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Draft Curriculum v3.6

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**References**

**Foreword**

Personalised care represents a new relationship between people, professionals and the system. It happens when we create the infrastructure that maximises the expertise, capacity and potential of people, families and communities to take increasing control of their health and wellbeing. People want:

* to be treated as a whole person by professionals they trust
* to be involved in decisions and about their health and care
* to be supported to manage their own health and wellbeing, through health coaching, access to self-management programmes and to peer support in the community
* their care to feel co-ordinated

These are the core elements of *personalised care* that are now accepted internationally as good clinical practice.

Over the last 3 years, NHS England and NHS Improvement have bought together the principles of personalised care with the more social care oriented principles of *personalisation* in the *Comprehensive Model for Personalised Care*

According to this model, people access personalised care through six key components or programmes that come together to deliver an all age, whole population approach to personalised care.

The deployment of these six components will deliver:

* whole-population approaches, supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build community resilience, and make informed decisions and choices when their health changes,
* a proactive and universal offer of support to people with long-term physical and mental health conditions to build knowledge, skills and confidence to live well with their health condition, and intensive and integrated approaches to empower people with more complex needs, including those living with multi-morbidity, to experience coordinated care and support that supports them to live well, helps reduce the risk of becoming frail, and minimises the burden of treatment.

Evidence from national surveys tells us that we could do more to provide personalised care. We also know that the skill-sets required to share decisions, plan care and support self-management overlap to a remarkable degree and are not taught consistently across the undergraduate and post-graduate curricula of the various Royal Colleges and other national representative bodies.

To provide consistent training, we have established the Personalised Care Institute

(PCI). The institute will be the training centre of excellence in personalised care for the healthcare workforce (practitioners).

**Acknowledgements**

The curriculum project was led on behalf of the RCGP by Pauline Foreman, assisted by Hayley Dunn, and the project was managed by Rebecca Hughes and Andy Riley.

The core curriculum group included Steve Walter, Sam Finnikin, Anya de Iongh, Petrea Fagan, Jayne Haynes, Suchita Shah, and Helene Irvine.

**Introduction to the curriculum**

**The purpose of the curriculum**

The curriculum articulates the values, behaviours and capabilities required by a multi-professional workforce to deliver personalised care. It sets out an educational framework for learning the essential elements to this approach and supports ongoing professional development.

The purpose of the curriculum is to unify the array of approaches that reflects the different ways of supporting Personalised Care, and thereby:

1. describe the learning outcomes for individual practitioners to deliver care according to *NHS England and Improvement Universal Personalised Care* quality standards1
2. inform the educational aims and objectives for training courses
3. provide a framework for accreditation and governance of training courses
4. describe, for commissioners and organisations, the skillsets needed within their teams to deliver personalised care.

**The philosophy of the curriculum**

The curriculum is based on the principles of Excellence by Design2 and incorporates generic professional capabilities across the spectrum of medical and non-medical professions.

Although the curriculum is intended primarily for workforce and training purposes, we have been conscious of keeping personalised care at the centre by using the language and ethos of collaboration and enablement. There is an intentional shift from problem-solving to collaborative models as a pre-requisite to facilitating changes in professional behaviours.

The curriculum is based on professional behaviours and high-level learning outcomes rather than providing a detailed syllabus. It was important that we strengthened the perspective of service users rather provided a list of tasks for the learners. Professional groups and organisations are encouraged to develop their own specific syllabi based on the scope and context of their practice.

Learning outcomes are intended to be applied to roles in delivering personalised care rather than defined by profession or assumed seniority and thus reflect a holistic approach to skills within an organisation. They provide the basis for blended learning strategies and suggestions for learning methods have been included

**Who is the curriculum for?**

* *Individual practitioners within the primary care and secondary workforce and community teams*. The curriculum provides a programme of learning for personalised care capabilities and guides personal professional development for medical, non-medical professional groups such as Physiotherapists, Occupational Therapists, Pharmacists, and the wider non-registered health and social care workforce such as care coordinators, link workers, health and wellbeing coaches, and nurse associates.
* *Education and training providers* who require accreditation for their courses by the Personalised Care Institute. The curriculum provides a blueprint for learning objectives and outcomes for the six components of personalised care and the relevant models and approaches, against which approval will be mapped. It also describes a framework for standards of training and governance.
* *Commissioners of education and training* for developing a future workforce with the skills, knowledge and behaviours that will be needed by employers to transform services. The curriculum enhances the confidence of the workforce in translating knowledge into action through the models and approaches of personalised care

1 Personalised Approaches: Empowering people in their lives and communities to enable an upgrade in prevention, wellbeing, health, care and support. NHS England. London. 2017.

2.Generic professional capabilities framework. 2017. General Medical Council. London.

This Personalised Care curriculum builds on the core foundation of ‘**Person-Centred Approaches – a core skills education and training framework. 2017’** to include a greater level of detail on

essential models and approaches, and the ‘Six Components’ of personalised care. See ‘The Structure of the Curriculum’ p. 12

Table 1. The Person-Centred Approaches framework:

|  |  |  |
| --- | --- | --- |
| **The core of personalised care** | | |
| Values  Core Communication and relationship-building skills  Conversations to engage with people | Conversations to enable and support people  Conversations with people to manage the highest complexity and significant risk | Enabling people to work in this way through:   * Development of the workforce * Development of the organisation * Supporting behaviour change   Valuing diversity and cultural differences |
| **Knowledge – which may include the following:** | | |
| Social determinants of health  Patient Activation  Quality Improvement  Technology to support health and wellbeing  Health Literacy  Accessible information  Standards | Patient and Public Involvement  Awareness of local services and resources  Coproduction  Asset-based approaches  Looking beyond traditional health and care solutions  Carer awareness | Communities  Prevention (primary, secondary, tertiary)  Person-centred measurement and outcomes  Statutory and mandatory regulation and governance  Relevant policy |
| **Activities – which may include the following:** | | |
| Shared Decision-Making  Social Prescribing  Care navigation  Care coordination  Advocacy  Supported self-management  Personalised Care and support planning  Health coaching  Personal Health Budgets | Motivational Interviewing  Peer support  Recovery  Personal Budgets  Supporting behaviour change  Signposting  Advanced Care Planning | Making Every Contact Count (MECC)  Managing risk  Working in partnership  Working in partnership at individual and service level  Integration of services across sectors  Measuring impact at individual and service level |

**The context of the curriculum**

Personalised Care has direct relevance to the wider workforce beyond the NHS, for example care homes, social care, local councils, and the voluntary sector. This curriculum can be used to support an integrated approach across all systems and communities of practice in health and social care.

Learners will not be expected to have any previous experience. Increasing levels of training will build on core skills and equip professionals with higher level skills according to their role.

It is also hoped that those people in organisations who hold positions of responsibility for developing their workforce through commissioning, training, and leadership will find the curriculum useful in providing clarity about the desired behaviours needed for implementing a personalised approach.

**The language of the curriculum**

Personalised Care is based on enabling the workforce to develop genuine partnerships with people, families, carers, communities and colleagues. Practising in health and social care is a complex combination of many behaviours, decisions, and interactions.

The diverse range of contexts in which personalised care is applied means that it is necessary to focus on generic capabilities and high level learning outcomes rather than a detailed syllabus covering the scope of practice of the many and varied groups of practitioners.

According to the context of the relationships, we use varying terms such as ‘people’, ‘individuals’, or ‘patients’. This is not based on any assumptions as to the nature of the relationships, nor does it infer any value judgement or define the status of those involved. Whenever any specific term is used it should be considered as interchangeable according to context and can be assumed to include all participants relevant to the specific circumstances, such as family, carers, networks and communities.

**Competence**

The ability to do something successfully and efficiently and ensures that the learner can fulfil the needs of their role in providing personalised care. In the context of personalised care, ‘competence’ is the summation of experience and outcomes from both parties’ perspectives i.e. the person delivering and the person receiving services (and colleagues in respect to teams).

**Capabilities**

This is the ability to perform tasks flexibly in a variety of contexts and at a higher level of complexity. Many of the qualities of professionals, are described by their relevant capabilities. The learning outcomes outlined in this curriculum specifically link to capabilities in Personalised Care.

**Descriptors of Professional Behaviour**

Each component of the curriculum has a set of professional behaviours. They are intended to illustrate the knowledge, skills and attitudes required in practice.

**Learning Outcomes**

Learning Outcomes capture the skills, knowledge and behaviours required. Learning outcomes are statements that set out those essential aspects of learning that must be achieved.

**The language of learning outcomes**

Specific capabilities in the curriculum are broken down into more specific professional learning outcomes. The following wording has been used:

Table 2. Modified Bloom’s taxonomy of learning

used in the

|  |  |  |
| --- | --- | --- |
| Recall or respond | The ability to recall previously presented information and/or comply with a give expectation | Accept, define, describe, follow, record |
| Comprehend | The ability to grasp the meaning of information in a defined context | Acknowledge, appreciate, clarify, identify, recognise |
| Apply | The ability to use rules and principles to apply knowledge in a defined context and/or display behaviour consistent with an expected belief or attitude | Adopt, apply, communicate, contribute, demonstrate, implement, measure, obtain, participate, use |
| Evaluate | The ability to analyse and judge information for a defined purpose and/ or justify decisions or a course of action | Analyse, appraise, compare, differentiate, discuss, evaluate, explore, interpret, justify, monitor, reflect on, review |
| Integrate | The ability to bring information together to demonstrate a deeper understanding and/or demonstrate behaviour consistent with the internalisation of professional values | Advocate, challenge, commit to, create, deliver, develop, enhance, facilitate, integrate, lead, manage, organise, plan, prioritise, promote, provide, respect, tailor, value |

Modified from principles in Anderson LW, Krathwohl (eds). A Taxonomy for Learning, Teaching, and Assessing: A Revision of Bloom’s Taxonomy of Educational Objectives. New York: Longman, 2001.

**Learning Outcomes for providing personalised care in practice:**

Approaches to training and the application/integration of learning will be highly contextual and therefore should to be tailored to specific working environments and professional role. Within any team there will be a mix of skills which are complementary but may require different levels of learning. The learning levels relate to the role of the learner within the team and are not defined by seniority or professional identity.

The training should facilitate moving from a focus on problem-solving ‘what’s the matter with you’ to collaboration, facilitation, or coaching based on ‘what matters to you’

Although separated in the curriculum for structural reasons, the levels of learning outcomes contribute to a spiral approach to the curriculum whereby each level provides a foundation for the next. Each of the levels learning outcomes are intended as complementary and may provide a framework for continuing professional development.

They have been considered in the following terms:

|  |  |  |
| --- | --- | --- |
| **Level 1** **Generic professional capabilities and values**  This is the first level of training and describes a foundation level of knowledge and understanding of personalised care. It is for everyone in direct contact with the general public or individuals using the health and care services. | | |
| **Level 2 Generic Capabilities in Personalised Care**  There is an expectation that the learner will build on previous knowledge and is able to apply it in a wider context. This level is intended to describe a higher level of capability of staff who have regular contact with patients or service users and have the opportunity to create an ongoing collaborative and enabling relationship. | |  |
| **Level 3 The six components of Personalised Care**  The learner incorporates a greater degree of complexity into the capabilities already achieved. These capabilities are applied in wider contexts which might include more intensive interactions and interventions. It will also include those professionals with responsibility for service pathways, delivery, evaluation and innovation.  **‘Models and Approaches’**  The specific models and approaches described in this section are tools which support the provision/embedding of the components of personalised care as business as usual. They support the development of the skills and mindset shift required to build a change in the relationship between professionals and practitioners to a more equal partnership between professionals and people recognising that people are experts in their own health and wellbeing confident. The ‘six components’ are cross-referenced to the relevant approaches in practice. |  | |

**Methods of Learning**

The following table lists a range of tools that can be used to deliver personalised care training. It is not intended to be prescriptive or an exhaustive list, but for illustration of the potential of blended learning strategies

Table 3. Methods of Learning

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Tool** | **Description** | **Level 1** | **Level 2** | **Level 3** |
| E-platforms | Using web-based or electronic tools to deliver training, such as e-learning models, remote coaching and accessing information and resources. |  |  |  |
| Videos of communication skills | To clearly demonstrate what good communication does and doesn’t look like. The video format also makes it replicable and scalable teaching tool. |  |  |  |
| Problem-based Learning | Learning about a topic from solving a problem as described in a prompt. |  |  |  |
| Reflective group work | Feeding back in groups to enable individuals to hear and learn from other perspectives and experiences, supported by trained facilitator to manage dynamics and interactions. |  |  |  |
| Action learning sets | Exploration in small groups, reflecting on challenges, exploring and problem solving new ways of doing things, and testing them in practice in a planned way48. |  |  |  |
| Role play | Using a relevant scenario in a safe learning environment to test skills and approaches, receive feedback from other learners or facilitators. This should include opportunities for re-rehearsal. Role play can be highly stressful for some learners, it requires skilled facilitation and is more appropriate as a means of ‘trying out’ than as a means of testing learners. |  |  |  |
| Mentoring | Formal or informal support from someone with more experience or knowledge of a topic49. |  |  |  |
| Self-assessment | Objective way to identify gaps for further learning and development. |  |  |  |
| Goal setting  – team and individual | Collaboratively setting goals that are   * meaningful and important to the individual * use a robust process to support individuals to translate intention into action * broken down into achievable chunks * followed up, to enable constructive debrief so the individual can move forwards. |  |  |  |
| Follow-up | Follow-up is needed to extend learning opportunities and support development of habitual behaviours.  This can be achieved through workforce development, continuous improvement programmes and reflective practice, as well as the tools listed in this table. |  |  |  |
| Modelling coaching approaches | Facilitation of groups and training sessions should model the coaching and asset-based approaches, using the values and tools described in this document. |  |  |  |
| Team and pathway-based training | Evidence shows that greatest impact is achieved when teams/pathways are trained together, with shared understanding, purpose and goals. This can be within or across organisations. |  |  |  |
| Co-delivery and co-facilitation | Delivering training in equal partnership with people and their carers who have experiences of using services, to model the principles of personalised approaches. |  |  |  |
| Shadowing and watching others | Using pre-existing services to shadow and see personalised care in practice, such as recovery education colleges and coaching services |  |  |  |
| Train the trainer | Enabling individuals to cascade the learning further through teams and pathways. This will include subject specific knowledge and facilitation skills. |  |  |  |
| Experiential learning | Learning through reflection having used or tried a skill50 |  |  |  |
| Work based learning | Training people in more than one-off sessions, so there is opportunity to put skills into practice, enabling ongoing development through a programme. |  |  |  |
| Using Feedback as a learning tool | Obtaining feedback on your performance from service users, focus groups, communities, colleagues and supervisors is invaluable for reflective practice, professional insight and personal development. |  |  |  |

**Personalised Care Institute Accreditation Framework**

**Background**

The Personalised Care Institute (PCI) is the central resource for personalised care training for NHS healthcare practitioners in England. It is a virtual organisation convened by the Royal College of GPs on behalf of NHS England.

