NHS England North East and Yorkshire

What is Personalised Care?

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NHSE – NEY Region

#NEYPersonalisedcare

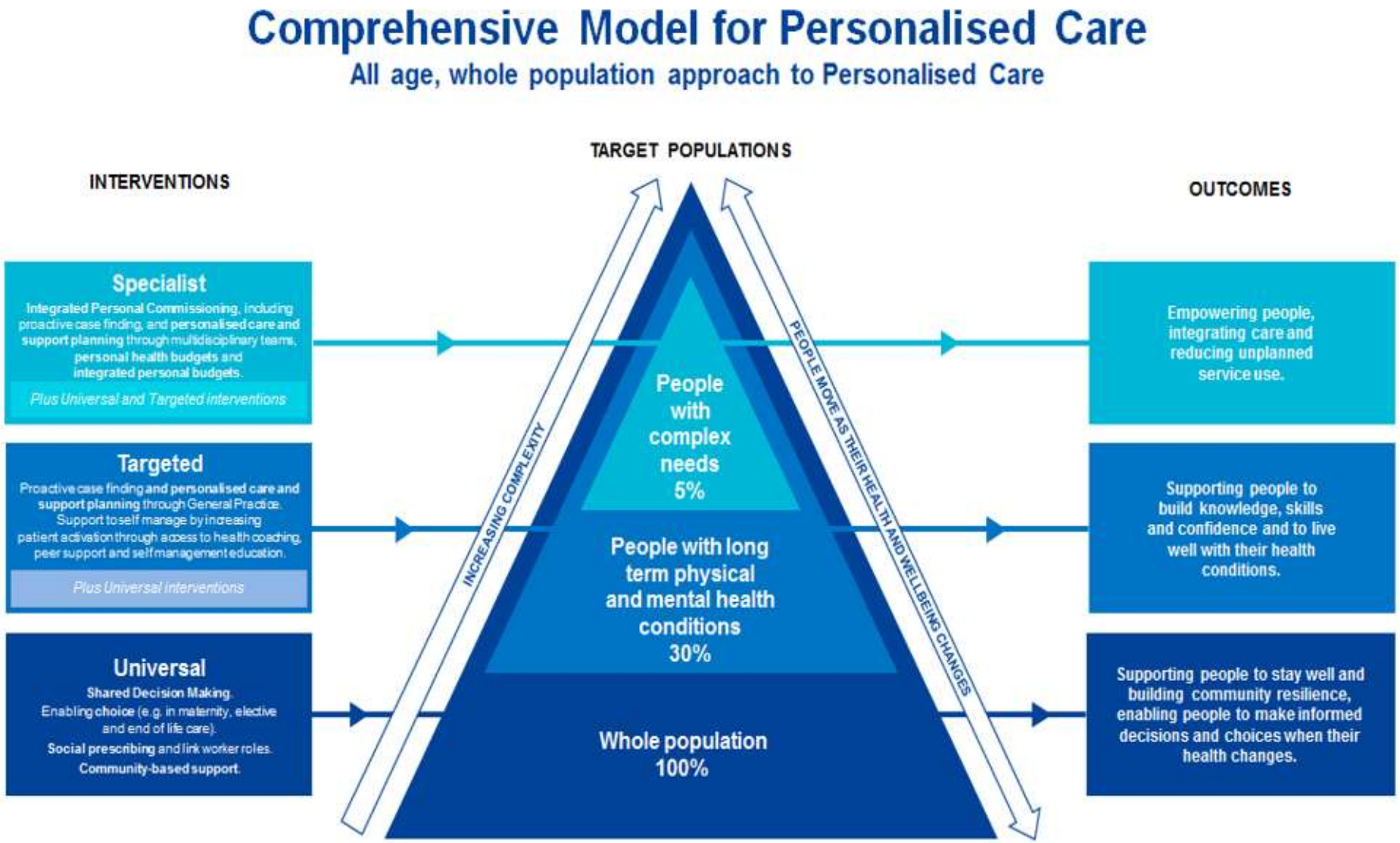
What is Personalised Care?

Enabling people to have choice and control over the way their care is planned and delivered, based on what matters to them and their individual strengths, needs and preferences.

