**Draft Personalised Care Curriculum v 3.6**

**RCOT consultation response 23rd July 2020**

**Prepared by Dr Stephanie Tempest, Professional Development Manager** [**stephanie.tempest@rcot.co.uk**](mailto:stephanie.tempest@rcot.co.uk)

**Introduction**

Thank you for the opportunity to contribute to the consultation for the draft personalised care curriculum. With a short window in which to provide feedback, this response will focus on key comments for consideration. For further information or discussion, please do not hesitate to contact the RCOT.

The concept of person-centred care has historically been present at varying levels within pre-registration curricula across the health and social care professions. A multi-professional curriculum, focused on the topic and presented in a logical and clear manner, offers an exciting opportunity to support the whole workforce to develop and enhance knowledge and skills in aspects of personalised care. Therefore, the RCOT broadly welcomes and recognises the importance of this work.

**Comments for consideration**

The following comments are offered constructively to support the accessibility of the curriculum to a multi-professional group of learners and to emphasise the importance of professional boundaries / working within a scope of practice.

1. The Forward states that “personalised care represents a new relationship between people, professionals and the system”. This is misleading as it suggests that person-centred care is new. This is a concept that has been firmly embedded into professions such as occupational therapy and social work for many years. *Suggestion: replace with “A personalised care curriculum for the whole health and social care workforce represents a new and sharpened focus to promote collaborative relationships between people, professionals and the system.”*
2. Avoid using the phrase “medical and non-medical professions” e.g. on page 3. *Suggestion: adopt a more inclusive term such as ‘the multi-professional workforce’ to reduce the risk of non-medics feeling othered and potentially dis-engaging from the curriculum document at the start.*
3. The use of the word ‘reflection’ within table 4 is unclear and problematic, especially as the term is used later in the document for a different purpose. *Suggestion: in table 4 replace with “use the person’s own language”.*
4. In the section on ‘Models and Approaches’ (page 24 onwards), it could be beneficial to refer to theoretical models that underpin various approaches e.g. a biopsychosocial model such as the International Classification of Functioning, Disability and Health (WHO 2001). Alternatively, this could be considered as part of the content for future advanced modules.
5. Use of the term ‘Patient Activation’ on page 37. It is good to see that a critique of this term is written within the learning outcomes later in this section, but it would be helpful to acknowledge the challenge with this term much earlier, especially as on first glance it feels incongruent with the concept of personalised care.
6. Consider additional learning outcomes within the sections on motivational interviewing and social prescribing to acknowledge the importance of learners knowing what is beyond their scope of practice e.g. when a referral to psychological therapies or occupational therapy is required.