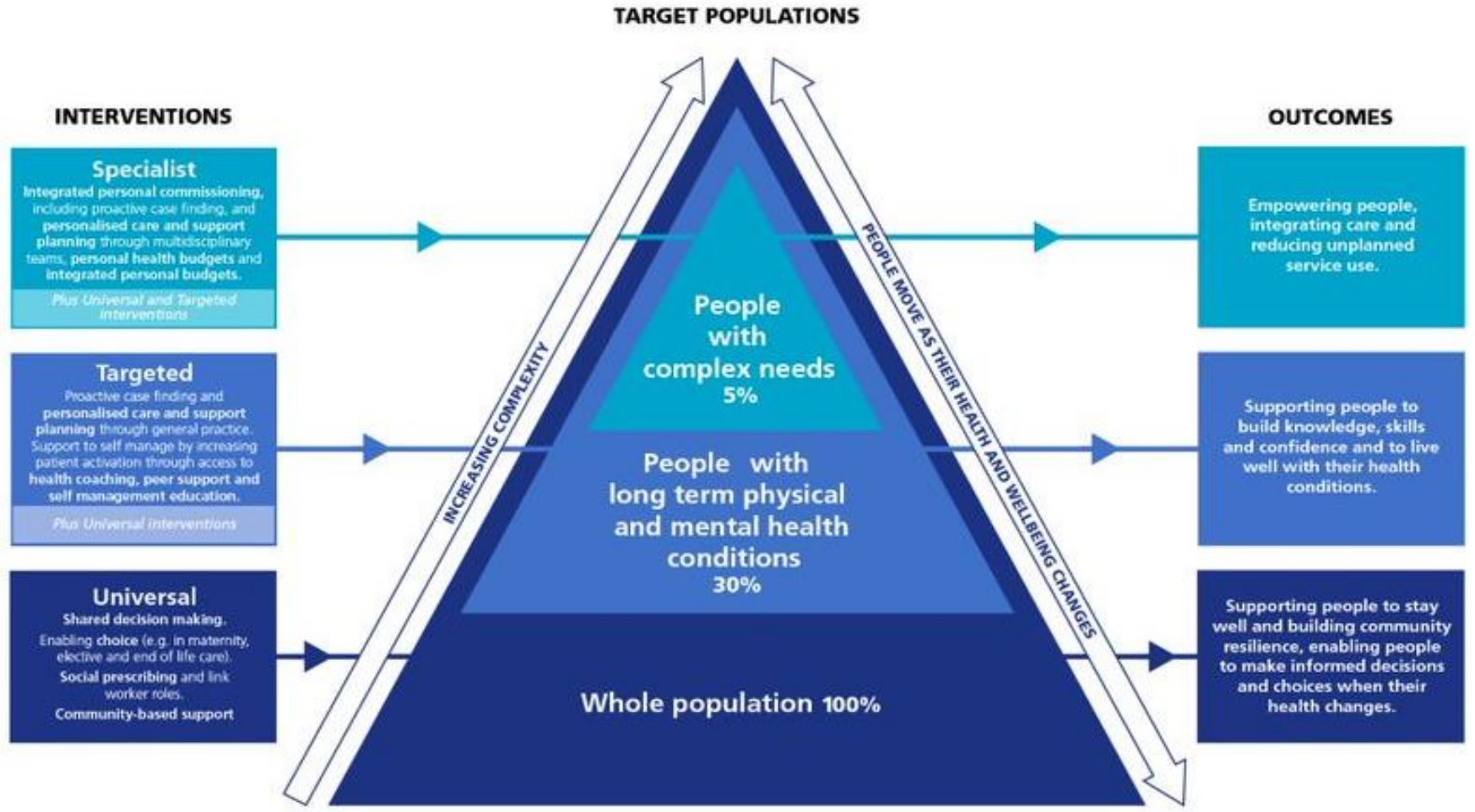
- Achieve better experiences and health outcomes for people by embedding the six components of the UPC model across our System, Place and Neighbourhoods.
- Reduce health inequalities by giving everyone the opportunity to lead the healthiest life they can, no matter where they live or who they are.

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 passive recipients of services to active
- Citizens
- It's about getting a life, not a service

**Adapted from the Leadership for Personalised Care Programme created by the Personalised Care Group in NHS England and Improvement and the NHS Leadership Academy in partnership with In Control.

The Universal Comprehensive Model



View more online at:

[NHS Comprehensive Personalised Care Model - Explainer Animation – YouTube]

[NHS Personalised Care Institute - YouTube]

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What is Leadership for Personalised Care?**

Leadership for personalised care is a person- and community-centred complex adaptive approach to leadership. It is co-productive, collaborative, cross-boundary and multi-disciplinary. No one leader or service can solve health inequalities or obesity, and long-term conditions need long-term supports for people themselves, not a single process 'fix'.