Accreditation by the PCI provides an independent validation of the quality of a programme of learning and enables commissioners such as Integrated Care Systems (ICSs) or Sustainability and Transformation Partnerships (STPs) to identify suitable training to meet the development needs of their workforce.

The PCI Accreditation Framework is underpinned by the learning outcomes and training standards set out in the multi-professional PCI curriculum.

Diagram to show structure of curriculum & link to full document (1)

In order to be accredited by the PCI, training providers will need to provide evidence that their programme maps to the curriculum outcomes they seek to deliver, and that it meets the training standards set out in the curriculum, including demonstrable understanding of the specific learning needs and context of the professional groups and NHS systems they seek to deliver to.

**Training Standards**

The training standards within the PCI curriculum are largely based on the HEE Health Coaching – Quality Framework 2015 (2), a synthesis of research and best practice in commissioning training and development programmes in a model of personalised care delivery. The standards also map to other professional standards for education and training such as the Academy of Medical Educators (3) and the Heath and Care Professions Councils Standards for Education and Training (4). Providers are required to provide evidence that they meet the PCI training standards required for course design, delivery, monitoring and evaluation and sustainability.

**Course Design**

* Evidence-based – designed on published evidence of benefit of personalised care and co-produced with patient and service users
* Reflect the values of the Personalised Care Institute
* Articulates the principles of the core capabilities, approaches and components of personalised care as set out in the PCI curriculum.
* Integrated – reflects the needs of local systems and pathways of care
  + Clear objectives and intended outcomes for patients, practitioners and systems
  + Connected to local and national strategic objectives
  + Targeted to appropriate audience
* Training meets the needs of a defined group who are actively engaged.
* Modular components are context / profession specific e.g. risk communication, maternity, serious illness and end of life conversations.
* Takes account of cultural factors and equality and diversity (see values statement above)
* Course structure allows sufficient time for a meaningful experience and the opportunity to practice - a core programme with ongoing activities separated over time to allow practice.
* Follow up to allow reflection, embed training, and revisit skills.
* Increasing levels of specialist training that builds on basic training and equip professionals to provide the standard of personal care at the appropriate skill level of the PCI requirements

**Course Delivery**

* Planning – communication is accurate, timely and transparent with sufficient lead time to encourage attendance. The group size for facilitated skills training (face to face and remote) should be appropriate, the recommended group size for face to face training is 12-18 people
* Practical – based on experiential learning with practical demonstrations opportunities to participate, discuss and reflect.
* Builds appropriately on existing capabilities of participants
* High quality facilitation – appropriately qualified and experienced trainers from varied professional backgrounds, with authentic and ongoing experience in the field.
* Sufficiently challenging content in a safe space environment

**Monitoring and Evaluation**

* Attendance and recording systems for starters and completers of training
* Process evaluation:
  + Peer and independent review of training quality
  + Feedback is sought and the learning incorporated in future improvement of training in a timely manner
  + Learning is shared with the wider health network
  + Consistent with the intended principles of its design and delivery
* Impact evaluation:
  + Agree Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) to assess service user impact and outcomes
  + Feedback on immediate and intermediate outcomes with evidence of training being put into practice
  + Feedback on immediate and intermediate outcomes with evidence of training being put into practice
  + Follow-up to check embedding of training at an appropriate interval

**Sustainability**

* Developing local capacity, local champions and train the trainer programmes
* Cascading learning resources
* Developing leadership and connecting to existing systems and wider networks
* Securing ongoing funding and sharing data
* Ensuring course content is kept up to date

Providers are strongly advised to review the specific learning methods and training standards for the core capabilities, models and approaches and components of the PCI curriculum they seek to deliver before applying for accreditation.

Providers will also be asked to provide a range of other evidence that relates to organisational and educational governance and quality assurance of the programme, as set out in the application form.

**Programme of assessment**

Key standards1 of an assessment programmes include:

1. Assessment processes aligned to stated learning outcomes
2. Defined levels of formative performance at points of progression and summatively
3. Assessment guidance and decision aids for critical progression and satisfactory completion of training

It is beyond the scope of this curriculum to define the details of curriculum mapping and assessment methodology, but it is expected that all forms of course assessment will be valid and constructively aligned to the learning outcomes for both the generic capabilities and the specified components of personalised care.

A blended learning approach will mean that a variety of teaching methods are employed, and each will include its own relevant and appropriate methods of assessing satisfactory engagement or completion.

These may include:

* Tests of factual knowledge
* Assessments of integrating and applying knowledge and skills into practice e.g. observation, role play, case discussions.
* Workplace based assessment to provide evidence of learning from real experiences in the relevant context of their practice. This will normally be underpinned by naturally occurring evidence in day to day work, satisfaction questionnaires or feedback from ‘patients’ and colleagues, reflective practice, supervision and mentorship.
* Assessment of advanced practice might include Quality Improvement projects and evidence of leadership capabilities.

**Equality and Diversity, including Health Inequality**

Equality, diversity and fairness are at the heart of the values of the Personalised Care Institute.  Truly personalised care values people for who and what they are and seeks to understand their cultural context.

It promotes a shift in power and decision making away from healthcare professionals towards a more equal and effective partnership with people utilising services and their carers. Although personalised care is aimed at all groups of people, some of the models and approaches described in this curriculum should have a particularly positive impact on some groups protected by the Equality Act 2010 and groups that face health inequalities.  For example, training in health literacy may enable healthcare professionals to engage people from BAME communities, refugees, homeless people and other groups who face exclusion, to access services with improved health outcomes. This may also necessitate working with advocates.

It is especially important to mitigate the impact of health inequalities and social determinants of health, for example how a person’s situation may have a direct correlation with another e.g. poor diet due to inability to afford healthy foods; not exercising as can’t afford trainers; or not accessing certain treatments such as around drug use because of where services are located

The learning outcomes described in this curriculum go beyond addressing individual learning needs and recognise the importance of whole system change and leadership to allow personalised care to become embedded in the NHS and health inequalities to be addressed.

**The Structure of the curriculum**

**The Personalised Care curriculum and syllabus**

The term curriculum ‘refers to all the activities, all the experiences and all the learning opportunities for which an institution or a teacher takes responsibility – either deliberately or by default’.

(Fish and Coles 2005)

In reality, the curriculum captures much more than the formal content and includes the gaps between planned, taught and learnt curriculum; the effect of inconsistency of the workplace as a site of learning; and the impact of assessment which drives learning (Prof. Deborah Gill. UCL. London. 2019)

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This curriculum provides high level learning outcomes related to relevant capabilities, learning methods and standards for training. Each professional group may then devise their own appropriate syllabus which provides the details of learning activities underpinned by mapping to the PCI curriculum.

Within the curriculum are ‘models and approaches’ that can be used to deliver the six components of personalized care. Whilst separated for conceptual reasons, they should be considered as part of an integrated whole. Each section can be used as a stand-alone module or in combination as part of an educational series which is underpinned by the common core capabilities.

**Core Capabilities**

These are the foundation of the personalised care curriculum.

**Models and Approaches**

The models and approaches are considered under the following headings:

* Definition and Introduction
* Key elements of the model(s)
* Stories from practice
* Learning Outcomes specific to this model or approach
* Appropriate methods of teaching
* Standards for course providers

**The Six Component**

The components are considered under the following headings:

* Introduction to the topic
* Descriptors of professional behaviours
* Learning Outcomes applied to both learners and users of services
* Stories and examples in practice
* Outlines for learning and assessment strategies
* Suggestions for advanced modules

**Core Capabilities**

The essential core capabilities common to all practitioners will include:

* Generic Professional Capabilities
* Values in Personalised Care
* Capabilities in Personalised Care
  + Core communication and relationship building skills
  + Capabilities to engage people
  + Capabilities to motivate, enable and support people

**Generic Professional Capabilities**

Personalised care is delivered within and beyond the NHS in services such as social care, residential homes, and the wider voluntary sector, and by individuals who are already trained in a range of statutory or profession-specific skills. In line with the ethos of personalised care, it is important to recognise how these mandated skills form a valuable base on which to develop personalised care specific skills and capabilities.

These generic (professional) capabilities and values are detailed in specific frameworks, such as the Core Skills Education and Training Framework (Skills for Health) which apply to anyone working in these settings.

Additionally, there are profession-specific training requirements established by bodies such as the Health & Care Professions Council (HCPC), the General Medical Council (GMC), and other professional bodies (Nursing and Midwifery Council, Chartered Society of Physiotherapists and Royal College of Occupational Therapists for example). These include common topics such as equality and diversity, safeguarding and information governance.

The NHS Constitution also establishes the principles and values of the NHS as well as the rights and responsibilities of staff and patients.

All of the content of the statutory and mandatory training is key to personalised care, because it creates the safe environment for staff and service users to provide and receive care. It is not the scope of this curriculum to repeat what has already been detailed in the statutory and mandatory frameworks.

In order to deliver personalised care, it is expected that all workforce members are up to date on the necessary statutory and mandatory training that is required of them in their role and profession.

In addition to meeting the standards for each area, it is expected that workforce members reflect on and are aware of how these apply to personalised care.

The learner will be able to:

Acknowledge:

* The boundaries of one’s own skills, competencies and role and when to refer with an effective handover

Understand:

* The legal frameworks and principles of good practice relating to disability and impairment (and the perspectives of people with disabilities advocating for this)
* Key policies relevant to personalised care including Equality and Diversity and Mental Capacity legislation
* Human factor principles and escalate safety or quality issues

Participate:

* In national surveys and quality assurance processes as required by regulation and statutory bodies (to measure progress of personalised care policies and further build an evidence base for personalised care approaches)
* In interprofessional learning, sharing good practice and promoting interprofessional learning (within the NHS and beyond to social care, local authority and voluntary sector colleagues)
* Practice in accordance with latest evidence (around personalised care) and understand and promote (personalised) innovation in healthcare

Implement:

* Appropriate systems for raising concern and seeking advice regarding capacity, Deprivation of Liberty Safeguards, and safeguarding vulnerable children and adults

Demonstrate:

* Principles of information governance, accountability and clinical governance
* Maintenance of accurate and relevant records of agreed care and support needs
* Identify when it is appropriate to share information with carers and so do
* The professional and legal aspects of consent, capacity, and safeguarding

Promote:

* Physical and mental health and wellbeing e.g. healthy eating, physical activity, and illness prevention.

**References:**

Skills for Health (2018) [*Core Skills Training Framework*](https://www.skillsforhealth.org.uk/services/item/146-core-skills-training-framework)

General Medical Council (2017) [*Generic Professional Capabilities Framework*](https://www.gmc-uk.org/-/media/documents/generic-professional-capabilities-framework--0817_pdf-70417127.pdf)

Health & Care Professions Council (2018) [*Standards of conduct, performance and ethics*](https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/)

Department of Health (2015) [*NHS Constitution*](https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england)

**Values in Personalised Care**

Values can be thought of as underpinning principles. Attitudes are the way a person applies their values and are expressed through their behaviours and what they say and do. The established values and attitudes of the individuals and teams delivering services are central to achieving personalised approaches. The values are described below, and the attitudes are described through the behaviours for each step in the framework.

These values are anchored in the belief that people, their circles of support, and communities have their own expertise and strengths, are resourceful, and have the capacity to develop their own solutions with the appropriate support. At a practical level for those delivering services, this strength-based approach places significant importance on working in ways that enable people to reach their potential of being capable, resourceful and empowered.

**A close up of a map

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From the Personalised Care Operating Model. NHS England.2019

For everyone delivering, leading or managing services this is summarised in *Person-Centred Approaches (2017)* as follows:

* It is important to me to afford people dignity, respect and compassion, without judging them.
* I am interested in and want to understand people’s perspective, their preferences and what’s important to them and their carers.
* I see people as individuals beyond just their presenting (health, care or wellbeing) needs, and as someone who has potential in the context of their lives and communities.
* I understand that my role is more than simply fixing the issues raised - supporting and enabling people to live meaningful lives is as important, whether or not cure or resolution is possible.
* It is important to me to develop rapport and relationship, achieving a shared sense of understanding, purpose and partnership that leads to increased confidence to self-manage their needs.
* It is important to me develop mutual trust enabling choice and control in all my interactions with people, their carers and communities.
* I value and acknowledge the experience and expertise of people, their carers and support networks.
* I am committed to ensuring coordinated current and future care, support and treatment, through working together in partnership with people, teams and organisations.
* I value and acknowledge the importance of communities, social networks and community development to support people’s health and wellbeing.
* I value collaborative involvement and co-production with people to improve the personalised design and quality of services.
* I recognise that given meaningful opportunity and support, people can grow and develop, building on the strengths and resilience that people, families, carers and circles of support can have within themselves.
* As an individual, I recognise that using personalised approaches may require me to reflect on and change how I do things.

For those in the workforce with specific leadership, managerial or commissioning responsibilities, these personalised values might mean:

* I embed personalised and community focused approaches in the co-production and delivery of care, support, wellbeing and prevention in its widest form and integrate this as a core part of everything I do.
* I communicate this vision and role model the principles and values in how I work with colleagues, helping them to understand the short, medium and long-term benefits for all.
* I enable staff to develop their knowledge, skills and confidence in personalised approaches - and support behavioural change in the workplace/community to make this what we all do every day.
* It is part of my role to ‘give permission’ for individuals and teams to work in this way.
* I role model and support services to ensure coproduction is central to service improvement.
* It is part of my role to support staff to understand the relationship with professional boundaries, negotiate risk and positive risk taking and manage the higher levels of emotional engagement that this way of working may bring.
* I measure and value personalised outcomes as well as clinical, systematic and financial outcomes.