Background


NHS
The NHS Long Term Plan
#NHSLongTermPlan
www.longtermplan.nhs.uk
NHS
Universal Personalised Care
Implementing the Comprehensive Model
#Personalisedcare
www.england.nhs.uk/personalisedcare

Universal Personalised Care



Universal Personalised Care: 6 interdependent components

Personalised Care and Support Planning

- Extensive evidence shows that people's well-being, satisfaction and experience improves through good personalised care and support planning.
- It has been shown to improve GP and other professionals' job satisfaction.
- There is some evidence of improved clinical outcomes and that it is at least cost neutral, with some evidence of small cost improvements.

Shared Decision Making

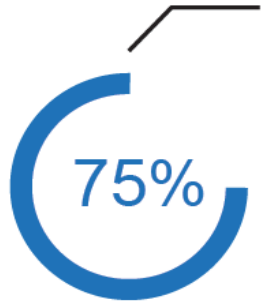
Clinicians and people routinely overestimate treatment benefits by **20%**

and underestimate treatment harms by **30%**

Shared decision making supports people to understand benefits and harms of options available and tends to reduce uptake of high risk, high cost interventions by **20%**

40% of adults report that they have had a conversation with a healthcare professional in their GP practice to discuss what is important to them.

Choice



of people who booked hospital outpatient appointments online felt that they were able to make choices that met their needs.

Supported Self-Management

Evidence from England shows people who have the highest knowledge, skills and confidence than those with the lowest levels of activation have

19% fewer GP appointments

38% fewer A&E attendances

A literature review of over 1,000 research studies found peer support can help people feel more knowledgeable, confident and happy, and less isolated and alone.

Social Prescribing and Community-Based Support

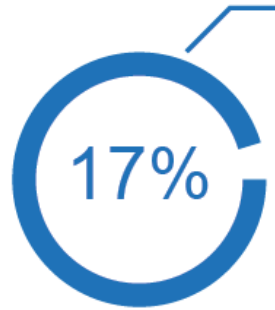
of GPs think social prescribing can help reduce their workload.

An independent evaluation found that people with a personal health budget had lower indirect costs with an average saving of £1,320 per person per year.

For people with the highest needs there were savings on average of £3,100 per person of per year.

Personal health budgets and Integrated Personal Budgets

people achieved what they wanted to with their personal health budget.



Personal health budgets provided an average 17% saving on the direct costs of conventional NHS Continuing Healthcare packages for home care.

End of life care

50% Two CCGs indicated a cost saving of 50% attributable to personal health budgets.

83% In one area personal health budgets enabled 83% of people to die in a place of their choosing, against a local average of 26%.

Being seen only as a **patient with symptoms** or separate conditions that need treating.

SHIFTS TO...

Being seen as a **whole person** with skills, strengths and attributes as well as needs to be met.

Being asked 'What's **the matter** with you?'

SHIFTS TO...

Being asked 'What **matters** to you?'

Being **told** what is wrong with you and how your health needs will be met.

SHIFTS TO...

Being valued as an **active partner** in conversations and decisions about your health and wellbeing.

Not having the information and support you need to make informed health and wellbeing choices and decisions.

SHIFTS TO...

Having the information and support you need to make **informed choices and decisions.**

Personalised Care: A shift in relationship between health and care professionals and people.

Feeling **powerless** against a complex health and care system.

SHIFTS TO...

Working in partnership with health and care professionals and **sharing power**.

Health and care professionals believing **they have all the knowledge**, expertise and responsibility for your health and wellbeing.

SHIFTS TO...

You and your health and care professional **sharing knowledge**, expertise and responsibility for your health and wellbeing.

Having to tell your story **again and again.**

SHIFTS TO...