Leaders therefore need the skill, will, knowledge and confidence to work across boundaries and systems to drive health improvements across the whole population.

Marmot in 2020 recommended:

- Focusing on preventing ill health and promoting good health as well as treating disease. That requires seeing the NHS as more than simply providing reactive services ***and focusing on what matters to people and their whole lives.***
- Thinking about 'place' and enabling cross-sector collaboration - leaders from health, care, housing, the voluntary sector and local communities working together.
- Understanding the local population and providing additional resources for more deprived communities and areas.

Leadership for personalised care is about creating the conditions for these things to happen.
We need leaders who are confident, willing and able to work across boundaries and to put what matters to people over the needs of a single organisation.

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Leadership Qualities for Personalised Care - Being

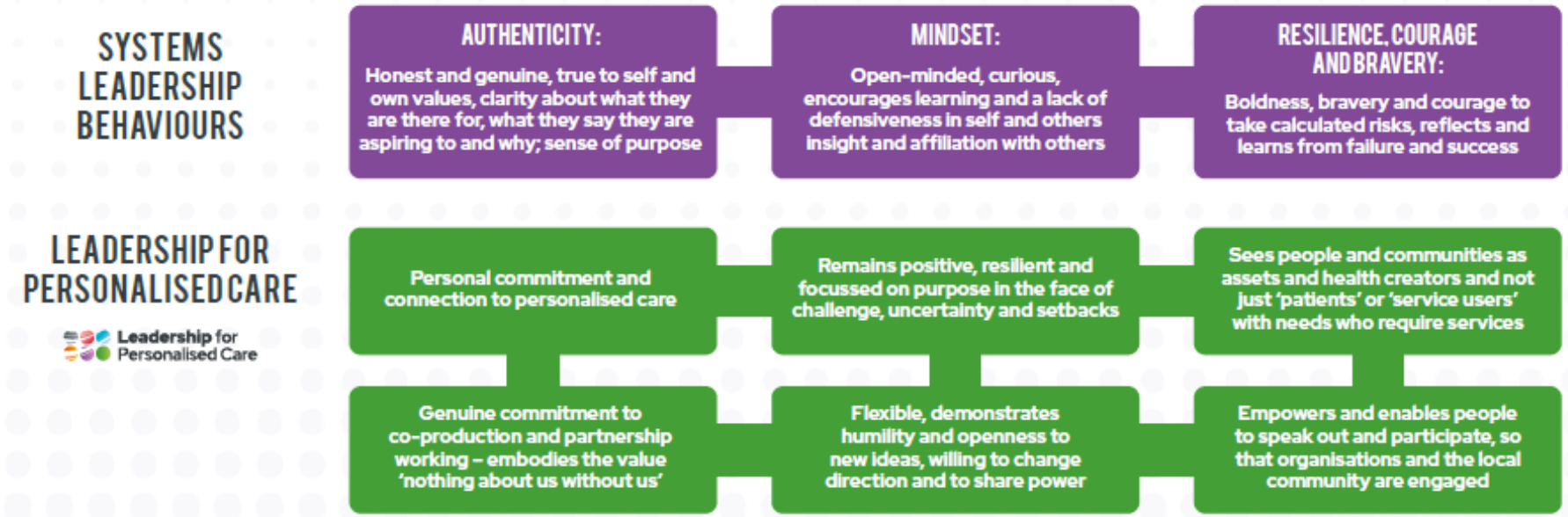
We have developed a framework to describe what we mean when we talk about leadership for personalised care. It should help you understand the qualities and behaviours that are needed – what to focus on yourself and what to encourage in others to achieve a system-wide shift toward personalised care.

The framework was co-produced with people who use services and carers, and draws on the expertise and practical experience of our leadership for personalised care team and partners.

The framework groups leadership for personalised care qualities into four themes.

Each theme includes a foundation of systems leadership behaviours with additional qualities specific to leadership for personalised care as follows:

- **Being**
- **Relating and communicating**
- **Leading and visioning**
- **Delivering**