**Capabilities in Personalised Care**

Personalised Care is a whole approach that includes six specific components that are: shared-decision making, personalised care & support planning, social prescribing and community-based support, supported self-management, enabling choice, and personal health budgets and integrated personal budgets.

Each of these components has unique value for the people who benefit from them, whilst also sharing a common underpinning set of skills – the core capabilities that are generic to anyone delivering personalised care in any role.

They build on the core professional capabilities of anyone working in healthcare detailed above and the values for personalised care (both above). These generic capabilities can be divided into:

* core communication and relationship building skills
* capabilities to engage people through even the shortest of interactions as a common baseline across the whole workforce. (Learning Outcomes Levels 1-2)
* capabilities specific to delivering the 6 components (Learning Outcomes Level 3)

**Core Communication and Relationship Building Skills**

At the heart of personalised care is the relationship between people, which is built from meaningful communication, and is strongly influenced by how we say things, how we listen and our non-verbal communication. The way in which we do this has an effect and impact on understanding, motivation and outcome and is much more than gathering and sharing information.

These skills are relevant to the whole workforce and include communications between staff members. For each cohort of people within the workforce, these skills will be taught in a different way, so they are meaningful to the roles those people have.

**Learning Outcomes**

The learner will be aware of:

* Their own values, beliefs, prejudices, assumptions and stereotypes when working with people

Understand:

* The value of really listening as an active process
* Communication in all its forms e.g. written, electronic, and remote, as a two-way process
* The impact of conversations and different verbal and non-verbal communication styles for a person during the conversation and afterwards10
* How to meet the communication and language needs, wishes and preferences of individuals

Be able to:

* Confidently demonstrate the core communication skills for relationship building and information gathering (see the table on the follow page for a description of each of these core communication and relationship building skills):

**Table 4. Core Communication skills and skills in building trusting relationships**

|  |  |
| --- | --- |
| **Skill** | **Description** |
| Hello my name is… | Clearly introducing self, role and setting the scene for the conversation45. |
| Use of open ended questions | Open ended questions are questions that cannot be answered with a yes or no. They invite broader responses during information gathering and allow the person to share their broader thinking and perspective. They also create a more equal conversation.  ‘tell me more about…’ ‘how was that…’  ‘what are you doing that you find helpful?...’ ‘when do you notice that?...’  ‘who supports you in your day to day life?...’ |
| Use of open focused questions to closed questions (cone) | Knowing how and when to move from open exploratory questions to ones that are more focused around a particular topic or subject. Understanding the place and value of closed questions. |
| Screening | Checking if there is ‘something else’ or ‘anything else’. There are many contexts when screening is helpful and can be used, for example, when exploring what is important, agenda setting and exploring importance and confidence. |
| Reflection | Using words to let the other person know you have heard what they have said. Non-verbal body language and facilitative cues are not enough on their own. Using the person’s language helps them feel heard, builds rapport and ensures that the person is an active partner in the dialogue. It is also very powerful to have your own thoughts and words reflected back. |
| Empathy | A deep reflection and using words to let the person know you understand or are trying to understand how it is for them emotionally. It is a complex skill however there are some key guiding principles including taking the other person’s perspective, staying out of  judgement, recognising emotion and communicating what you notice. |
| Affirmation | A positive statement and acknowledgement of the effort or achievement somebody has made, offering emotional support or encouragement.  E.g. ‘you told me you tried to change before, that shows great determination’. |
| Normalisation | An acknowledgement that the [for example] feeling, process, symptom is normal and other people report similar experiences. It helps the person feel validated, that they are not alone and that the worker has experience of working with people like them. |

|  |  |
| --- | --- |
| **Skill** | **Description** |
| Active listening | Being present psychologically, socially and emotionally, making a conscious effort to hear and understand what people are saying.  Picking up on and responding to verbal and non-verbal cues.  Active listening requires the listener to feedback what they hear to the speaker re-stating what they have heard.  These are valuable skills which can be developed with practice. |
| Summarising | The deliberate step of providing an explicit verbal summary to the person. There are two kinds of summary;   1. Internal summary which focusses on a specific part of the conversation 2. End summary which concisely pulls together the entire conversation   Both are useful to pull information together, review where we have got to, order information, identify gaps and allow space to consider next steps. |
| Clarification | Confirming and checking, making it more understandable and accurate [for example clarification of words, statement or situation]. |
| Signposting | Introducing and drawing attention to what we are about to say. It helps add structure to the conversation and enables the person to understand the direction that the conversation is taking. It can also be used to point people in the direction of helpful resources, specialist services and support organisations.  Summarising and signposting are ‘twin skills’ that are often used to help structure conversations. |
| Use of Non-verbal / body language | This is the information we convey non-verbally including   * posture * proximity * touch * body movements * facial expression * eye behaviour * vocal cues * use of time * physical presence * use of pausing and silence * gentle cues such as nods |
| Environmental awareness | How the room, chairs, tables, desk etc are arranged. Who is taking part, where the conversation is taking place, how public or private it is for example. Understanding the impact of the environment on an individual and adapting for this. |
| Ask before advising | Before giving information checking what the person knows, what they would like to know, that they would like to receive the information and how they would like to receive it. |

**Capabilities to engage people (Level 1)**

The learner will

Be aware of:

* The strengths and resilience that people, families, carers and circles of support can have within themselves (strengths or asset based approaches)
* The concept of co-production and its importance to individual health and care, and in wider service design
* Personalised care activities
* The importance of engaging and building rapport and relationships to create a safe environment where people and carers can share feelings, thoughts and ideas
* Local resources relevant to the discussion to which people can be signposted
* The importance of continually reflecting on whether services and process are optimal and opportunities to improve these further through coproduction
* The impact that a range of social, economic, and environmental factors can have on outcomes for individuals, carers and their circles of support.
* The need for appropriate record keeping and IT skills that capture and record conversations, decisions and agreed outcomes in a way that makes sense to the person.

Know:

* How to sensitively introduce subjects that a person might find challenging

Understand:

* How (mental and physical) health conditions commonly coexist and interact in any individual
* the importance of social networks and circles of support for individuals and their carers to lessen feelings of psychological or social isolation
* the impact of health inequalities and social determinants of health
* When and how to refer a person onto more specialised, tailored or intensive sources of support

Be able to**:**

* Recognise the opportunity to have a conversation with a person and choose to take the opportunity
* Identify what is important to the person both generally and in the context of a conversation
* Use different communication styles and language depending on an individual’s needs and understanding
* Create the opportunity for the person to engage, explore, and reflect on a potential decision or way forward, sharing and checking understanding of the full range of options, including taking no action
* Set own goals to embed this approach into everyday conversations e.g. to identify a peer to work with once back in the workplace/community and think about what this means for the team.
* Identify the people who play an important caring role for others, involving them in management decisions and offering them additional support
* Use technologies that might meet needs and preferences for information and communication

Provide:

* access to information and advice that is clear and timely and meets individual information needs and preferences, through a knowledge of meaningful and relevant information for individuals and awareness of local resources for signposting
* access to resources in the local community to support personal wellbeing;

Create:

* The time to listen and understand in a way that builds trusting and effective relationships and support to develop a plan in a safe and reflective space
* A safe environment for potentially difficult conversations which facilitates and respects ownership of decisions

**Capabilities to motivate, enable and support people (Level 2)**

The Learner will

Be aware of:

* Key relevant and current policies around personalised approaches
* The different levels of prevention (primary, secondary and tertiary)
* The range of specific personalised tools
* The implications of case law and NICE guidance for consent and shared decision making
* Models for patient activation, health literacy, and the Accessible Information Standard

Know:

* the principles of behaviour change
* established health coaching tools and techniques
* the impact that a range of social, economic, and environmental factors can have on outcomes for individuals, carers and their circles of support

Understand:

* That each person is an expert in their own life, along with their carer
* the importance of values, mindset and motivation
* The need to prioritise wishes holistically, and respect concerns and expectations in the context of cultural and social awareness
* the need to undertake challenging conversations whilst allowing for reasonable adjustments and respecting autonomy
* the detail of different personalised activities and the skills in the context of these
* the value and importance of preparation before interactions or conversations
* the potential value and importance of non-traditional locations and settings for interactions or conversations
* the importance of measuring personalised outcomes

Be able to:

* Support people to make plans to develop habitual behaviours
* Find out the individual’s priorities and what outcomes are important to them
* Support people to integrate their ideas, opinions and perspectives into the conversation
* Gather information that is meaningful for the individuals and their carers
* Take an individualised approach to discussing consent, risk and shared decision making taking into account the person’s individual views, their preferences, values and assessment of the options together with the relevant facts, information and evidence
* Enable a person to make decisions by;
  1. understanding the outcomes that are important to them
  2. explaining in non-technical language all the available options (including the option of doing nothing)
  3. exploring with them the risks, benefits and consequences of each option and discussing what these mean to the person in the context of their life and goals
  4. supporting them to be able make the decision and / or agreeing together the way forward
* Support people to self-reflect and understand the relationships and connections between their emotions, feelings and behaviours
* Assess individuals’ levels of activation and health literacy, modify conversation accordingly and support people in a way that develops these two factors
* Co-produce and negotiate a shared agenda with an individual
* Facilitate shared decision making use of appropriate tools such as Ask Three Questions and Decision Support Tools
* Use action planning and goal setting models – including breaking goals into achievable chunks and identifying opportunities for follow up
* Appropriately prioritise a range of options in line with latest evidence that explores risk, benefits and consequences of options;
* Confidently support positive risk taking

**Models and Approaches**

**Using a Range of Consultation Models**

**Definition and Introduction**

There are numerous consultation models used in healthcare and many incorporate aspects of personalised care such as the importance of establishing relationships, exploring a person’s beliefs and sharing understanding. It is unlikely that strictly following one model will be sufficient to engender personalised care in most settings, so practitioners would benefit from being aware of various models and approaches in order to incorporate aspects of these into an approach that is appropriate to the person, setting, and their unique experience and skills as a practitioner.

**Key elements of the model(s)**

* No one model is suitable for all encounters, but aspects of various models may be incorporated to an individual’s scope of practice
* Different models may be required for different consultation types. For example, reactive Vs proactive consultations.
* Having a model to work with brings a structure to consultations but there should be flexibility in application to support person centred consultations.
* Person centred consultations require a greater emphasis on gaining understanding of the patient’s preferences and values. Consider the key principles of collaborative agenda setting, robust action planning & goal setting and follow-up
* Effective communication of individually tailored options along with the risks and benefits of each, and what they mean to and for the individual in the context of their life as a whole, is an important part of personalised care.
* The role of group consultation models in appropriate settings

**Learning Outcomes specific to utilising this model or approach**

The learner will

**Level 1**

Know

* the different types of consultation model, when and how to use them (or not) appropriately

Be able to

* describe the structure of a personalised consultation which is appropriate to the learner’s scope of practice, drawing on established consultation models.

**Level 2**

Be able to

* Identify the key aspects of observed consultations and comment on their effectiveness in promoting person centred care.
* Participate in simulated consultation, video, feedback etc. to understand the strengths and weaknesses in the learner’s consultation approach from the person’s and professional’s perspectives.
* adapt the approach to consultations to different situations such as time limitations,
* modify consultations that incorporate a barrier to communication, group settings, difficult conversations and complexity.

**Level 3**

Be able to

* Demonstrate a structured personalised consultation in a simulated environment
* Reflect on and learn from consultations performed in practice in a structured way
* Identify the key aspects of consultation models in theory and practice and comment on their effectiveness in encouraging person centred care.

**Stories from practice**

***(tbc)***

**How to learn this approach**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Learning method | Description | Level 1 | Level 2 | Level 3 |
| e-Learning | To provide an appropriate introduction to consultation models perhaps supported by face-to-face small group teaching. | **•** | **•** | **•** |
| Work based learning | Use learning opportunities in the workplace to provide context in which to apply knowledge and skills and identify further learning needs. |  | **•** | **•** |
| Recording and role play | Observation and structured discussion on pre-recorded simulated consultations either in a virtual or small group setting |  | **•** | **•** |
| Self-directed learning and Reflective practice | St Structured reflecting on recorded consultations with or without expert or peer input |  | **•** | **•** |
| Multi-source feedback | Obtaining feedback from colleagues and patients is essential to evaluate and develop learning needs |  | **•** | **•** |
| Small group, multi-professional, and peer learning | Small group teaching incorporating simulated consultations with expert facilitation with or without actors |  |  | **•** |

**Standards for training**

Training courses should satisfy the following requirements at the appropriate levels of learning described above

|  |  |
| --- | --- |
| Course Design | * Evidence-based curriculum that articulates the principles of using models of consultations in personalised care and incorporates the perspective of lived experience * Clearly describes the theory and practice of using consultation models * Relevant e-learning resources for consultation models with recorded evidence of achievement at the appropriate level of knowledge * Content is aligned to, and actively engages with the needs of a defined group of learners |
| Course Delivery | * Proactive and transparent planning has been undertaken which includes expert facilitation in communication and consultation. * Course structure of a core programme with timetabled ongoing developmental activities * Practical experiential learning is provided, based on existing levels of experience within the group. * Sufficient level of challenge within a safe and supportive environment to encourage active participation e.g. in role play. * Recording consultations /interactions with self-assessment and feedback on a range of models. Observed real life and simulated consultations assessed against published criteria (for example using OPTION5) * Facilitated analysis of a consultations and a reflection on their strength, weaknesses and effectiveness. * Formative assessment and support of learners with a summative sign off process for satisfactory completion |
| Monitoring and Evaluation | * Attendance, attrition, and completion data recorded. * Peer and external review of training quality is sought * Feedback is used to inform future improvements. * Cultural factors, Inclusion, Equality and Diversity are all considered. * Impact evaluation of outcomes in practice with sharing of good practice and data. |
| Sustainability | * Cascaded model to widen local training faculty with expertise in consultation and communication skills * Identifying local champions and leaders. * Financial viability for future developments |

**Suggestions for advanced modules**

**tbc**

**Making Every Contact Count**

**Definition and Introduction**

Making Every Contact Count (MECC) is an approach to behaviour change that utilises the millions of day-to-day interactions organisations and staff have with people to support them in making positive changes to their physical and mental health and wellbeing.