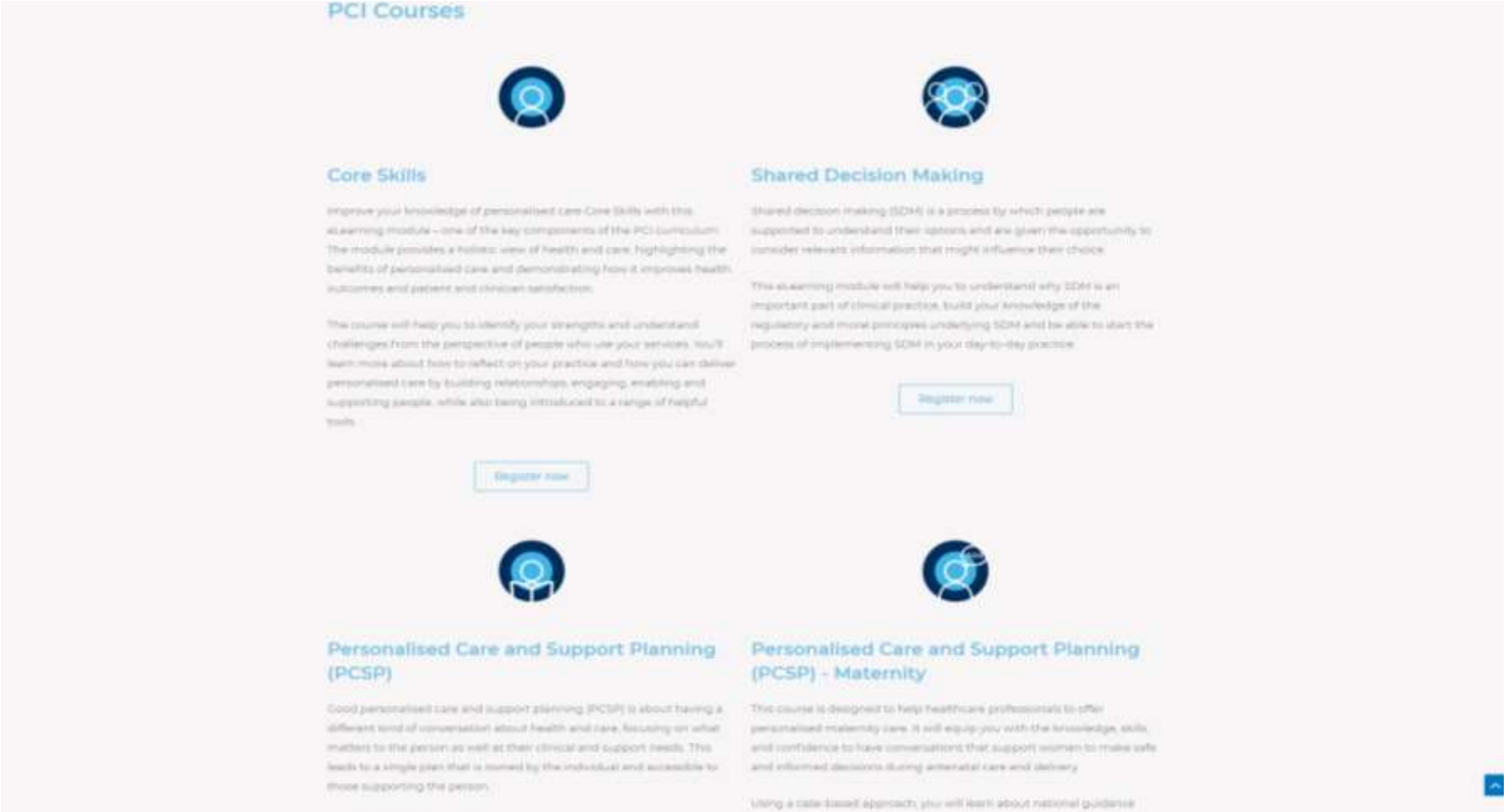
Only needing to tell your story **once.**

A **'One-size-fits-all'** approach to meeting your health and wellbeing needs.

SHIFTS TO...

Having more **choice and control** so your health and wellbeing needs are met effectively in a way that makes sense to you.

Training


PCI Courses
Core Skills
Improve your knowledge of personalised care Core Skills with this eLearning module – one of the key components of the PCI curriculum. The module provides a holistic view of health and care, highlighting the benefits of personalised care and demonstrating how it improves health outcomes and patient and clinician satisfaction.
The course will help you to identify your strengths and understand challenges from the perspective of people who use your services. You'll learn more about how to reflect on your practice and how you can deliver personalised care by building relationships, engaging, enabling and supporting people, while also being introduced to a range of helpful tools.
Register now
Shared Decision Making
Shared decision making (SDM) is a process by which people are supported to understand their options and are given the opportunity to consider relevant information that might influence their choice.
This eLearning module will help you to understand why SDM is an important part of clinical practice, build your knowledge of the regulatory and moral principles underlying SDM and be able to start the process of implementing SDM in your day-to-day practice.
Register now
Personalised Care and Support Planning (PCSP)
Good personalised care and support planning (PCSP) is about having a different kind of conversation about health and care, focusing on what matters to the person as well as their clinical and support needs. This leads to a single plan that is owned by the individual and accessible to those supporting the person.
Personalised Care and Support Planning (PCSP) - Maternity
This course is designed to help healthcare professionals to offer personalised maternity care. It will equip you with the knowledge, skills and confidence to have conversations that support women to make safe and informed decisions during antenatal care and delivery.
Using a case-based approach, you will learn about national guidance

