Personalised Care: a maturity framework for embedding Personalised Care in Service Development Plans

This checklist is designed to help anyone who is responsible for implementing and embedding Personalised Care in their local Service.

Coventry and Warwickshire Integrated Care System

1. What Personalised care is:

- 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.
- It is a 2022-23 CQUIN, to be embedded in Service Development Plans for 2023-24 and beyond.

2. Why it matters:

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.

3. The foundations of excellent personalised care:

Excellent personalised care is illustrated in the NHSE Shared Decision Making ('SDM') implementation framework (see Figure 1).

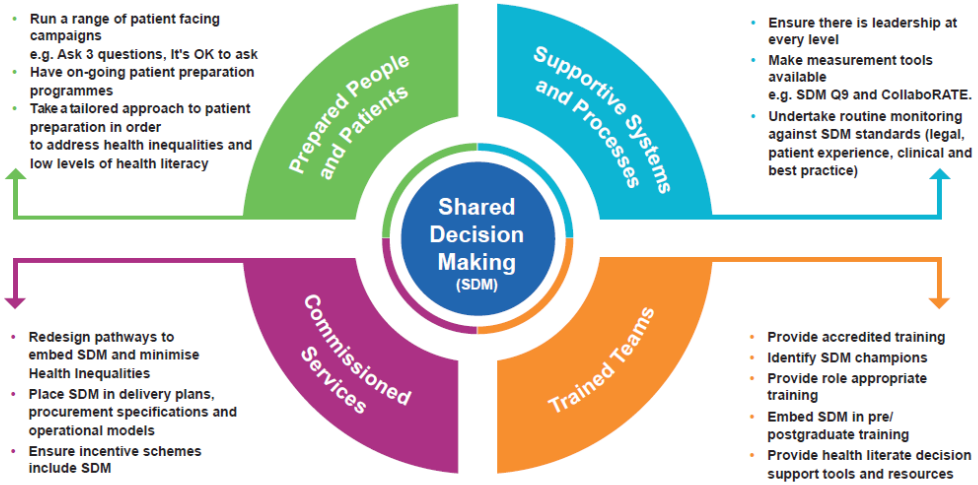

Figure 1: ***NHS England Shared Decision Making implementation framework***

4. How to do it:

Using the SDM framework above 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 in Service Development Plans almost always means changing and redesigning the clinical pathway. Using the framework will also help you put in place the essential elements needed for a successful change programme.

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.

Personalised care can be offered in your service using one or more of the following six components:

1. **Shared decision making *(see Fig. 1)***
2. **Enabling choice**
3. **Social prescribing and community support**
4. **Supported self–management**
5. **Personalised care and support plans *(see Fig. 2)***
6. **Personal health budgets**

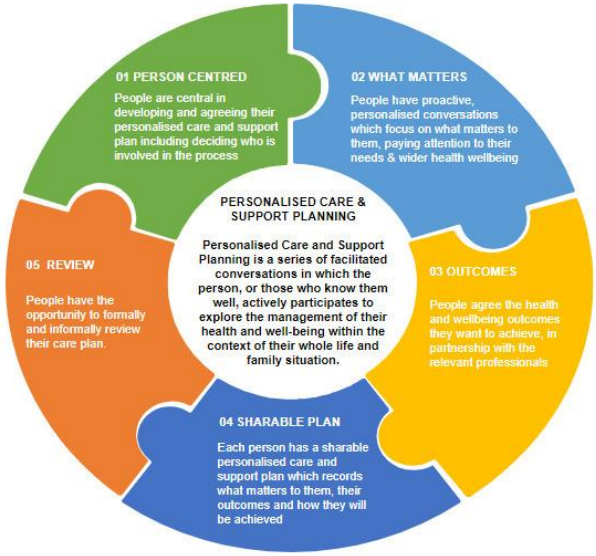

Figure 2: ***NHS England foundations for excellent PCSPs***

5. Personalised Care Checklist

Personalised care can be offered using any of the components:

Personalised Care Component	Foundation	Where is your Service now?
Shared Decision Making *(See Fig. 1)*	**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 • SDM is a routine element of all clinical audit activity, including through a peer-review process for assessing and providing peer feedback to team members on their shared decision-making practice.	
	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. • There is a Personalised Care Champion/Ambassador in the Directorate.	

	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.
	• SDM is included as a requirement in all relevant procurement specifications.	

Personalised Care and Support Plans (PCSP) ***(See Fig. 2)***	**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. • Staff are able to access support from the Personalised Care programme and access website resources and toolkits.	
	2.2 Our PCSP process supports the criteria set out in Fig 2 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. • People have the opportunity to formally and informally review their care plan.	

	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, dementia 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. WWW DOWNLOADS AVAILABLE MARCH 23 • Long Term Conditions • Maternity Services • Outpatients • Waiting Lists for Elective Procedures • Case Studies	
	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.	
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.	
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.	
Personal Health Budgets	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.