**Key elements of the model(s)**

* MECC is about using the opportunity of everyday conversations to make a difference by delivering consistent and concise healthy lifestyle information.
* Health inequality and social determinants of health have a significant impact. They include environment, nutrition, poverty, educational opportunities, occupation, home and family life and the community.
* The use of appropriate tools such as ‘open-discovery’ or Capability-Motivation-Opportunity – Behaviour Change (‘COM-B’) and ‘Behaviour Change Wheel’2 models can assist in asking the right questions. They help in understanding more about a person and their individual circumstances, which helps in responding to the needs that are important to them.
* MECC complements routine health and care interactions for a brief or very brief discussion on health or wellbeing; but they don’t necessarily need to be undertaken by a health professional – indeed it is often others in the team or system who are better placed. By developing some simple key communication skills and communicating evidence based healthy lifestyle messages every member of the primary care team has a role:

**

* The ‘Five Ways to Wellbeing’2 introduces the concept of wellbeing and describes how a set of evidence-based actions to help improve people’s wellbeing can be implemented in a variety of settings. The 5 actions are:
  + - Give
    - Be active
    - Keep learning
    - Connect with the people around you
    - Take notice

**Learning Outcomes specific to utilising this model or approach**

**Level 1:**

The learner will

Be aware of

* National health and wellbeing resources that are available for signposting – e.g. NHS Choices, One You, Every Mind Matters, Good Thinking
* Local support and resources available through local authorities e.g. Housing, smoking cessation

Know

* What is meant by wellbeing and how health and wellbeing are linked
* The main sources of information about key health and wellbeing messages
* what to consider when providing information or signposting

**Level 2:**

In addition to Level 1, the learner will

Know

* Brief intervention and behaviour change skills e.g. 3 step approach to MECC conversations – (Ask, Advise, Assist)
* The ‘Five Ways to Wellbeing’

Understand

* What MECC and is and who it is for; and to understand the difference between objective measures of health and the subjective nature of wellbeing
* Appropriate opportunities for starting a conversation about health and wellbeing
* Models of open questioning and how to use them

Be able to

* Describe what is makes us healthy
* Identify factors which influence our behaviour and enable change
* Demonstrate core communication and relationship-building behaviours to enable a personalised conversation
* Apply and adapt the ‘Five Ways to Wellbeing’ model

**Level 3:**

In addition to Level 1-2, the learner will

Be able to

* Demonstrate their own personal professional development and to support others as a future MECC champion at home or in the workplace

**Stories from practice**

***(tbc)***

**How to learn this approach**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Learning method | Description | Level 1 | Level 2 | Level 3 |
| e-Learning | Web-based e-learning resources to provide factual information and engage in interactive learning methods. Self-test and certification. | **•** | **•** | **•** |
| Problem-based learning | Using topic based teaching to orientate and adapt knowledge and skills appropriately. Use of ‘case-based discussions’. |  | **•** | **•** |
| Work based learning | Use learning opportunities in the workplace to provide real-life context in which to apply knowledge and skills and identify further learning needs.  ? QIPP |  | **•** | **•** |
| Recording and role play | Using video recording or role play to learn and apply models of consultation; provide analysis and feedback to identify learning needs. Use exemplars of good practice for discussion. |  | **•** | **•** |
| Self-directed learning and Reflective practice | Adult learning involves the capability for self-directed study such as reading around a topic, reflecting on experience and searching for evidence |  | **•** | **•** |
| Multi-source feedback | Obtaining feedback from colleagues and patients is essential to evaluate and develop learning needs |  | **•** | **•** |
| Small group, multi-professional, and peer learning | Peer learning can have a powerful influence on enhancing professional development. It enables sharing experiences, learning together, and self-directed learning groups |  |  | **•** |
| Supervision and Mentoring | Provides the means of monitoring professional progress, role-modelling, and facilitating reflective practice and giving formative feedback |  |  | **•** |

**Standards for training**

Training courses should satisfy the following requirements at the appropriate levels of learning described above

|  |  |
| --- | --- |
| Course Design | * Evidence-based curriculum that articulates the principles of MECC and incorporates the perspective of those with lived experience * Articulates the theory and practice of using consultation models * Relevant e-learning resources for MECC with recorded evidence of achievement at the appropriate level of knowledge * Content is aligned to, and actively engages with the needs of a defined group of learners |
| Course Delivery | * Proactive and transparent planning has been undertaken which includes expert facilitation in MECC * Course structure of a core programme with timetabled ongoing developmental activities * Practical experiential learning is provided, based on existing levels of experience within the group. * Sufficient level of challenge within a safe and supportive environment to encourage active participation e.g. in role play. * Recording and reflecting on MECC interactions through self-assessment and feedback on a variety of very brief, brief, and extended interventions undertaken * Analysis of an encounters and interventions demonstrating a specific case / topic illustrating MECC and to include a report on their effectiveness in their outcomes * Formative assessment and support of learners with a summative sign off process for satisfactory completion |
| Monitoring and Evaluation | * Attendance, attrition, and completion data recorded. * Peer and external review of training quality is sought * Feedback is used to inform future improvements. * Cultural factors, Inclusion, Equality and Diversity are all considered. * Impact evaluation of outcomes of MECC in practice with sharing of good practice and data. |
| Sustainability | * Cascaded model to widen local training faculty with expertise in consultation and communication skills * Identifying local champions and leaders. * Financial viability for future developments |

2. Michie, S., van Stralen, M.M. & West, R. The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Sci* **6,**42 (2011). https://doi.org/10.1186/1748-5908-6-42

**Health Literacy**

## **Definition and Introduction**

Health literacy is an essential part of personalised care including care and support planning, health promotion, patient safety, self-management, shared decision-making and fostering effective relationships with patients, families and carers. (1) It is also a complex and evolving concept, with no universally accepted definition. (2)

One definition of health literacy is “people having the appropriate skills, knowledge, understanding and confidence to access, understand, evaluate, use and navigate health and social care information and services.” Health literacy incorporates, but is not limited to, language, literacy and numeracy skills and is “influenced by the provision of clear and accessible health and social care services and information for all (service responsiveness).”(3)

This definition shifts away from the notion that health literacy solely depends on people’s own abilities to understand and navigate health information and systems, towards a recognition of the wider environment in shaping this ability, along with the role that healthcare providers play in making their services clear and accessible to all. Health literacy is a determinant of health and a key contributor to health inequalities.(3) Improved health literacy can improve health outcomes, reduce health inequalities, and empower citizens.

## **Key elements of the model(s)**

The following integrated model (2) highlights key elements of health literacy, which are:

* Accessing, understanding, appraising and applying health-related information. These abilities generate the knowledge, competence and motivation to navigate three domains or settings within the healthcare continuum: healthcare settings, disease prevention, and health promotion
* Individual and population level perspectives
* Influences on health literacy (determinants)
* Health outcomes based on health literacy.

A close up of a device

Description automatically generatedSource: Sorensen et al. 2012

The health literacy of families, communities, professionals (such as the healthcare workforce), and organisations is also important.

The complex nature of health literacy requires a multi-faceted approach to intervention. (3) At a health practitioner level, many of the core communication and relationship-building skills described earlier can improve health literacy. Additionally, there are a number of evidence-informed standards for improving health literacy across a range of clinical scenarios, primarily underpinned by communication tools such as “Teach back”, “chunk and check”, and use of plain language and avoidance of jargon. (1)(4)

**Learning Outcomes specific to utilising this model or approach**

This section primarily focuses on learning outcomes for healthcare professionals; however, some outcomes may also apply to health literate organisations.

**Level 1:**

The learner will

Be aware of

* The vital role of health literacy in achieving health equity
* Barriers to an individual’s understanding of health information, including those related to the individual such as learning disability, the healthcare professional, and the wider environment
* Key interventions to address low health literacy
* The emotional impact of health information
* The attitudes and behaviours needed for successful partnerships with patients, carers and families in helping to improve health literacy.
* The national information standard

Know

* What is meant by health literacy and digital health literacy
* How poor health literacy affects people’s health, health services, and the wider society
* The factors (e.g. age, ethnicity, education) that can affect a person’s health literacy, taking care to avoid making assumptions or stereotyping
* Key signs and behaviours in people that are suggestive of low levels of health literacy
* That anyone’s health literacy can change or be affected by factors such as ill health, stress, anxiety, new or distressing information, and new technologies
* Key tools and techniques for enhancing understanding of health information (e.g. “teach back method”)
* Key strategies and behaviours for effective communication with patients, including use of plain language, avoiding jargon, and a non-judgmental approach
* How and where to search for health information and resources on health literacy.

**Level 2:**

In addition to Level 1, the learner will

Know

* Key interactions and transitions in the patient journey where health literacy is important, including high risk situations where the ability to understand health information may be impeded (e.g. Covid-19 restrictions, hospital discharge and clinic visits; shared decision making and consent for treatments procedures, changes to medication)
* Health literacy tools for health promotion, disease prevention, risk communication, and chronic disease management
* Relevant legislation when implementing health literacy interventions (e.g. Equality Act, AIS, confidentiality).

Understand

* The relationship between health literacy, social determinants of health, and health inequalities
* What is “good” information, taking into account factors such as source of the information, content/coverage, accuracy, bias, ease of use/ accessibility, and relevance
* The need to balance simplicity with accuracy when developing or communicating health information, so that key information is not lost or becomes less relevant and useful.

Be able to

* Use a non-judgmental approach in all conversations with people who have limited health literacy
* Use appropriate tools, techniques and strategies to enhance the understanding of health-related information when communicating with patients, including those with low health literacy and those with specific needs due to disability, illness, language or other factors
* Involve or signpost to the wider multidisciplinary team or other agencies with expertise in health literacy.

**Level 3:**

In addition to Level 1-2, the learner will

Be able to

* Evaluate and critically appraise health information
* Demonstrate their own professional or personal development and, where relevant, address the capability of staff in their organisation to support patients’ health literacy needs (including their own health literacy needs)
* Apply health literacy best practices to health programs and interventions, where relevant
* Ensure the intended audience and those who support them are included in the design, implementation, and evaluation of health education, information and services
* Develop inclusive and transparent partnerships with key stakeholders that advance health literacy in the community.

**Stories from practice**

***(tbc)***

**How to learn this approach**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Learning method | Description | Level 1 | Level 2 | Level 3 |
| e-Learning | Web-based e-learning resources to provide factual information and engage in interactive learning methods | **•** | **•** | **•** |
| Problem-based learning | Using topic based teaching to orientate and adapt knowledge and skills appropriately. ‘case-based discussions’ | **•** | **•** | **•** |
| Work based learning | Use learning opportunities in the workplace to provide real-life context in which to apply knowledge and skills and identify further learning needs. | **•** | **•** | **•** |
| Recording and role play | Using video recording or role play to learn and apply models of consultation; provide analysis and feedback to identify learning needs. Use exemplars of good practice for discussion. |  | **•** | **•** |
| Self-directed learning and Reflective practice | Adult learning involves the capability for self-directed study such as reading around a topic, reflecting on experience and searching for evidence |  | **•** | **•** |
| Multi-source feedback | Obtaining feedback from colleagues and patients is essential to evaluate and develop learning needs |  | **•** | **•** |
| Small group, multi-professional, and peer learning | Peer learning can have a powerful influence on enhancing professional development. It enables sharing experiences, learning together, and self-directed learning groups |  |  | **•** |
| Supervision and Mentoring | Provides the means of monitoring professional progress, role-modelling, and facilitating reflective practice and giving formative feedback |  |  | **•** |

**Standards for training**

Training courses should satisfy the following requirements at the appropriate levels of learning described above

|  |  |
| --- | --- |
| Course Design | * Evidence-based curriculum that articulates the principles of health literacy and incorporates the perspective of those with lived experience * Clearly describes the theory and practical, real-world application of health literacy skills of the challenges of improving their health literacy * Relevant health literacy resources with recorded evidence of achievement at the appropriate level of knowledge * Content is aligned to, and actively engages with the needs (including health literacy needs) of a defined group of learners |
| Course Delivery | * Proactive and transparent planning has been undertaken which includes expert facilitation in health literacy skills * Course structure of a core programme with timetabled ongoing developmental activities * Facilitated analysis of encounters using health literacy skills and a reflection on their strength, weaknesses and effectiveness in outcomes * Formative assessment and support of learners with a summative sign off process for satisfactory completion where appropriate |
| Monitoring and Evaluation | * Attendance, attrition, and completion data recorded * Peer and external review of training quality is sought * Feedback is used to inform future improvements * Cultural factors, Inclusion, Equality and Diversity are all considered * Impact evaluation of outcomes in practice with sharing of good practice and data |
| Sustainability | * Cascaded model to widen local training faculty with expertise in health literacy skills * Identifying local champions and leaders * Financial viability for future developments |

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3. Public Health England, UCL Institute of Health Equity. Improving health literacy to reduce health inequalities. 2015.

4. World Health Organization. Health literacy : The solid facts. 2013.

## Additional Resources

* Health Education England. Health Literacy Toolkit. 2018. Available from: <https://www.hee.nhs.uk/our-work/population-health/training-educational-resources>
* Institute for Healthcare Advancement. Centre for Health Literacy Solutions. Resources for Health Literacy - Centre for Health Literacy Solutions. Available from: <https://www.healthliteracysolutions.org/home>
* Making it Easier - a health literacy action plan for Scotland 2017-2025. Available from: http://www.healthliteracyplace.org.uk/blog/2017/news/making-it-easier-a-health-literacy-action-plan-for-scotland-2017-2025/

**Patient Activation – knowledge, skills, and confidence**

**Definition and Introduction**

Patient activation describes the knowledge, skills and confidence a person has in managing and taking action regarding their own health and care. In being supported to increase their activation, people are more ready and able to engage with self-management. This is associated with individuals having improved health outcomes and experiences of using services. For the healthcare system, this is also linked with lower service use and costs. Understanding a person’s level of activation (by using tools such as the Patient Activation Measure and coaching skills), and tailoring approaches to support them and increase their activation is a key principle of supported self-management as described in Universal Personalised Care (NHS England, 2019).

**Key elements of the model**

* Knowledge, skills, and confidence can be measured by a number of different tools such as self-efficacy scales, patient-reported impact measures or the Patient Activation Measure (PAM).
* The PAM is a licenced product from Insignia™ and consists of 13 questions, about a persons’ perspective on managing different aspects of their health and wellbeing. It produces a score from 0 – 100, which relates to an Activation Level from 1 to 4 (with 1 being the lowest level of activation, and 4 being the highest level of activation).