My lived experience with Personalised care

- EDS type 3 – diagnosed late
- Hundreds of dislocations
- Frequent visits to GP
- Multiple specialists referrals
- Unplanned admissions
- Daily medication
- Limited mobility
- Weekly infections
- Chronic pain
- Repeat opioid medications 10 years
- Always increasing dosage
- Increasing side effects
- Feeling powerless

2018…

- Started using Personalised Care interventions
- Great GP – shared decision making conversation
- What mattered to me?
- Reduction on pain meds
- Daily gentle exercise gradually increasing strength
- Accepting pain & how to live with it
- Use of green & blue social prescribing – open water swimming, walking, jogging, hiking
- Became medication free in 2020
- Regained control
- Still have EDS type 3 but have a quality of life

Further information:

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Personalised Care Collaborative Network

References and case studies:
https://future.nhs.uk/PCCN/view?objectId=14697424

Personalised Care Institute

Dr Becky Kinchin

GP - Clifton Court Darlington

Darlington PCN Pain Management Lead

Live Well with Pain

Clifton Court Medical Practice.

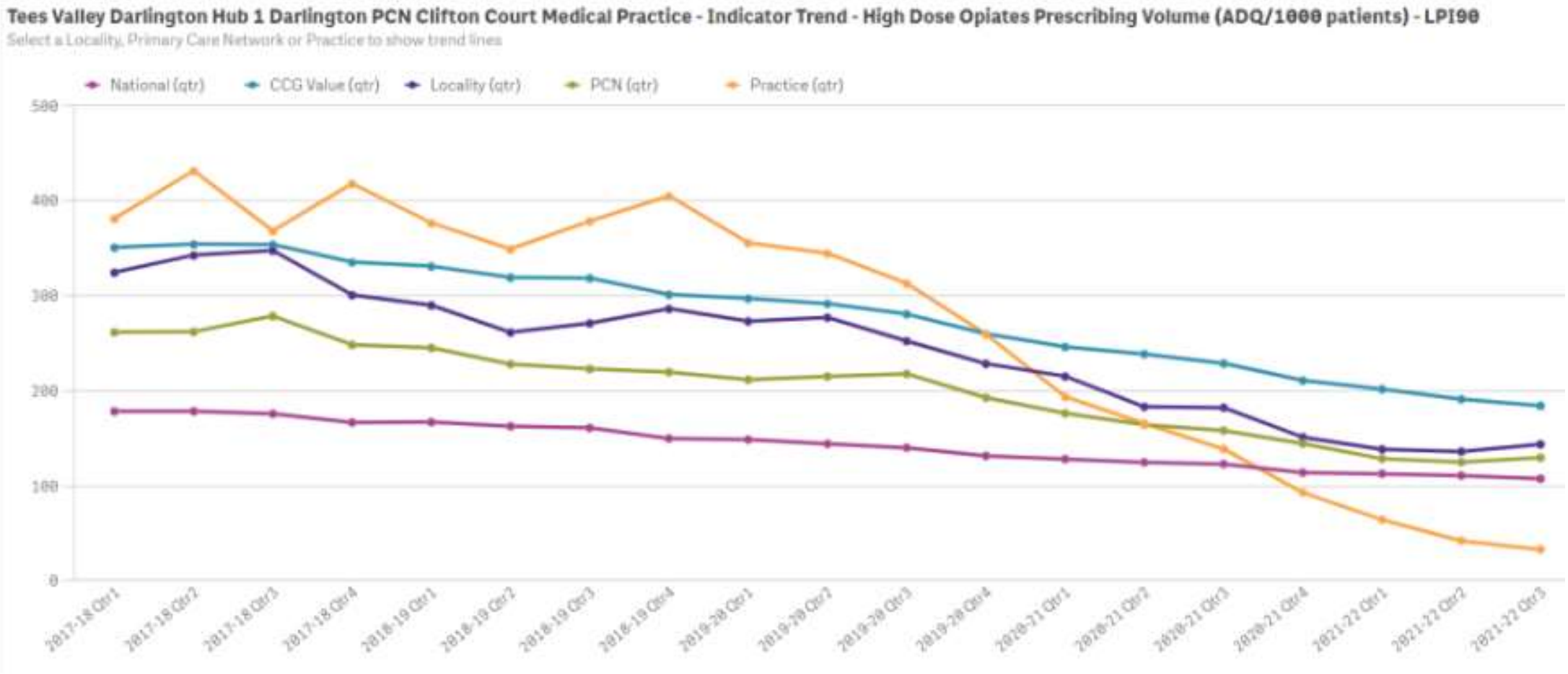
- Area of high deprivation
- Highest prescribers of Gabapentinoids and Morphine in Darlington
- Polypharmacy ++
- Needed tackling
- We collaborated with LWWP and Durham University.
  - GOTT Trial (Gabapentinoid and Opiate Tapering Toolbox).