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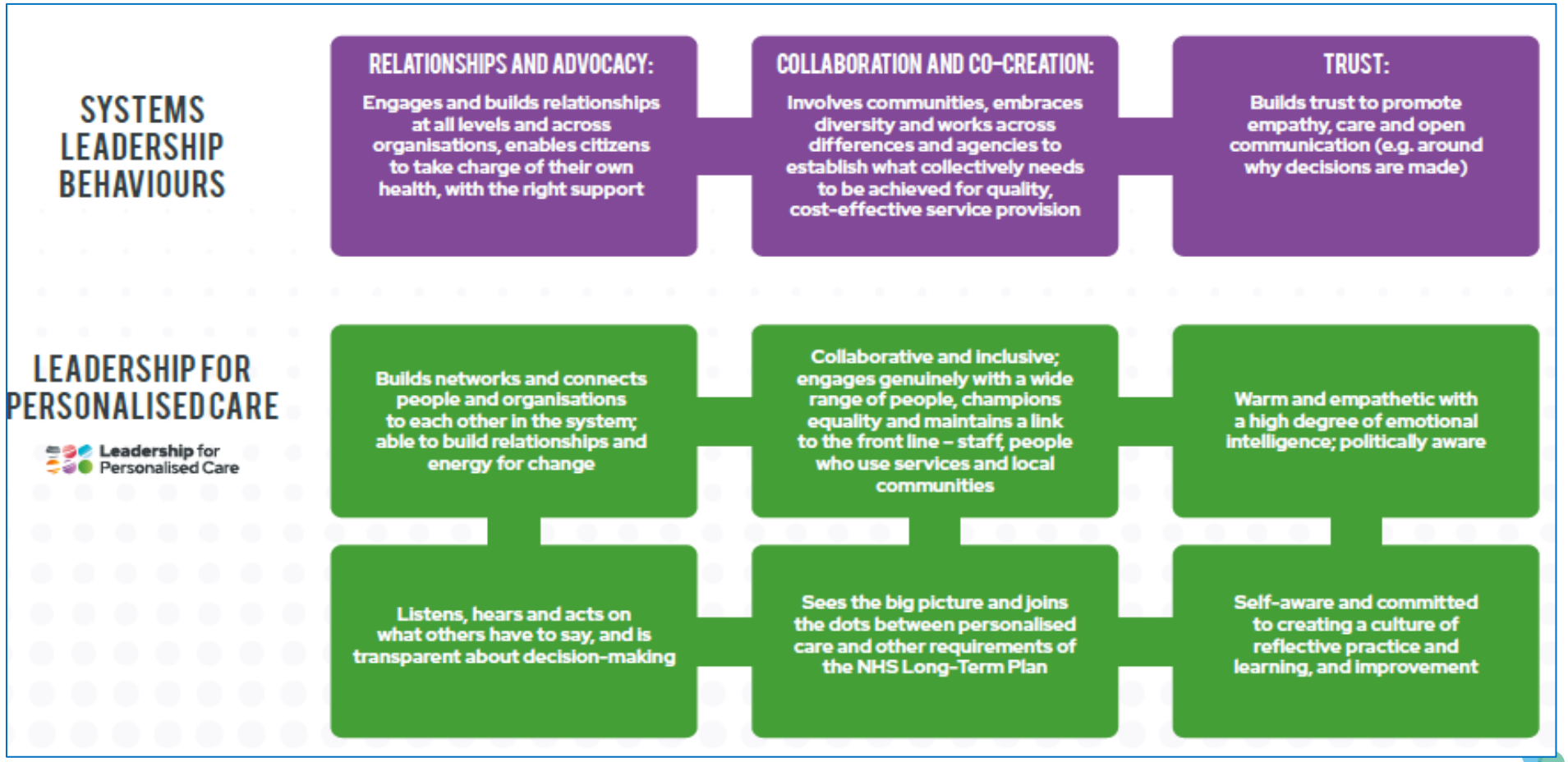
Leadership Qualities for Personalised Care – Relating and Communicating