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*Image source: NHS England,* [*PAM implementation quick guide*](https://www.england.nhs.uk/wp-content/uploads/2018/04/patient-activation-measure-quick-guide.pdf) *(2018)*

* People with different levels of knowledge, skills, and confidence may need and want different things from their healthcare, so the services offered, and the approach taken needs to reflect how important playing an active role in self-management is for the person, and how confident, knowledgeable and skilled they feel in doing this.
* Evidence-based approaches to supporting individuals with a lower level of knowledge, skills, and confidence include health coaching, self-management education and peer support, as well as social prescribing. These may be specific services or integrating a health coaching approach within typical clinical consultations.
* The Universal Personalised Care model expects these interventions to increase the level of knowledge, skills, and confidence. If using the PAM, this would represent an increase of 15 points for 75% of people at Level 1 or 2, and lead to a reduction in GP appointments (9%) and A&E attendances (19%).

**Learning Outcomes specific to utilising this model or approach**

**Level 1:**

The learner will

Be aware of

* Knowledge, skills, and confidence within in the wider culture in healthcare – where alongside people who use services, healthcare professionals, services and systems also need to recognise and reflect on how important it is for them to have the knowledge, confidence and skills to support self-management
* Some of the critique of the language of ‘activation’ and negative connotations it may hold for some people being labelled a ‘patient’ or as having ‘low activation’

Level 2:

In addition to Level 1, the learner will

Know

* The Model for Patient Activation, and associated concepts such as self-efficacy

Understand

* An individual’s level of knowledge, skills, and confidence in the context of them as a whole person, using an asset-based approach
* Other cues to an individual’s level of activation that can be picked up through conversation, beyond the use of questionnaire

Be able to

* Sensitively and appropriately introduce the questionnaires to assess knowledge, skills, and confidence and complete it in line with the standardised method
* Share the results of a PAM with the person, using appropriate sensitive language
* Modify conversation approaches accordingly and support the person in way that develops their knowledge, confidence and skills

**Level 3:**

In addition to Level 1-2, the learner will

* Use assessment of knowledge, skills, and confidence in an integrated way across local healthcare system – recording it appropriately on healthcare records to facilitate sharing across services

**Stories from practice**

***(tbc)***

**How to learn this approach**

|  |  |
| --- | --- |
| Method | Expected content |
| e-learning or self-directed reading/study | Background to the model, the detail of the questionnaire and evidence-base of tailored interventions |
| Face to face workshop using problem-based learning and role play approach (local and pathway specific) | Understanding an individual’s level of activation (informal cues and formal tools), discussing tools and |
| Reflective practice / supervision | After period of time implementing following face to face workshop, focusing on experience of implementing the model and outcomes |
| Work-based action-learning sets | To work across local pathways to reflect on its broader implementation and outcomes in a coordinated system. |

**Standards for training**

Training courses should satisfy the following requirements at the appropriate levels of learning described above

|  |  |
| --- | --- |
| Course Design | * Evidence-based curriculum that articulates the principles of patient activation and incorporates the perspective of those with lived experience * Clearly describes the theory and practice of facilitating patient activation * Relevant e-learning resources for Patient Activation with recorded evidence of achievement at the appropriate level of knowledge * Content is aligned to, and actively engages with the needs of a defined group of learners |
| Course Delivery | * Proactive and transparent planning of a Self-directed, e-learning or face to face workshop that includes expert facilitation in Patient Activation. * Course structure of a core programme with timetabled ongoing developmental activities and active-learning sets * Practical experiential learning is provided, based on existing levels of experience within the group. * Sufficient level of challenge within a safe and supportive environment to encourage active participation * Facilitated analysis of an interaction demonstrating patient activation, and a reflection on their strength, weaknesses and effectiveness. * Evidence of reflection and supervision on patient activation in relation to case load – recorded in supervision note |
| Monitoring and Evaluation | * Attendance, attrition, and completion data recorded. * Peer and external review of training quality is sought * Feedback is used to inform future improvements. * Cultural factors, Inclusion, Equality and Diversity are all considered. * Impact evaluation of outcomes in practice with sharing of good practice and data. |
| Sustainability | * Cascaded model to widen local training faculty with expertise in consultation and communication skills * Identifying local champions and leaders. * Financial viability for future developments |

**Resources**

NHS England (2020) [*Patient Activation and PAM FAQs*](https://www.england.nhs.uk/personalisedcare/supported-self-management/patient-activation/pa-faqs/)

NHS England (2019) [*Universal Personalised Care: implementing the comprehensive model*](https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf)

NHS England (2018) [*PAM Implementation Quick Guide*](https://www.england.nhs.uk/wp-content/uploads/2018/04/patient-activation-measure-quick-guide.pdf)

Kings Fund (2014) [Supporting people to manage their health: an introduction to patient activation](https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/supporting-people-manage-health-patient-activation-may14.pdf)

Insignia Health (2020) [*Patient Activation Measure*](https://www.insigniahealth.com/products/pam-survey)

Health Foundation (2018) [*Webinar: understanding and using the patient activation measure in the NHS*](https://www.health.org.uk/event/webinar-understanding-and-using-the-patient-activation-measure-in-the-nhs)

**Supporting behaviour change**

**Description and introduction**

Supporting behaviour change is a key component of personalised care. This may be for people using services who are making lifestyle and health behaviour changes, staff and workforces who are adapting to or adopting new ways of working and organisations who are changing how they deliver services and support communities. How people do things results from a complex combination of behaviours, decisions and interactions. Changing these behaviours and habits is not easy. It is much more than developing new skills and knowledge and following guidance or instructions. To achieve and sustain positive impact research suggests that taking a structured behavioural approach is more successful than isolated training.

**Key elements of the approach**

* It is essential to understand the principles of behaviour change and the factors that can impact a person’s ability to learn, together with their motivation and confidence to implement new skills and behaviours. These include the psychological, social, economic and cultural factors within people’s lives, working environments and networks of support.
* Successful approaches include the necessary combination of capability, together with the opportunity and motivation for behaviour change.
* In practice this means people need to;

-Know what to do

-Know how to do it

-Think it is a good thing

-Believe that they are capable

-Believe that it is their role

-Believe that people who are important to them think it is the right thing to do

-Work or live in an environment that allows and supports them to do it

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*Source: Making the Change, Realising the Value (2016)*

* Other specific models that support health behaviour change include Making Every Contact Count (MECC), Health Coaching and Motivational Interviewing (these are covered separately in the curriculum and share many core skills).

**Learning Outcomes specific to utilising this model or approach**

**Level 1:**

The learner will

Be aware of:

* The relevance of behaviour change techniques for: one to one interactions, how teams/groups work together, the Public Health agenda, how organisations deliver services
* Relevant resources and models to support behaviour change including COM B, Making Every Contact Count, Motivational Interviewing, Health Coaching
* Their own biases and how these might impact behaviour change interactions with others
* Their own response and contribution to change
* Their role in supporting others through change
* The challenges for others when changing behaviours

Know:

The components that affect an individual’s ability to adapt to or adopt new behaviours

* When to refer to more specialist services and support

Be able to:

* Identify when to use behaviour change techniques
* Develop rapport and engagement to explore areas for change using a non-judgmental, collaborative and enabling approach

**Level 2**

In addition to level 1, the learner will be able to:

* Identify, agree and apply relevant structured behavioural approach
* Explore, understand and collaboratively agree: the problem, identify and implement the way forward, measure and evaluate outcomes that are important to those involved
* Understand and consider relevant criteria when designing behavioural change interventions which may include clinical guidelines, health and social care policy, affordability, practicability, effectiveness and cost-effectiveness, acceptability, side-effects/safety
* Create and develop key relationships within the community which support the behaviour change intervention
* Participate in appropriate service improvement methodology

**Level 3**

The learner will be able to:

* Apply leadership skills to improve services and performance using behavioural change approaches and appropriate service improvement methodology
* Support colleagues through change and new ways of working
* Work collaboratively with service user(s) and workforces to identify new ways of working including meaningful outcome and evaluation measures
* Build effective networks outside own organisation to deliver service innovation and improvement across the communities

**Stories from practice**

***(tbc)***

**How to learn this approach**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Learning method | Description | Level 1 | Level 2 | Level 3 |
| e-Learning | Web-based e-learning resources to provide factual information and engage in interactive learning methods  Self-test and certification | **•** | **•** | **•** |
| Problem-based learning | Using topic based teaching to orientate and adapt knowledge and skills appropriately  ‘Case-based discussions’ |  | **•** | **•** |
| Work based learning | Use learning opportunities in the workplace to provide real-life context in which to apply knowledge and skills and identify further learning needs |  | **•** | **•** |
| Recording and role play | Using video recording or role play to learn and apply tools for behaviour change interactions; provide analysis and feedback to identify learning needs. Use exemplars of good practice for discussion |  | **•** | **•** |
| Self-directed learning and Reflective practice | Adult learning involves the capability for self-directed study such as reading around a topic, reflecting on experience and self-behaviours, searching for evidence |  | **•** | **•** |
| Multi-source feedback | Obtaining feedback from colleagues and service users and broader communities is essential to evaluate and develop learning needs |  | **•** | **•** |
| Small group, multi-professional, and peer learning | Peer learning can have a powerful influence on enhancing professional development. It enables sharing experiences, learning together, and self-directed learning groups |  | **•** | **•** |
| Supervision and Mentoring | Provides the means of monitoring professional progress, role-modelling, and facilitating reflective practice and giving formative feedback |  | **•** | **•** |

**Standards for training**

Training courses should satisfy the following requirements at the appropriate levels of learning described above

|  |  |
| --- | --- |
| Course Design | * Evidence-based curriculum that articulates the principles of behaviour change and incorporates the perspective of those with lived experience * Clearly describes the theory and practice of behaviour change models * Relevant e-learning resources for behaviour change, with recorded evidence of achievement at the appropriate level of knowledge * Content is aligned to, and actively engages with the needs of a defined group of learners * Certificate of completion for formal learning including e-learning modules and experiential training |
| Course Delivery | * Proactive and transparent planning has been undertaken which includes expert facilitation in behaviour change * Course structure of a core programme with timetabled ongoing developmental activities * Practical experiential learning is provided, based on existing levels of experience within the group. * Sufficient level of challenge within a safe and supportive environment to encourage active participation e.g. in role play. * Analysis of an encounters and interventions demonstrating the application of principles of behaviour change and to include a report on their effectiveness in their outcomes * Completion of self-reflective exercises including exploring self-bias * Written ‘case study’ demonstrating a specific case / topic illustrating supporting behaviour change in the workplace and to include a report on learning, outcomes and evaluation, next steps, relevant feedback from colleagues and service users. * Formative assessment and support of learners with a summative sign off process for satisfactory completion |
| Monitoring and Evaluation | * Attendance, attrition, and completion data recorded. * Peer and external review of training quality is sought * Feedback is used to inform future improvements. * Cultural factors, Inclusion, Equality and Diversity are all considered. * Impact evaluation of outcomes in practice with sharing of good practice and data. |
| Sustainability | * Cascaded model to widen local training faculty with expertise in consultation and communication skills * Identifying local champions and leaders. * Financial viability for future developments |

**Suggestions for advanced modules**

**tbc**

**Motivational Interviewing**

**Description and Introduction**

Motivational interviewing is based on eliciting people’s intrinsic motivation to change their behaviour and improve their health rather than it being imposed externally. It is reliant on appropriately identifying their values and aspirations to support changes in behaviour. The skill of the professional influences the success of motivational interviewing.

Clinical trials have shown that people exposed supported through MI (versus treatment as usual) are more likely to enter, stay in and complete treatment, participate in follow-up visits, decrease alcohol and illicit drug use and quit smoking. (RCN reference)

**Key elements of the approach**

* It is essential that the approach is non-judgemental and non-confrontational, focusing on the change that the person is interesting making.
* Motivational interviewing uses reflective listening aimed at raising awareness of positive benefits in the future that are relevant to key personal goals in life.

* It is important to recognise that people may be at different levels in their readiness to change, ranging from never having thought about it, to actively trying to change their behaviour but with varying success. The interviewer engages with the individual at the appropriate level with empathy and understanding and accepts that they need to work with resistance and ambivalence.
* It is the individuals themselves that make the psychological shift necessary to drive and take ownership of the change that they need. They require support to develop self-efficacy, optimism and build confidence in making this commitment.
* There are 4 general skills that can be applied (Motivational Interviewing: Helping People Change. 3rd Edition. Miller & Rollnick 2012):

Develop empathy (‘OARS’ Open-ended questions – Affirmations – Reflections - Summaries)

Support self-efficacy

Roll with resistance

Develop discrepancy

* Techniques for motivational interviewing can be integrated into a wide range of interactions and complements existing skillsets rather than requiring a change of approach.

**Learning Outcomes specific to utilising this model or approach**

**Level 1:**

The learner will

Know

* The ethos and principles of motivational interviewing
* The cycle of change and how to apply it in practice

Understand

* Methods of personalised communication and working and engaging collaboratively.

**Level 2:**

In addition to Level 1, the learner will

Understand

* Skills required to elicit the level of motivation through active listening and use of language
* Identify readiness to engage in positive behaviour change
* ‘maintenance’ and ‘change’ talk in motivational interviewing.
* The difference between executive and performance coaching and the tension this creates when balancing changes of importance to the person and changes of importance to the workforce or system
* Executive versus performance coaching

Be able to:

* Recognise and work with individuals who express resistance and ambivalence

**Level 3:**

In addition to Level 1-2, the learner will

Be able to

* Recognise and work with individuals who express resistance and ambivalence
* Reflecting on alternative approaches to increasing individual’s intrinsic motivation - undertaking behaviour change conversations in contexts of highest complexity and significant risk.