What did GOTT focus on?

Improving knowledge skills and confidence

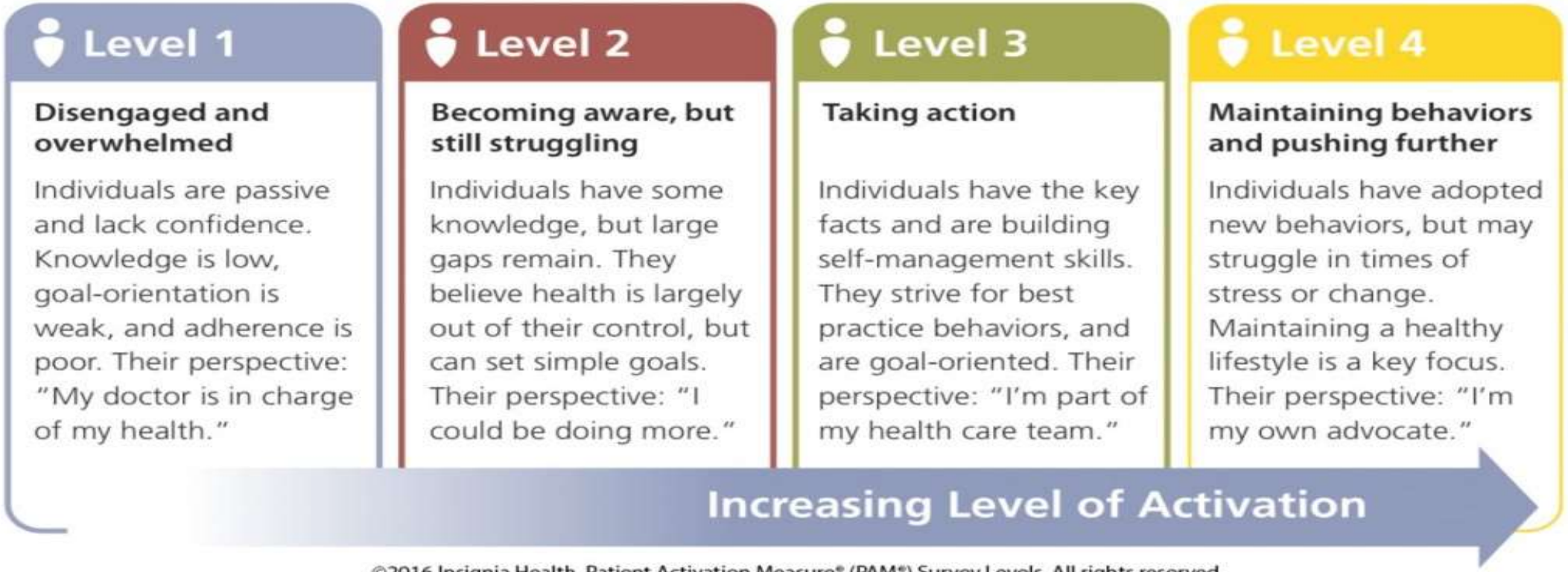
1. Clinician - Education
2. **Patients- Supported self management, personalised approach.**
3. Reducing Prescribing

What have we achieved?