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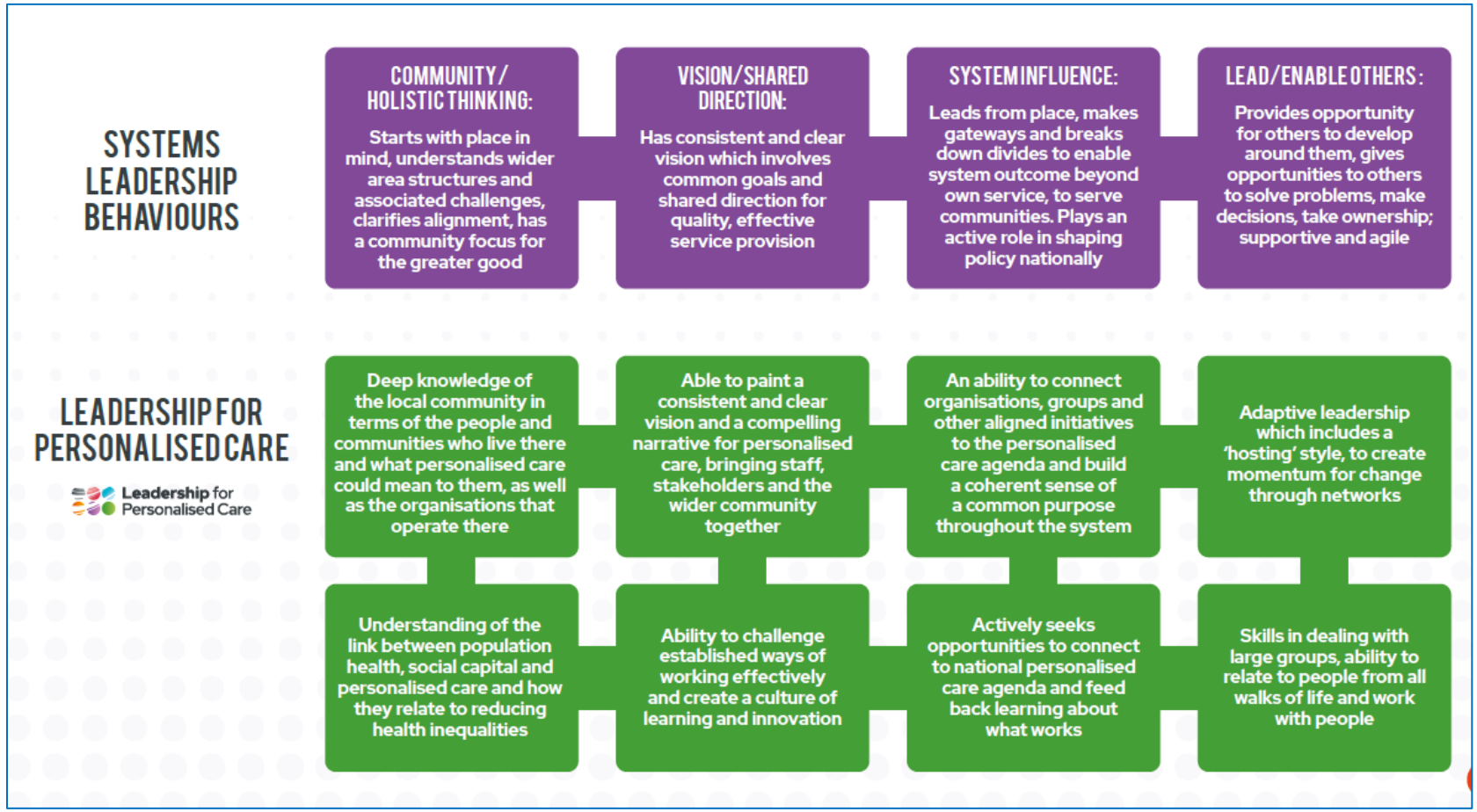
Leadership Qualities for Personalised Care – Leading and Visioning



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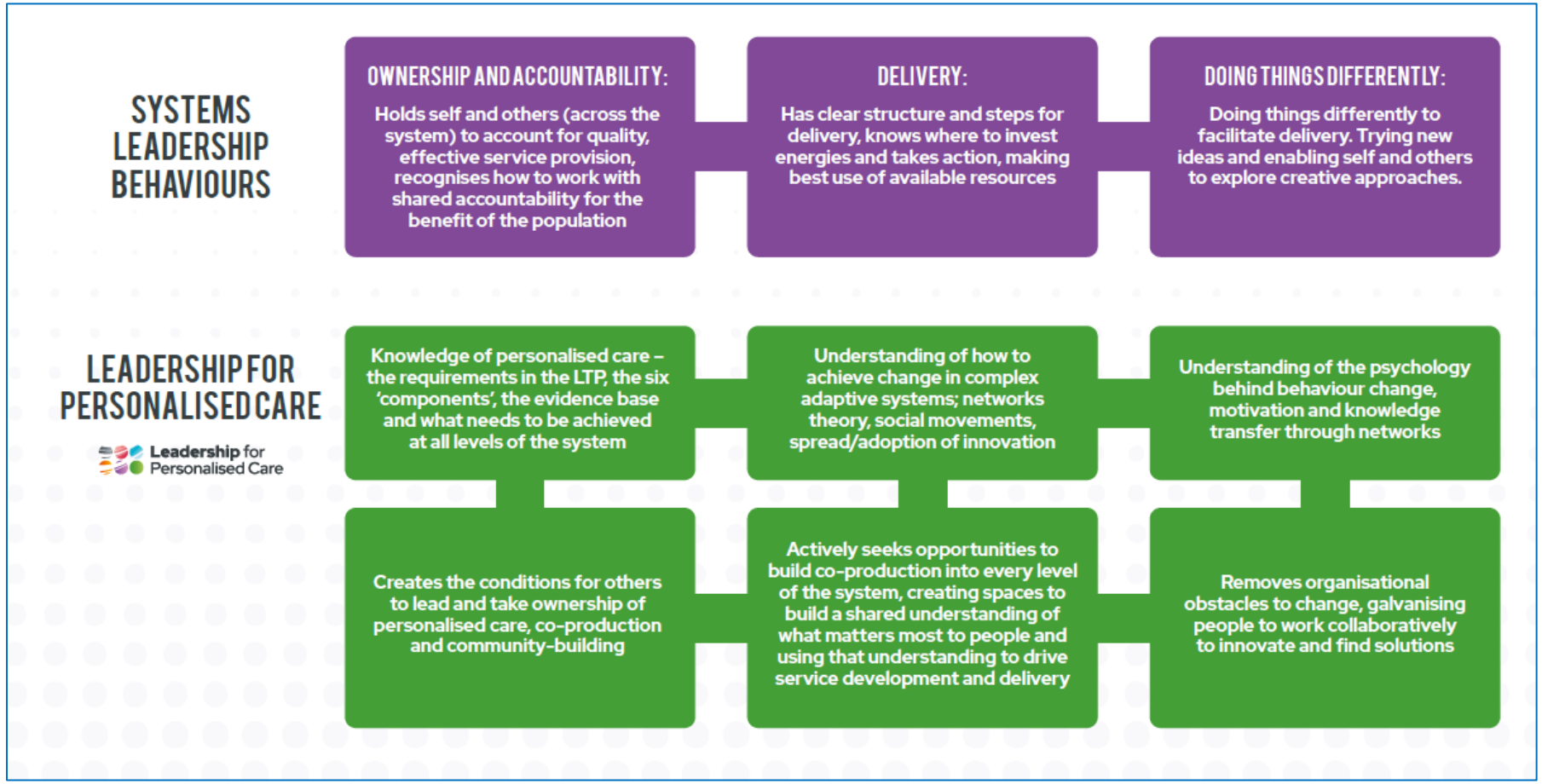
Leadership Qualities for Personalised Care – Delivering