**Stories from practice**

***(tbc)***

**How to learn this approach**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Learning method | Description | Level 1 | Level 2 | Level 3 |
| e-Learning | Web-based e-learning resources to provide factual information and engage in interactive learning methods. Self-test and certification. | **•** | **•** | **•** |
| Work based learning | Use learning opportunities in the workplace to provide real-life context in which to apply knowledge and skills and identify further learning needs. | **•** | **•** | **•** |
| Recording and role play | Using video recording or role play to learn and apply models of consultation; provide analysis and feedback to identify learning needs. Use exemplars of good practice for discussion. |  | **•** | **•** |
| Self-directed learning and Reflective practice | Adult learning involves the capability for self-directed study such as reading around a topic, reflecting on experience and searching for evidence |  | **•** | **•** |
| Multi-source feedback | Obtaining feedback from colleagues and patients is essential to evaluate and develop learning needs |  | **•** | **•** |
| Small group, multi-professional, and peer learning | Peer learning can have a powerful influence on enhancing professional development. It enables sharing experiences, learning together, and self-directed learning groups |  |  | **•** |
| Supervision and Mentoring | Provides the means of monitoring professional progress, role-modelling, and facilitating reflective practice and giving formative feedback |  |  | **•** |

**Standards for Training**

Training courses should satisfy the following requirements at the appropriate levels of learning described above

|  |  |
| --- | --- |
| Course Design | * Evidence-based curriculum that articulates the philosophy and principles of Motivational Interviewing and incorporates the perspective of those with lived experience * Embeds an introduction to MI skills in the core curriculum and clearly describes the theory and practical application. * Relevant e-learning resources for Motivational Interviewing with recorded evidence of achievement at the appropriate level of knowledge and capability * Content is aligned to, and actively engages with the needs of a defined group of learners |
| Course Delivery | * Proactive and transparent planning has been undertaken which includes expert facilitation in Motivational Interviewing * Course structure of a core programme with timetabled ongoing developmental activities * Practical experiential learning is provided, based on existing levels of experience within the group. * Sufficient level of challenge within a safe and supportive environment to encourage active participation e.g. in role play. * Analysis of an encounters and interventions demonstrating Motivational Interviewing and to include a report on its effectiveness in health outcomes * Formative assessment and support of learners with a summative sign off process for satisfactory completion |
| Monitoring and Evaluation | * Attendance, attrition, and completion data recorded. * Peer and external review of training quality is sought * Feedback is used to inform future improvements. * Cultural factors, Inclusion, Equality and Diversity are all considered. * Impact evaluation of outcomes in practice with sharing of good practice and data. |
| Sustainability | * Cascaded model to widen local training faculty with expertise in consultation and communication skills * Identifying local champions and leaders. * Financial viability for future developments |

**Health Coaching**

**Description and Introduction**

Health coaching is defined in Universal Personalised Care as: ‘Helping people gain and use the knowledge, skills and confidence to become active participants in their care so that they can reach their self-identified health and wellbeing goals’.

https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the- comprehensive-model/

**Key elements of the approach**

* The founding premise of coaching is a belief that everybody has their own resourcefulness potential. The process of health coaching is to encourage people to tap into and grow their internal resources, so that they can improve and maintain their health.
* It can be a valuable approach in helping people developing confidence to manage their own health and reduce dependency on services
* It involves a partnership approach between the coach and the individual, agreeing outcomes that matter to the person, and topics on which to focus.
* It requires a mindset in which people and practitioners are viewed as equals, recognising the expertise the person has in their own life and the central role they have in terms of self-managing their own health
* Time is spent exploring the person’s experiences, situation and perspective to help them identify their own solutions and plans to achieve their goals. Support is tailored around the capabilities the person, and their assets within the context of their life and support networks. It will also involve breaking down goals into manageable steps using a structured approach and recognised tools
* The principles and techniques of health coaching are described in ‘A better conversation’. The Health Coaching Coalition (2016):

**https://irp-cdn.multiscreensite.com/0856eb26/files/uploaded/A\_Better\_Conversation\_Resource\_Guide.pdf**

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**Learning Outcomes specific to utilising this model or approach**

**Level 1:**

The learner will

Know

* the principles and concepts of health coaching

Understand

* the different types of health coaching being used

**Level 2:**

The learner will

Know

* how to structure conversations using a coaching approach to increase personal accountability for plans

Understand

* the use of approaches that focus on strength and positive emotions
* health behaviour and barriers to change (cognitive, emotional, behavioural, etc.)

Be able to

* use effective questions to raise awareness and provide supportive challenge
* apply a range of directive and non-directive communication approaches
* apply the principles of patient activation and readiness for change
* Support the person to set goals which encourage intrinsic motivation and enable them to achieve the outcomes which are important to them
* Utilise the appropriate specific coaching and behaviour change techniques in a variety of circumstances

Gather meaningful feedback from service users and people using services

**Level 3:**

The learner will

Be able to

* provide reports on health coaching services
* further develop their facilitation skills and encourage a community of practice for supervision

**Stories from practice**

***(tbc)***

**How to learn this approach**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Learning method | Description | Level 1 | Level 2 | Level 3 |
| e-Learning | Web-based e-learning resources to provide holistic information and engage in interactive learning methods. Self-test and certification. | **•** | **•** | **•** |
| Work based learning | Use experiential learning opportunities in the workplace to provide context in which to apply health coaching skills and identify further learning needs. | **•** | **•** | **•** |
| Recording and role play | Using video recording or role play to learn and apply models of health coaching; provide analysis and feedback to identify learning needs. Use exemplars of good practice for discussion. |  | **•** | **•** |
| Self-directed learning and Reflective practice | Self-directed study such as reading reflecting on experience and searching for evidence. Finding resources for health coaching that are personally meaningful |  | **•** | **•** |
| Multi-source feedback | Obtaining feedback from colleagues and patients is essential to evaluate and develop learning needs |  | **•** | **•** |
| Small group, multi-professional, and peer learning | Peer learning can have a powerful influence on enhancing professional development. It enables sharing experiences, learning together, and self-directed learning groups |  | **•** | **•** |
| Supervision and Mentoring | Provides the means of monitoring professional progress, role-modelling, and facilitating reflective practice and giving formative feedback |  |  | **•** |

**Standards for Training**

Training courses should satisfy the following requirements at the appropriate levels of learning described above

|  |  |
| --- | --- |
| Course Design | * Evidence-based curriculum that articulates the principles of Health Coaching and incorporates the perspective of those with lived experience * Embeds an introduction to Health Coaching skills in the core curriculum and clearly describes the theory and practical application. * Relevant e-learning resources for Health Coaching with recorded evidence of achievement at the appropriate level of knowledge * Content is aligned to, and actively engages with the needs of a defined group of learners |
| Course Delivery | * Proactive and transparent planning has been undertaken which includes expert facilitation in Health Coaching * Course structure of a core programme with timetabled ongoing developmental activities * Practical experiential learning is provided, based on existing levels of experience within the group. * Sufficient level of challenge within a safe and supportive environment to encourage active participation e.g. in role play. * Analysis of an encounters and interventions where Health Coaching has been used, and to include a report on its effectiveness in health outcomes * Formative assessment and support of learners with a summative sign off process for satisfactory completion. |
| Monitoring and Evaluation | * Attendance, attrition, and completion data recorded. * Peer and external review of training quality is sought * Feedback is used to inform future improvements. * Cultural factors, Inclusion, Equality and Diversity are all considered.   Impact evaluation of outcomes in practice with sharing of good practice and data. |
| Sustainability | * Cascaded model to widen local training faculty with expertise in consultation and communication skills * Identifying local champions and leaders. * Financial viability for future developments |

References

1. <https://www.england.nhs.uk/publication/health-coaching-summary-guide-and-technical-annexes/>
2. <https://www.hee.nhs.uk/sites/default/files/documents/Health%20coaching%20quality%20framework.pdf->

**Personalised Care in the remote and virtual environment**

**Definition and Introduction**

A remote consultation or interaction is one which takes place when the person using the service and the person providing the service are in different sites and not face to face. This may be via telephone, video link or via virtual interactive platforms. There are a number of reasons that an interaction may take place in this way and it is important to understand when it is appropriate, how it differs from face to face interactions, how to go about it and how to ensure it meets the needs of all participants.

Reasons for undertaking a remote consultation may include safety (such as cross infection risks, physical safety and public health priorities), choice preference, geographical challenge, efficacy and cost effectiveness.

It is particularly important to remember that many of the ways in which we build rapport and gather and share information are altered or even absent when consulting via a virtual environment. It is also harder to judge how people receive and respond to information, feedback or news. Additionally, normal mechanisms and networks of support maybe reduced or absent.

**Key elements of the ‘model’**

* Virtual interactions should take place when appropriate and safe. This includes situations such as when the need is straightforward, direct physical examination is not necessary, all required information can be gathered and shared to meet both parties’ needs, there is access to relevant records, the person has capacity, the virtual environment for both parties provides for the necessary level of confidentiality, dignity and respect.
* It is necessary to understand and implement a number of modifications to all components of the interaction including the set up and preparation phase as well as during the progression of the consultation itself.
* Preparation, testing and confidence of the equipment is essential for both parties prior to the interaction. Equal attention should be paid to the environment and the context of those participating.
* Consultations via video can potentially replace some of the non-verbal communication lost during a telephone consultation but evidence suggests that it is still not equivalent to face to face interactions and preference of the individual should be taken into account
* Consent in this context includes agreement for video consultation, confirmation of participants & identity (both on screen and in the room), confirmation that confidentiality is in place and that no party is recording the interaction.
* Equity of access and ‘digital literacy’ should be considered when offering care via virtual environments as this form of consulting requires necessary equipment, reliable internet access and confidence to navigate virtual environments.
* Virtual environments are increasingly being used for professional and workforce meetings and peer support groups and interactions. Robust systems and structures need to be in place to support these to be safe, effective and adhere to legal and professional guidelines and codes of practice.
* Local policies and practices should be in place, documented and accessible.
* In the event of the need to beak bad news through a virtual environment (if circumstance means this is the ONLY option) particular care must be taken to prepare and check guidelines, best practice and seek guidance/support if required.
* It is essential that the need to create clarity and structure within a virtual consultation is not achieved at the detriment of the personalised nature of the interaction. Clear collaborative agenda setting and sharing of anticipated outcomes for the consultation at the start will help, together with consideration of the adapted core communication skills below.

**Learning Outcomes specific to utilising this model or approach**

**Level 1**

**The learner will:**

Be aware of

* The choice and opportunity for virtual interactions and processes for booking and accessing care via virtual and electronic methods.
* The need to adapt and modify both content and process skills when undertaking interactions in the virtual environment.
* The impact that interacting via a virtual environment has on communication skills, rapport building, trust and consent.
* The potential impact for the other person after the interaction has finished.

Know

* Where to access local policies and procedures and national and professional guidelines relating to virtual interactions and consultations.

Level 2

Understand

* When to use virtual environments for interactions and consultations.

Be able to

* Adhere to local, national and professional policies and guidelines
* Apply adaptive communication and consultation models
* Effectively prepare for virtual interaction
* Be competent and confident to apply modified content, process and relationship building skills in the virtual environment.
* Assess and identify networks of support and appropriate safety netting for after the interaction.
* Assess when not to proceed with a virtual interaction / consultation
* Document content and outcomes of virtual interactions in line with local, national and professional guidelines
* Evaluate efficacy of virtual interactions using range of outcome measures (from clinical, service and user perspective).

Level 3

Be able to

* Apply principles of virtual interactions in leadership role and team interactions.
* Work with teams, service users and communities to build health literacy and equity of access to care, education and support via virtual environments.
* Oversee/co-ordinate governance for areas of service responsibility for virtual interactions.
* Co-produce service evaluation and improvement measures with teams, organisations, communities and service users.

**Stories from practice**

***(tbc)***

**How to learn this approach**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Learning method | Description | Level 1 | Level 2 | Level 3 |
| e-Learning | Web-based e-learning resources to provide information about the appropriate use and practicalities of remote consultations and engage in interactive learning methods. Self-test and certification. | **•** | **•** | **•** |
| Work based learning | Use experiential learning opportunities for remote consulting in the workplace to provide context in which to apply and adapt consultation skills and identify further learning needs. | **•** | **•** | **•** |
| Recording and role play | Using video recording or role play to learn and apply models of consulting in a remote or virtual environment; provide analysis and feedback to identify learning needs. Use exemplars of good practice for discussion. |  | **•** | **•** |
| Self-directed learning and Reflective practice | Self-directed study such as reading reflecting on experience and searching for evidence. Finding resources for remote consulting that are personally meaningful |  | **•** | **•** |
| Multi-source feedback | Obtaining feedback from colleagues and patients is essential to evaluate and develop learning needs in remote consulting |  | **•** | **•** |
| Small group, multi-professional, and peer learning | Peer learning can have a powerful influence on enhancing professional development. It enables sharing experiences, learning together, and self-directed learning groups |  | **•** | **•** |
| Supervision and Mentoring | Provides the means of monitoring professional progress, role-modelling, and facilitating reflective practice and giving formative feedback |  |  | **•** |

**Standards for Training**

Training courses should satisfy the following requirements at the appropriate levels of learning described above

|  |  |
| --- | --- |
| Course Design | * Evidence-based curriculum that articulates the principles of Personalised care in a remote or virtual environment and incorporates the perspective of those who use the service * Embeds an introduction to Remote and virtual consulting skills in the core curriculum and clearly describes the theory and practical application. * Relevant e-learning resources for remote consulting with recorded evidence of achievement at the appropriate level of knowledge * Content is aligned to, and actively engages with the needs of a defined group of learners |
| Course Delivery | * Proactive and transparent planning has been undertaken which includes expert facilitation in remote and virtual consulting skills * Course structure of a core programme with timetabled ongoing developmental activities * Practical experiential learning is provided, based on existing levels of experience within the group. * Sufficient level of challenge within a safe and supportive environment to encourage active participation e.g. in role play. * Analysis of an encounters and interventions where remote or virtual consulting has been used, and to include a report on its effectiveness in health outcomes * Formative assessment and support of learners with a summative sign off process for satisfactory completion. |
| Monitoring and Evaluation | * Attendance, attrition, and completion data recorded. * Peer and external review of training quality is sought * Feedback is used to inform future improvements. * Cultural factors, Inclusion, Equality and Diversity are all considered. * Impact evaluation of outcomes in practice with sharing of good practice and data. |
| Sustainability | * Cascaded model to widen local training faculty with expertise in consultation and communication skills * Identifying local champions and leaders. * Financial viability for future developments |

**Advanced modules**

**(tbc)**

**The Six Components of Personalised Care**

The Comprehensive Model for Personalised Care has been co-produced with people with

lived experience and a wide range of stakeholders and brings together six evidence-based

and inter-linked components, each of which is defined by a standard, replicable delivery

model.

The components are:

1. Shared decision making
2. Personalised care and support planning
3. Social prescribing and community-based support
4. Supported self-management
5. Enabling choice, including legal rights to choose
6. Personal health budgets and integrated personal budgets.