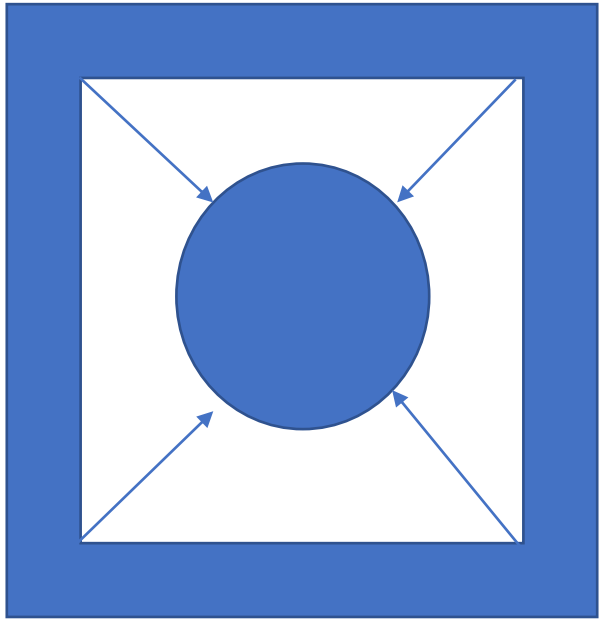
A painful problem!

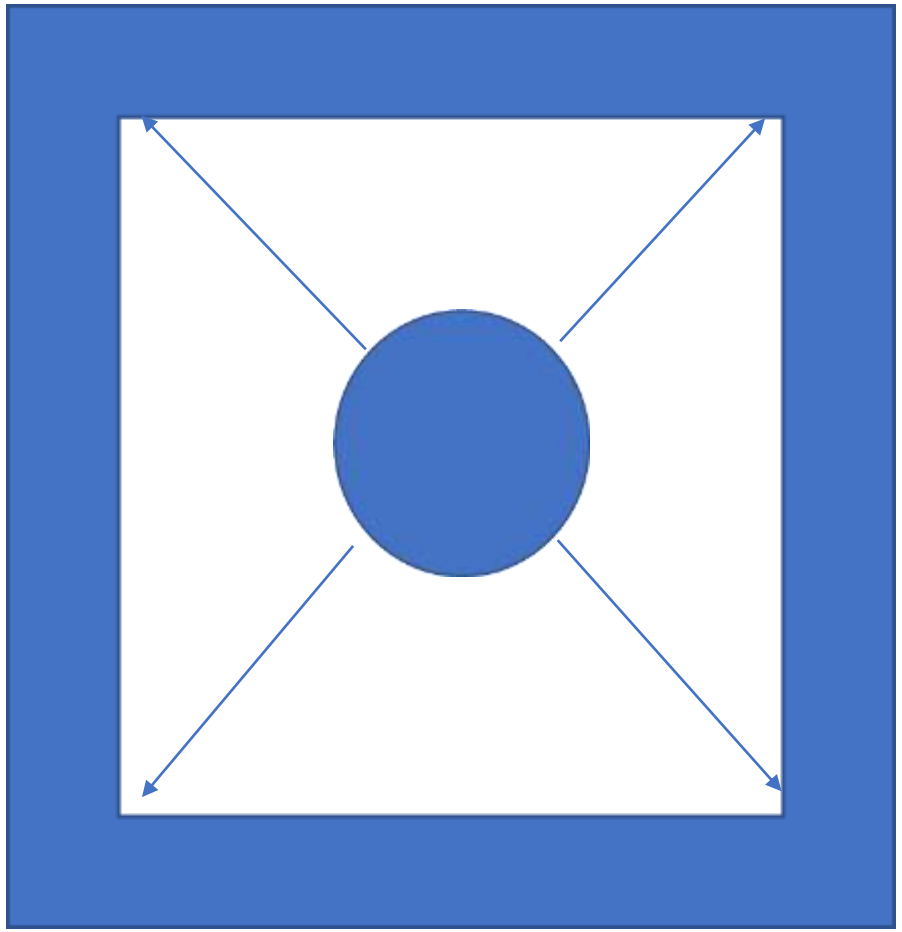
Readiness to change



Helping patient to understand

- Add back in what the pain has taken away
- But how?