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Delivering Personalised Care

Personalised care can be offered using any of six components:

1. **Shared decision making** - equal partnerships and better conversations between people and those supporting them.

2. **Enabling choice** – have choice over your treatment and the services you can access.

3. **Social prescribing and community support** - connecting people to their communities and non-medical supports.

4. **Supported self–management** – health coaching, self-management education and peer support.

5. **Personalised care and support plans -** everyone with a long-term condition has the chance to have a conversation about what matters to them, in the context of their whole life.

6**. Personal health budgets** - giving people with the most complex needs direct control over their care.

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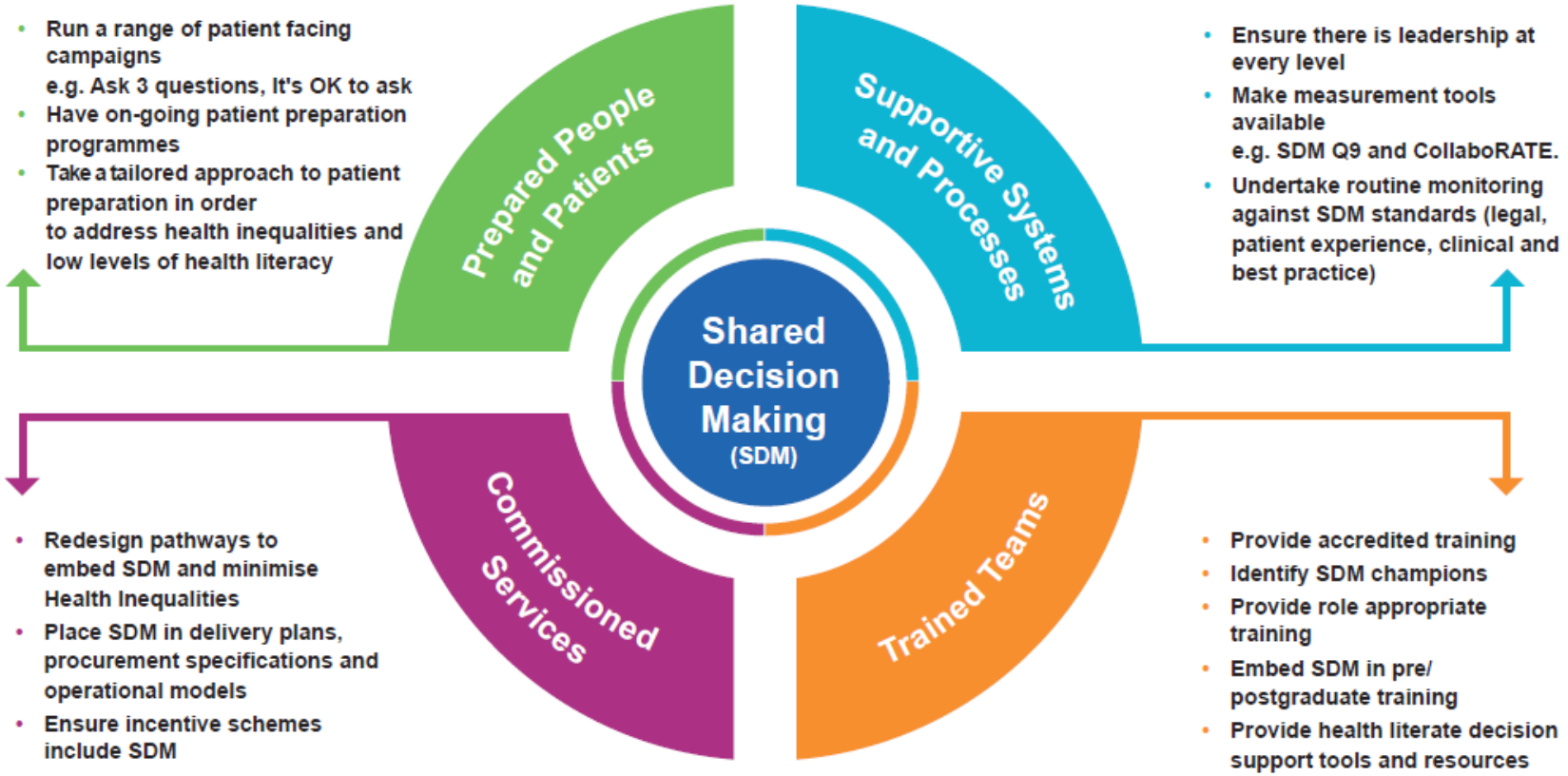
Shared Decision Making: *the foundation of excellent personalised care*