A screenshot of a social media post

Description automatically generated

**1. Shared Decision-Making**

**Definition and Introduction**

The Universal Personalised Care definition states that ‘Shared decision making: People are supported to a) understand the care, treatment and support options available and the risks, benefits and consequences of those options, and b) make a decision about a preferred course of action, based on evidence-based, good quality information and their personal preferences.’

There are a number of key reasons for shared decision making:

Ethical standard- support for autonomy

Moral principle- patents want to be more involved

Professional code of conduct, especially consent

Ensures we provide care and treatment that informed patients want, so can help with allocating resources at a population level and therefore contributes to reducing unwarranted variation and maximising value

An understanding of these reasons is important for anyone looking for ways of improving their services. It requires shifts in culture and systems, prepared professionals, and supported individuals.

Shared decision making (SDM) ensures that individuals are supported to make decisions that are right for them.  It is a collaborative process through which a clinician supports a patient to reach a decision about their treatment.

The conversation brings together:

* the clinician’s expertise, such as treatment options, evidence, risks and benefits
* what the patient knows best: their preferences, personal circumstances, goals, values and beliefs.

SDM is a process in which people who experience a change in their health work together with clinicians to select tests, treatments, management or support packages.

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| **Descriptors of professional behaviours: Ensuring that individuals are supported to make decisions that are right for them and based on shared understanding.**  The practitioner   * Appreciates the value of health being more than the absence of disease and a means of enabling a person to live their lives to their fullest potential * Enquires routinely into physical, psychological and social factors and integrates these into a holistic understanding * Interprets personal stories in their unique context, including environmental, cultural, and spiritual or existential factors * Demonstrates the ability to Integrate a diverse range of options into an appropriately evidence-based plan according to personal preferences and circumstances,   **Learning Outcomes applied to both learners and users of services** |
| ***(Level 1 and 2 -*** *see generic capabilities and capabilities in personalised care).*  **Level 3:**  In addition to Level 1-2, the learner will  Know   * legal requirements of patient and carer involvement in shared decisions * a range of relevant patient decision support tools and resources   Understand   * the importance of appropriately preparing people for shared-decision-making conversations * the role of evidence in shared decision-making; communicate and interpret evidence in a meaningful way for to enable informed decisions about management.   Be able to   * Take account of lower levels of health literacy and the impact it has on engaging in SDM conversations * Recognise and balance preferences and decisions for highly complex present and future needs that include social and mental wellbeing. * Identify when a timely shift of focus from curative to palliative approaches to care is appropriate * Represent the importance of co-production in care pathways and service design and apply principles of co-production within organisations, and across sectors.   **Stories from practice**  ***(tbc)***  **How to learn this component**   |  |  | | --- | --- | | **Relevant Models and Approaches** | | | Range of consultations; Health Literacy; Patient Activation | | | **Learning method** | **Description** | | e-Learning | Web-based e-learning resources to provide factual information and engage in interactive learning methods. Self-test and certification. | | Problem-based learning | Using topic based teaching to appropriately orientate and adapt knowledge and skills. Use of ‘case-based discussions’ to apply theory to practice | | Work based learning | Use opportunistic learning based on ‘PUNS and DENs’\* in the workplace to provide relevant context to the individual’s professional role in the SDM process | | Recording and role play | Using video recording or role play to learn and apply models of consultation; provide analysis and feedback to identify learning needs. Use exemplars of good practice in SDM for discussion. | | Self-directed learning and Reflective practice | Learning how to undertake self-directed study such as reading around a topic, reflecting on experience and searching for and synthesising evidence | | Multi-source feedback | Obtaining feedback from colleagues and patients is essential to evaluate and direct continuing professional development. | | Small group, multi-professional, and peer learning | Peer learning can have a powerful influence on enhancing professional development. It enables sharing experiences in SDM, learning together, and self-directed learning groups | | Supervision and Mentoring | Provides the means of monitoring professional progress, role-modelling, and facilitating reflective practice and giving formative and summative feedback |   *\* ‘Patients Unmet Needs’ and ‘Doctors Educational Needs’*  **Standards for Training**  Training courses should satisfy the following requirements at the appropriate levels of learning described above   |  |  | | --- | --- | | Course Design | * Evidence-based curriculum including patient stories that articulate the underlying philosophy and principles of Shared Decision Making * Embed an introduction to the principles of SDM skills in the core curriculum * Reflects the needs of local and national strategies for systems and pathways of care * Addresses the specific needs of, and actively engages with a defined group of learners * The structure allows sufficient time for meaningful experience of Shared Decision-Making – such as a course structure of a core programme with timetabled ongoing developmental activities | | Course Delivery | * Proactive and transparent planning has been undertaken which includes expert facilitation in Health Coaching * Practical experiential learning is provided, based on existing levels of experience within the group. * Sufficient level of challenge within a safe and supportive environment to encourage active participation e.g. in role play. * Analysis of an encounters and interventions where Health Coaching has been used, and to include a report on its effectiveness in health outcomes * Formative assessment and support of learners with a summative sign off process for satisfactory completion where appropriate. | | Monitoring and Evaluation | * Attendance, attrition, and completion data recorded. * Peer and external review of training quality is sought * Feedback is used to inform future improvements. * Cultural factors, Inclusion, Equality and Diversity are all considered.   Impact evaluation of outcomes in practice with sharing of good practice and data. | | Sustainability | * Cascaded model to widen local training faculty with expertise in consultation and communication skills * Identifying local champions and leaders.   Financial viability for future developments |   **Suggestions for advanced modules**  **tbc** |

**2. Personalised Care and Support Planning**

**Definition and Introduction**

Personalised Care and Support Planning is a series of facilitated conversations in which the person, or those who know them well, actively participates to explore the management of their health and well-being within the context of their whole life and family situation.

This process recognises the person’s skills and strengths, as well as their experiences and the things that matter the most to them. It addresses the things that aren’t working in the person’s life and identifies outcomes and actions to resolve these.

Personalised Care and Support Planning is a proactive approach to shared decision making. It is key for people receiving health and social care services. It is an essential tool to integrate the person’s experience of all the services they access so they have one joined-up plan that covers their health and wellbeing needs.

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| **Descriptors of professional behaviours: facilitating active participation in the management of individual health and well-being within the context of their whole life and family situation.**  The practitioner   * Recognises that every person has a unique set of values and experiences of health and illness and is able to agree outcomes that are proportionate, flexible and coordinated and adaptable to their health condition, situation and care and support needs. * Provides individually tailored, advice and support to enable them to optimise their lifestyle and well-being * Engages in a dialogue with the individual and other relevant health, education and social care professionals to incorporate these perspectives into in any decisions * Acknowledges the impact of the problem on the patient, such as how it affects daily functioning, education, occupation and relationships and recognises the impact of the problem on the patient’s family and carers, social context and community * Anticipates the health issues that may commonly arise during the expected transitions of life (including childhood development, adolescence, adulthood, ageing and dying) * Formulates a plan that includes a description of the person, what matters to them and all the necessary elements that would make the plan achievable and effective   **Learning Outcomes applied to both learners and users of services**  ***(Level 1 and 2 -*** *see generic capabilities and capabilities in personalised care).*  **Level 3:**  In addition to Level 1-2, the learner will  Know   * how to prepare for the role of engaging in support planning   Understand   * The uncertainty of achieving specific outcomes in clinical practice and adapt management accordingly |
|  |
| Be able to:   * review personalised care and support plans formally and informally |
| * Co-produce and implement care plans for people with complex lives to facilitate positive changes and take account of the impact this may have on other services and people; * contribute to the success of a multi-professional team by sharing good practice and promote interprofessional learning around support planning * reach a shared agreement when managing highly complex situations, and those that involve significant risk |

**Stories from practice**

***(tbc)***

**How to learn this component**

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| **Relevant Models and Approaches** | |
| MECC; Patient Activation; Health Coaching | |
| **Learning method** | **Description** |
| e-Learning | Web-based e-learning resources to provide factual information and engage in interactive learning methods. Self-test and certification. |
| Problem-based learning | Using topic based teaching to appropriately orientate and adapt knowledge and skills. Use of ‘case-based discussions’ to apply theory to practice |
| Work based learning | Use opportunistic and structured learning based in the workplace to provide relevant context to the individual’s professional role in care and support planning |
| Multi-source feedback | Obtaining feedback from colleagues and patients is essential to evaluate and direct continuing professional development in support planning. |
| Small group, multi-professional, and peer learning | Peer learning can have a powerful influence on enhancing professional development. It enables sharing experiences in care and support planning and provides the opportunity of learning together, as an active learning set |
| Supervision and Mentoring | Provides the means of monitoring professional progress, role-modelling, and facilitates reflective practice through formative and summative feedback |

**Standards for training**

Training courses should satisfy the following requirements at the appropriate levels of learning described above

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| Course Design | * Evidence-based and including patient experience that articulate the underlying philosophy and principles of Personalised Care and Support planning * Embed an introduction to the principles of Support planning skills in the core curriculum * Reflects the needs of local and national strategies for systems and pathways of care * Addresses the specific needs of, and actively engages with a defined group of learners * The structure allows sufficient time for meaningful experience of Support Planning – such as course structure of a core programme with timetabled ongoing developmental activities |
| Course Delivery | * Proactive and transparent planning has been undertaken which includes expert facilitation in Health Coaching * Signpost to relevant e-learning resources for support planning with recorded evidence of achievement of knowledge at the appropriate level * Practical experiential learning is provided, based on existing levels of experience within the group. * Sufficient level of challenge within a safe and supportive environment to encourage active participation * Formative assessment and support of learners with a summative sign off process for satisfactory completion. * Provide opportunities for practice through face to face workshops, simulated modalities and in the workplace |
| Monitoring and Evaluation | * Attendance, attrition, and completion data recorded. * Peer and external review of training quality is sought * Feedback is used to inform future improvements. * Cultural factors, Inclusion, Equality and Diversity are all considered. * Impact evaluation of outcomes in practice with sharing of good practice and data. |
| Sustainability | * Cascaded model to widen local training faculty with expertise in consultation and communication skills * Identifying local champions and leaders. * Financial viability for future developments |

**Suggestions for advanced modules**

**tbc**

**3. Social Prescribing and Community-Based Support**

**Definition and Introduction**

[***https://www.england.nhs.uk/personalisedcare/upc/comprehensive-model/case-studies/social-prescribing-in-practice/***](https://www.england.nhs.uk/personalisedcare/upc/comprehensive-model/case-studies/social-prescribing-in-practice/)

Social prescribing replaces the one-size-fits all approach with care that is tailored to people’s own mental and physical needs. It recognises that health is not just physical but emotional and social too. Social prescribing enables local GPs and other local agencies to refer people to link workers, who operate at the heart of primary care.  They provide specialist support to individuals who need more than just medical care to help them live healthier, more fulfilling lives. By spending time with a person, they help to unpick the things that may be holding them back and help them identify and connect up with organisations and activities in their community.

A standard model of social prescribing has been developed in partnership with stakeholders, which shows the key elements that need to be in place for effective social prescribing;



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| **Descriptors of professional behaviours: utilising link workers, community groups, and statutory services to provide a holistic practical and emotional support.**  The practitioner   * Understands the structure of the local healthcare system, including the various roles, responsibilities and organisations within it, applies this understanding to improve the quality and safety of the care you provide * Recognises that groups or communities of patients may share and value certain characteristics and have common health needs and use this understanding to enhance care, while continuing to acknowledge that people are individuals * Facilitates appropriate long-term support that is realistic and avoids dependence by utilising appropriate support agencies (including primary healthcare team members) targeted to the needs of the patient and/or his or her family and carers * Demonstrates approaches that balance the needs of individual patients with the health needs of the local community, within available resources * Recognises how roles and influence span across the healthcare system, including coordination of complex and long-term care; patient advocate; service navigator and gatekeeper; and in reducing health inequalities |
| **Learning Outcomes applied to both learners and users of services**  ***(Level 1 and 2 -*** *see generic capabilities and capabilities in personalised care).*  **Level 3:**  In addition to Level 1-2, the learner will  Know   * how local services can be accessed and use this understanding to inform your referral practices   Understand   * the importance of effectively utilising social networks in managing time and resources; * the possibly conflicting priorities between the needs of individuals and the requirements of the wider population, the resources available in the community, and adopt approaches to manage these tensions * individuals, families and communities form a continuum, with each affecting the other, requiring a system-wide understanding of health and social care   Be able to |
| * Recognise potential red flags and refer appropriately * Proactively address factors that have an impact of social and environmental factors on health. * Support resilience and capacity in community networks and resources * Utilise and integrate public health epidemiology and 'big data' sources into practice * reflect on your role as a commissioner and quality improver and contribute to the development of new services in your organisation or locality * Demonstrate the ability to analyse and identify the health characteristics of the populations with which you work, including the cultural, occupational, epidemiological, environmental, economic and social factors and the relevant characteristics of ‘at-risk’ groups |

**Stories from practice**

***(tbc)***

**How to learn this component**

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| **Relevant Models and Approaches** | |
| Supporting Behaviour Change; Health Coaching; | |
| **Learning method** | **Description** |
| e-Learning | Accessing local training and web-based e-learning resources to engage in interactive learning methods. Self-test and certification. |
| Problem-based learning | Using topic based teaching to appropriately orientate and adapt knowledge and skills. Use of ‘case-based discussions’ to apply theory to practice |
| Work based learning | Use opportunistic and structured learning based in the workplace to provide relevant context to the individual’s professional role in social prescribing |
| Multi-source feedback | Obtaining feedback from colleagues and service users to evaluate your own practice and inform continuing professional development in social prescribing. |
| Small group, multi-professional, and peer learning | Peer learning can have a powerful influence on enhancing professional development. It enables sharing experiences in care and support planning and provides the opportunity of learning together, as an active learning set |
| Supervision and Mentoring | Provides the means of monitoring professional progress, role-modelling, and facilitates reflective practice through formative and summative feedback |

**Standards for training**

Training courses should satisfy the following requirements at the appropriate levels of learning described above

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| Course Design | * Evidence-based curriculum including patient experience * Embed an introduction to the principles of social prescribing skills in the core curriculum * Reflects the role of community support in local and national strategies for systems and pathways of care * Addresses the specific needs of, and actively engages with a defined group of learners * The structure allows sufficient time for meaningful experience of Shared Decision-Making – such as a course structure of a core programme with timetabled ongoing developmental activities |
| Course Delivery | * Proactive and transparent planning has been undertaken which includes expert facilitation in Social Prescribing and Support Planning * Signpost to relevant e-learning resources for support planning with recorded evidence of achievement of knowledge at the appropriate level * Practical experiential learning is provided, based on existing levels of experience within the group. * Sufficient level of challenge within a safe and supportive environment to encourage active participation * Provide opportunities for practice through face to face workshops, simulated modalities and in the workplace * Formative assessment and support of learners with a summative sign off process for satisfactory completion. |
| Monitoring and Evaluation | * Attendance, attrition, and completion data recorded. * Peer and external review of training quality is sought * Feedback is used to inform future improvements. * Cultural factors, Inclusion, Equality and Diversity are all considered. * Impact evaluation of outcomes in practice with sharing of good practice and data. |
| Sustainability | * Cascaded model to widen local training faculty with expertise in consultation and communication skills * Identifying local champions and leaders. * Financial viability for future developments |

**Suggestions for advanced modules**

**tbc**

**4. Supported Self-Management**

**Definition and Introduction**

Supported self-management (SSM) proactively identifies the knowledge, skills and confidence (‘activation’) people have to manage their own health and care, and provides the support to enable the person to have knowledge skills and confidence to proactively manage their health and wellbeing

Health and care professionals tailor their approaches to working with people, based on the person’s individual assets, needs and preferences, as well as taking account of any inequalities and accessibility barriers, and so working in a personalised way based on ‘what matters’ to the person. It also means ensuring approaches such as health coaching, peer support and self-management education are systematically put in place to help build knowledge, skills and confidence.