NHS England Shared Decision Making implementation framework

Using the Shared Decision Making (SDM) framework will help you start conversations with key stakeholders so that you can understand where your service is in terms of delivering personalised care.

Embedding Personalised Care almost always means changing and redesigning clinical pathways. **Changing established pathways requires a programme of work that is co-designed by all local stakeholders including the people who use services and teams providing care.**

Using the framework will also help you put in place the essential elements needed for a successful change programme.

What if I do Nothing? In this video, Claire Valsler talks about the difference a shared decision making approach has made to her.

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Social Prescribing

Social prescribing is when GPs and local agencies refer people to community supports and groups instead of traditional services. This happened in some places in the past but has been made more universally possible through the funding provided through the long-term plan for social prescribing linkworkers, based in local primary care networks.

Linkworkers 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.

Read more about social prescribing here.

Case Study from The You Trust, Portsmouth

Toby was referred by his Physiotherapist as he required hip replacement surgery but was unable to access it. As he was homeless he could not secure a surgery date (risk of infection) nor access Adult Social Care without the surgery date. Toby had stayed in hostels and used the day services but did not feel comfortable being there, so his situation was not improving. In addition to this, it was very difficult to contact Toby as he had no credit for his mobile.

We paid for credit for the phone to support his ongoing communications with services.

The first step was to complete his housing application and secure temporary accommodation. With this, he would be a step closer to being in a suitable situation to have his surgery and receive the care he would need for the recovery. Through working together with The Society of St James, his physiotherapist, and housing options, Toby is now in a secure hostel that he feels safe in, has finalised his benefit claim, and enquiries have now been made as to when he can be put onto the surgery waiting list. In the meantime we look for permanent accommodation.

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Supported Self-Management

Supported self-management is about helping people with long-term conditions to increase their knowledge, skills and confidence to better manage their health and wellbeing.

This includes support such as health coaching, self-management education and peer support. The voluntary sector plays a key role in enabling peer support and mutual aid to flourish, and it is vital that leaders recognise and work with communities to provide peer support and mutual aid.

Watch this video of Stephen's Story from The Personalised Care Institute – gaining skills and knowledge to ensure a better healthy lifestyle.

Health coaching is a supportive, structured, goalfocused conversation that aims to increase someone's confidence to manage their own health. Health coaching usually takes place over a number of sessions.

Peer support describes a range of formal and informal mutual help, advice and mentoring that people give to others who are going through similar life experiences. This can range from online forums, to more formal 1-2-1 peer support services provided by charities.

Self-management education courses are structured learning opportunities for people with long-term conditions – these could be offered when someone is newly diagnosed with a condition or later on.

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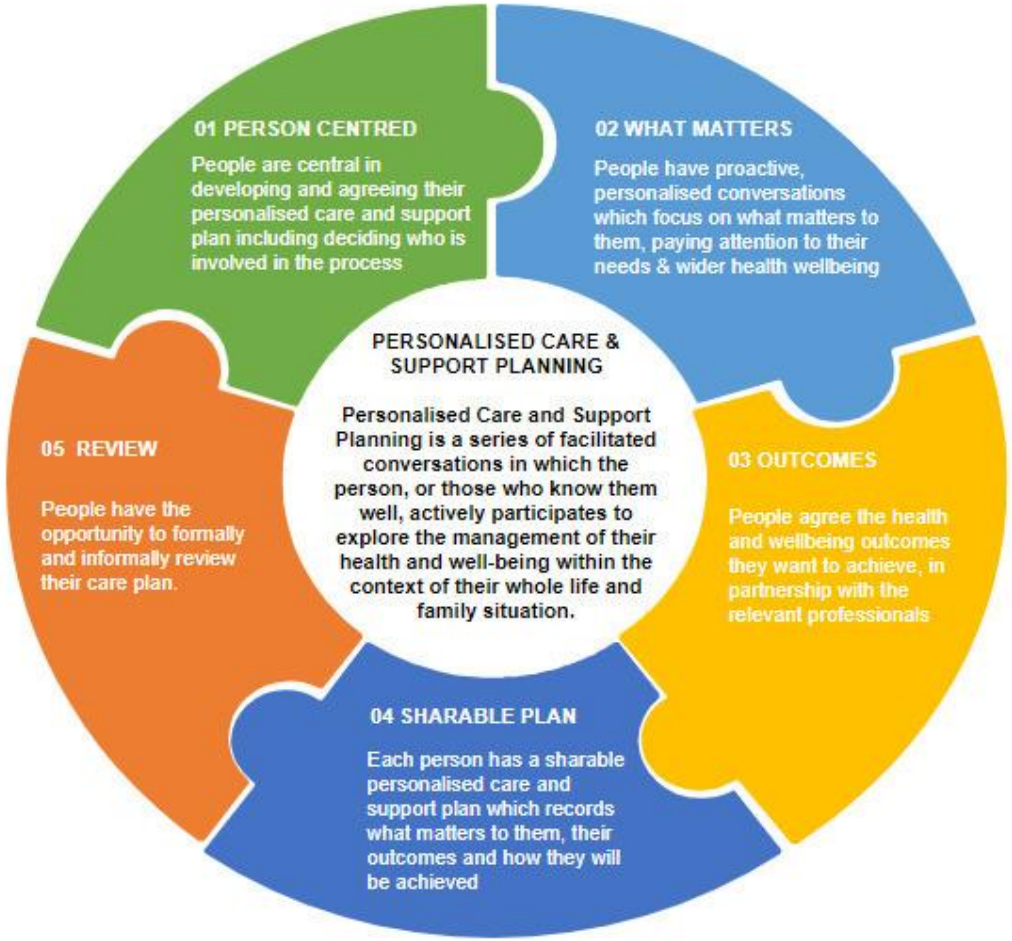
NHSE Foundations for Excellent Personalised Care and Support Plans



Personalised care and support planning is a 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.

Care and support planning brings together contributions from family, friends, community, health and social care and sometimes education and housing. It is the opposite of slotting people into service spaces – it determines how services will be designed and organised around the person. If appropriate, the plan will also detail how the person's personal budget will be spent. The plan is reviewed on an annual basis to reflect on what is working and not working and to make changes.**

In this video for the Personalised Care Institute, Zainab describes why care and support planning is important to her.

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Choice & Personal Health Budgets

Enabling Choice

In many cases there is a legal right to choose where you have your NHS treatment. NHS England wants 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 an opportunity to choose a suitable alternative provider because I was going to wait longer than the maximum waiting time specified in my legal rights**
- **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**

For more information on the NHS Choice Framework **read here**

Personal Health Budgets

A personal health budget is an amount of money to support a person's health and wellbeing needs. It isn't new money, but a different way of spending health funding.

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.

A personal health budget may be used for a range of things, including therapies, personal care and equipment.

In this video, Dylan talks about how his personal wheelchair budget has saved money and given him independence.

Read more about personal health budgets here. For guidance on Personal Health Budgets for professionals follow this link.

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Case Study: a patient's story

The History	19/05/2022 Patient Reported Outcome Measurements:	*The Personalised/PHM approach adopted in Coventry:*	27/05/2022 Patient Reported Outcome Measurements:
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 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.	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: 144 (really high)	**Description**: an individually tailored, psychologically informed physiotherapist-led intervention. **Patient selection:** Coventry patients identified with persistent lower back pain. 80% from mid or highly deprived areas, a high % have mental health disorders (>50%), 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 are typically high users of primary care, with ***an average of 32 contacts per year.*** **Activities undertaken**: Initial physiotherapist-led holistic 90-minute assessment. The results 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).	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: 34 (normal)

Please Note: *This case study 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.*