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| **Descriptors of professional behaviours: proactively identifying the knowledge, skills and confidence people have to manage their own health and care.**  The practitioner   * Recognises that individuals experience problems that cannot be readily labelled or clearly categorised and demonstrates a positive attitude and commitment to self-management where it is appropriate * Supports an individual’s desire to have meaning in their life * Encourages and actively facilitates health promotion and supports individuals in taking steps to increase their health resilience * Identifies the impact of environment health, including home circumstances, education, occupation, employment and social and family situation; and offers support in addressing these factors. Understands the importance of respecting dignity * Adopts safe and effective approaches for individuals with complex health needs and implements measures to use resources cost-effectively. * Communicates risk in an effective manner, assisting individuals to refocus on improving their health and well-being * Manages uncertainty through the use of risk assessment, communication, appropriately informed self- monitoring, and follow-up |
| **Learning Outcomes applied to both learners and users of services**  ***(Level 1 and 2 -*** *see generic capabilities and capabilities in personalised care).*  **Level 3:**  In addition to Level 1-2, the learner will  Understand   * the potential need to allow for positive risk-taking and shared decision-making in the presence of significant complexity and severity * the potential tensions in acute situations between the desire for self-management and the need for accepting external support   Be able to   * avoid making assumptions when dealing with people who may have been labelled with complex diagnoses * Understand and apply tools for stratified risk assessment, using appropriate technologies and informatics * Recognise the limitations and challenges of applying protocol-driven means of decision-making when managing complex needs   **Stories from practice**  ***(tbc)***  **How to learn this component**   |  |  | | --- | --- | | **Relevant Models and Approaches** | | | Health Literacy; Patient Activation; Motivational Interviewing | | | **Learning method** | **Description** | | Problem-based learning | Using topic based teaching to appropriately orientate and adapt knowledge and skills. Use of ‘case-based discussions’ to apply theory to practice | | Work based learning | Use opportunistic and structured learning based in the workplace to provide relevant context to the individual’s professional role in supported self-management | | Multi-source feedback | Obtaining feedback from colleagues and service users to evaluate your own practice and inform continuing professional development in support planning. | | Small group, multi-professional, and peer learning | Peer learning can have a powerful influence on enhancing professional development. It enables sharing experiences in care and support planning and provides the opportunity of learning together, as an active learning set | | Supervision and Mentoring | Provides the means of monitoring professional progress, role-modelling, and facilitates reflective practice through formative and summative feedback |   **Standards for training**  Training courses should satisfy the following requirements at the appropriate levels of learning described above   |  |  | | --- | --- | | Course Design | * Evidence-based curriculum including patient experience of supported self-management * Embed an introduction to the principles of supported self-management skills in the core curriculum * Reflects the role of supported self-management in local and national strategies for systems and pathways of care * Addresses the specific needs of, and actively engages with a defined group of learners * The structure allows sufficient time for meaningful understanding of supported self-management – such as a course structure of a core programme with timetabled ongoing developmental activities | | Course Delivery | * Proactive and transparent planning has been undertaken which includes expert facilitation in supported self-management * Signpost to relevant e-learning resources for support planning with recorded evidence of achievement of knowledge at the appropriate level * Practical experiential learning is provided, based on existing levels of experience within the group. * Sufficient level of challenge within a safe and supportive environment to encourage active participation * Provide opportunities for practice through face to face workshops, simulated modalities and in the workplace * Formative assessment and support of learners with a summative sign off process for satisfactory completion. | | Monitoring and Evaluation | * Attendance, attrition, and completion data recorded. * Peer and external review of training quality is sought * Feedback is used to inform future improvements. * Cultural factors, Inclusion, Equality and Diversity are all considered. * Impact evaluation of outcomes in practice with sharing of good practice and data. | | Sustainability | * Cascaded model to widen local training faculty with expertise in consultation and communication skills * Identifying local champions and leaders. * Financial viability for future developments |   **Suggestions for advanced modules**  **tbc** |

**5. Enabling choice including legal right to choose**

**Definition and Introduction**

The NHS England vision for patient choice is that all patients are aware of the choices available to them, particularly where these are legal rights and they have the information they need to make meaningful choices; that all providers make good quality, up to date information about their services available and accept all appropriate patient referrals in line with the NHS Standard Contract,

All commissioners will assess how well choice is working within their (CCG) and put improvement plans in place to address areas that need strengthening; and all opportunities to extend choice beyond existing standards are explored and implemented.

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| **Descriptors of professional behaviours: capabilities in enabling choice**  The practitioner   * Recognises the impact of the problem on the individual and their family and/or carers and offers support for the physical, psychological and social aspects of the individual * Accesses information about the individual’s psychosocial history in a non-judgemental manner that puts them at ease. * Recognises and shows understanding of the limits of a single pathway of care in providing the holistic care of the patient * Utilises appropriate support agencies targeted to the specific needs of the individual and their carers.   **Learning Outcomes applied to both learners and users of services**  ***(Level 1 and 2 -*** *see generic capabilities and capabilities in personalised care).*  **Level 3:**  In addition to Level 1-2, the learner will |
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| Be able to   * Coordinate care pathways and services in partnership with individuals and negotiate and enables access to a range of services in complex situations * Manage uncertainty of treatment success or failure and formulate management plans beyond the guidelines * Recognise the implications if care might be inappropriate, fragmented or uncoordinated * Provides the opportunity for, and uses feedback on experiences of services and potential for quality improvement |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Stories from practice**  ***(tbc)***  **How to learn this component**   |  |  | | --- | --- | | **Relevant Models and Approaches** | | | Health Literacy; Patient Activation; Motivational Interviewing | | | **Learning method** | **Description** | | e-Learning | Local resources and web-based e-learning resources to provide factual information and engage in interactive learning methods. Self-test and certification. | | Problem-based learning | Using topic based teaching to appropriately orientate and adapt knowledge and skills. Use of ‘case-based discussions’ to apply theory to practice | | Work based learning | Use opportunistic learning to provide relevant context to the individual’s professional role in the process of enabling choice | | Self-directed learning and Reflective practice | Learning how to undertake self-directed study such as reading around a topic, reflecting on experience and searching for and synthesising evidence | | Multi-source feedback | Obtaining feedback from colleagues and patients is essential to evaluate and direct continuing professional development. | | Supervision and Mentoring | Provides the means of monitoring professional progress, role-modelling, and facilitating reflective practice and giving formative and summative feedback |   **Standards for training**  Training courses should satisfy the following requirements at the appropriate levels of learning described above   |  |  | | --- | --- | | Course Design | * Evidence-based curriculum including patient experience * Embed an introduction to the principles of enabling choice skills in the core curriculum * Reflects the opportunity for enabling choice and the legal right to choice within local and national systems and pathways of care * Addresses the specific needs of, and actively engages with a defined group of learners * The structure allows sufficient time for meaningful experience of enabling choice – such as a course structure of a core programme with timetabled ongoing developmental activities | | Course Delivery | * Proactive and transparent planning has been undertaken which includes expert facilitation in Enabling Choice * Signpost to relevant e-learning resources for support planning with recorded evidence of achievement of knowledge at the appropriate level * Practical experiential learning is provided, based on existing levels of experience within the group. * Sufficient level of challenge within a safe and supportive environment to encourage active participation | | Monitoring and Evaluation | * Attendance, attrition, and completion data recorded. * Peer and external review of training quality is sought * Feedback is used to inform future improvements. * Cultural factors, Inclusion, Equality and Diversity are all considered. * Impact evaluation of outcomes in practice with sharing of good practice and data. | | Sustainability | * Cascaded model to widen local training faculty with expertise in consultation and communication skills * Identifying local champions and leaders.   Financial viability for future developments |   **Suggestions for advanced modules**  **tbc** |

**6. Personal Health budgets and Integrated personal budgets.**

**Definition and Introduction**

A personal health budget is an amount of money to support your health and wellbeing needs, which is planned and agreed between you (or someone who represents you), and your local NHS team. It is not new money, but it may mean spending money differently so that you can get the care that you need.

<https://www.nhs.uk/using-the-nhs/help-with-health-costs/what-is-a-personal-health-budget/>

Personal health budgets are a way of personalising care, based around what matters to people and their individual strengths and needs. They give people with disability and people with long term conditions more choice, control and flexibility over their healthcare.

A personal health budget may be used for a range of things to meet agreed health and wellbeing outcomes. This can include therapies, personal care and equipment. There are some restrictions in how the budget can be spent.

Adults in England who are eligible for [NHS Continuing Healthcare](https://www.nhs.uk/conditions/social-care-and-support-guide/money-work-and-benefits/nhs-continuing-healthcare/) and children in receipt of continuing care have had the right to have a PHB since October 2014.

The key principles of Personal Health Budgets are:

* The person knows how much they have available for healthcare and support within the budget.
* The person is involved in the design of the care plan.
* The person is able to choose how they would like to manage and spend their budget, as agreed in the care plan.

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| **Descriptors of professional behaviours: capabilities in in Personal Health budgets and Integrated personal budgets**  The practitioner   * Understands and works confidently with personal health budgets integrated budgets and direct payments * Exemplifies the importance of collaboratively agreeing and measuring person centred outcomes personalised outcomes; * Works in partnership with individuals and their families and is able to listen to what they feel is important to them to find a solution and care package that works.   **Learning Outcomes applied to both learners and users of services**  ***(Level 1 and 2 -*** *see generic capabilities and capabilities in personalised care).*  **Level 3:**  In addition to Level 1-2, the learner will  Understand |
| * and explain the objectives and requirements for personal health budgets   Be able to   * to assist in navigating the complexity of care funding and support using a budget * demonstrate multi-agency teamworking skills - negotiating, assessing priorities, managing complex and dynamic situations |
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**Stories from practice**

***(tbc)***

**How to learn this component**

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| **Relevant Models and Approaches** | |
| Health Literacy; Patient Activation; Health Coaching | |
| **Learning method** | **Description** |
| e-Learning | National and local resources and web-based e-learning resources to provide factual information and engage in interactive learning methods. Self-test and certification. |
| Work based learning | Use opportunistic learning to provide relevant context to the individual’s professional role in the process of enabling choice |
| Supervision and Mentoring | Provides the means of monitoring professional progress, role-modelling, and facilitating reflective practice and giving formative and summative feedback |

**Standards for training**

Training courses should satisfy the following requirements at the appropriate levels of learning described above

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| Course Design | * A curriculum that articulates the underlying philosophy and principles of Personal Health Budgets * Embed an introduction to the knowledge base of Personal Health Budgets in the core curriculum |
| Course Delivery | * Signpost to relevant e-learning resources with recorded evidence of achievement of knowledge at the appropriate level * Adequate structured teaching time to allow embedding of knowledge, skills and for reflection |
| Monitoring and Evaluation | * Attendance, attrition, and completion data recorded. * Peer and external review of training quality is sought * Feedback is used to inform future improvements. * Cultural factors, Inclusion, Equality and Diversity are all considered. * Impact evaluation of outcomes in practice with sharing of good practice and data. |
| Sustainability | * Cascaded model to widen local training faculty with expertise in consultation and communication skills * Identifying local champions and leaders. * Financial viability for future developments |

**Suggestions for advanced modules**

**tbc**

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**Appendix 1: Professional Development Capabilities in Personalised Care1**

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| **1. Professional Values and Behaviours** | * Maintaining CPD; Self-monitoring; Ability to learn by reflection and constructive feedback; being a role model |
| **2. Professional Skills** |  |
| * Practical Skills | * Digital and legal governance |
| * Communication and Interpersonal skills | * Situational awareness and sensitivity to the impact of their behaviour. |
| * Dealing with Complexity and Uncertainty | * Manage the personal challenges of coping with uncertainty. Resilience and diligence |
| * Clinical Skills | * Training in use of medical devices; maintenance and adverse incident reporting. Infection control and communicable diseases. |
| **3. Professional Knowledge** |  |
| * Professional requirements | * Keep up to date with professional regulatory guidance; CPD and annual appraisal |
| * National legislative requirements | * Employment law; coroner referral |
| **4. Capabilities in Health promotion and illness prevention** | * Keep up to date with professional regulatory guidance; CPD and annual appraisal |
| **5. Capabilities in leadership and teamworking** | * Understanding why leadership and team-working is important for safe and effective care. Demonstrating leadership principles and applying them in practice. Promoting a culture of learning and critical enquiry |
| **6. Capabilities in patient safety and quality improvement** |  |
| * Patient Safety | * Raise safety concerns appropriately through clinical governance systems |
| * Quality improvement | * Audit, QIPP, and critical appraisal |
| **7. Capabilities in Safeguarding vulnerable groups** | * Complies with statutory training requirements |
| **8. Capabilities in education and training** | * Safe clinical supervision in the workplace; Effective education and training activities. |
| **9. Capabilities in research and scholarship** | * Keep up to date through CPD |

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