The Checklist

Personalised Care Component	Foundation	Where is your Service now?
Shared Decision Making	**1.1 Leadership at every level, including clinical** • Our SDM programme is led by a clinical lead, a person with lived experience, a representative from the voluntary and community sector, a programme manager, and both an executive and non-executive sponsor. • All clinical team members have an awareness of the importance of SDM	
	1.2 Trained Teams: • The workforce has access to personalised care training via the Personalised Care Institute (Your learning options (personalisedcareinstitute.org.uk)) to support and embed SDM. • Staff are supported to attend workshops/webinars on how to apply personalised care in their day-to-day practice. • Staff are able to access support from the Personalised Care programme and access website resources and toolkits. • All clinical team members have an awareness of the importance of SDM • All members of clinical teams have been trained in SDM and simplified communication techniques, which helps check whether complex information has been explained effectively i.e. in a way that makes sense to people (e.g. 'teach back' across the pathway). • All clinical team members demonstrably practice shared decision making. • There is a long-term programme in place to build SDM capability within the Service workforce. • SDM forms part of every new member of staff's induction. • SDM is recognised as an ongoing CPD need for clinicians.	
	1.3 Prepared patient: • There is a programme to develop patients' skills, knowledge and confidence to participate in SDM conversations – e.g., the C&W ICS "prepared patient" resource/campaign - It's ok to Ask, which encourages people to ask key questions, so they are better supported to make a decision about care, support or treatment options; and mechanisms for providers to actively engage patients in this approach – copies available from the Personalisation programme team • We have patient and public input into developing health literate decision support resources. • We can use videos such as this to support our prepared patient approach: https://youtu.be/V-poY45LNgg • We use a validated tool to measure patient and clinical involvement in shared decision making (eg . CollaboRATE, Sure, SDM-Q9, SDM-Q-DOC).	
	1.4 Commissioned services • We use a range of shared decision-making evaluation and monitoring tools for example: CollaboRATE, Sure, SDM-Q9 / SDM-Q-DOC • Our third-party providers use a relevant clinical code to capture that an SDM conversation has taken place between clinician and patient. • We have a defined set of process and outcome metrics. • We measure the financial impact, including return on investment, of implementing SDM.	

The Checklist

Personalised Care Component	Foundation	Where is your Service now?
Personalised Care and Support Plans	**2.1 Workforce training:** • The workforce has access to personalised care training via the Personalised Care Institute (Your learning options (personalisedcareinstitute.org.uk)) to support and embed Personalised Care and Support Plans. • Staff are supported to attend workshops/webinars on how to apply personalised care in their day-to-day practice.	
	2.2 Our PCSP process supports the criteria for a great plan: • People are central in developing and agreeing their personalised care and support plan including deciding who is involved in the process. • People have proactive personalised conversations which focus on what matters to them, paying attention to their needs and wider health wellbeing. • People agree the health and wellbeing outcomes they want to achieve, in partnership with the relevant professionals. • Each person has a sharable personalised care and support plan which records what matters to them, their outcomes and how they will be achieved.	
	2.3 Staff are aware that PCSPs are recommended for: all long-term condition pathways, plus maternity services, palliative and end of life care, residential care settings, cancer, and cardiovascular diseases.	
	2.4 Staff working with patients in the following areas are able to: access specific resources to support the development of PCSPs from the ICB website **happyhealthylives.uk** • Long Term Conditions • Maternity Services • Outpatients • Waiting Lists for Elective Procedures	
	2.5 Staff are able to: evidence how personalised care and support planning is used and reviewed to give patients more choice over how services are delivered.	

Personalised Care Component	Foundation	Where is your Service now?
Social Prescribing	**3.1 Staff understand the role of social prescribing** to support patients with their needs and wider health and wellbeing.	
	3.2 Staff have access to local social prescribing services to enable referrals in primary care and community provision.	
	3.3 Staff are aware of the hospital social prescribing service to support patients on discharge and how to refer into it.	

The Checklist

Personalised Care Component	Foundation	Where is your Service now?
Supported Self Management	**4.1 There is evidence that supported self-management is embedded into offer/service delivery model** with patients, e.g. evidence of appropriate interventions such as health coaching, self-management education and peer support that can help people to develop the capacity to live well with their condition(s).	
	4.2 Staff have the resources and support to develop information for patients.	
	4.3 Digital options are available for some patients: e.g. NHS@Home supports more connected personalised care, using technology such as remote monitoring devices to support people to better self-manage their health and care at home with education and support from clinical teams.	

Personalised Care Component	Foundation	Where is your Service now?
PHBs	5.1 **Staff understand how** PHBs support patients, know how to access PHBs, have opportunities to utilise them, and evidence their use.	
	5.2 **Staff are aware that PHBs are flexible and agile** in order to meet the individual needs of the individual patient.	

For information on the support available from the Coventry & Warwickshire ICS Personalisation Programme, contact Programme Manager Karen.Higgins@geh.nhs.uk, or Programme Coordinator Laura.Quirke@geh.nhs.uk.