Tools I use during consultations.

- Live Well with Pain Health Check
- Pain cycle cool kit
- Opiate Lottery side effect.

Live Well with Pain Health Check.

NHS
Clifton Court Medical Practice

Live Well with Pain **Health Check**

Exploring how pain affects your health and life

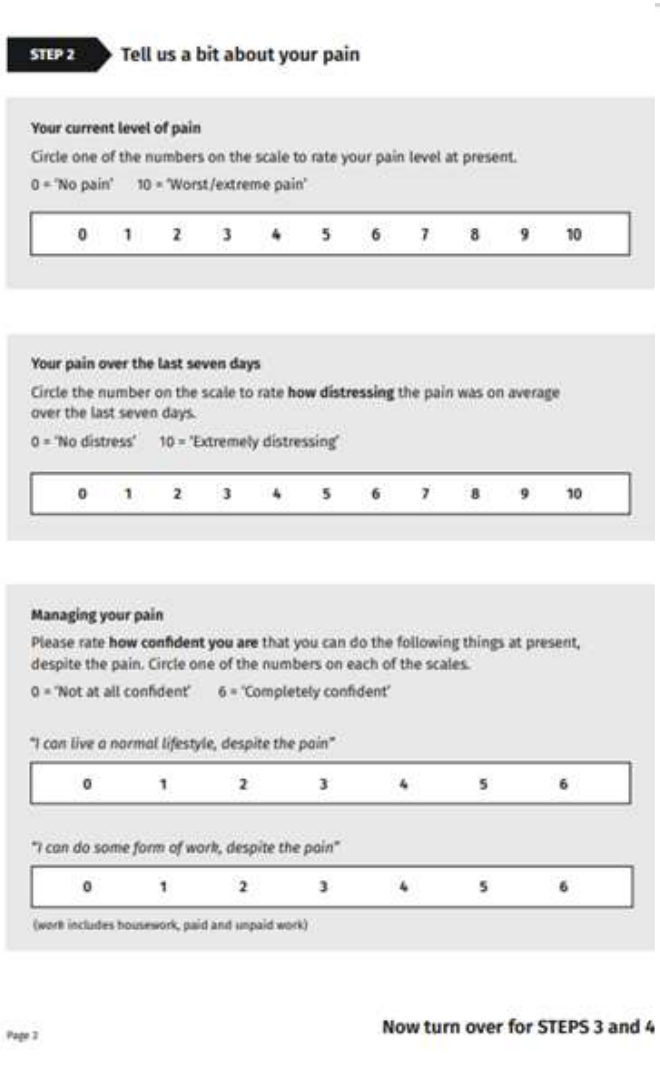
Please help us understand about your health and the main obstacles to improving your quality of life and self managing with confidence.

There are **four steps** to completing this Health Check. Please complete all four steps – tick or circle all the answers that apply to you.

STEP 1 **How do you feel?**

	all of the time	most of the time	more than half the time	less than half the time	some of the time	at no time
I have felt cheerful and in good spirits	5	4	3	2	1	0
I have felt calm and relaxed	5	4	3	2	1	0
I have felt active and vigorous	5	4	3	2	1	0
I woke up feeling fresh and rested	5	4	3	2	1	0
My daily life has been filled with things that interest me	5	4	3	2	1	0

Page 1



STEP 2 **Tell us a bit about your pain**

Your current level of pain

Circle one of the numbers on the scale to rate your pain level at present.

0 = 'No pain' 10 = 'Worst/extreme pain'

0 1 2 3 4 5 6 7 8 9 10

Your pain over the last seven days

Circle the number on the scale to rate **how distressing** the pain was on average over the last seven days.

0 = 'No distress' 10 = 'Extremely distressing'

0 1 2 3 4 5 6 7 8 9 10

Managing your pain

Please rate **how confident you are** that you can do the following things at present, despite the pain. Circle one of the numbers on each of the scales.

0 = 'Not at all confident' 6 = 'Completely confident'

"I can live a normal lifestyle, despite the pain"

0 1 2 3 4 5 6

"I can do some form of work, despite the pain"

0 1 2 3 4 5 6

(work includes housework, paid and unpaid work)

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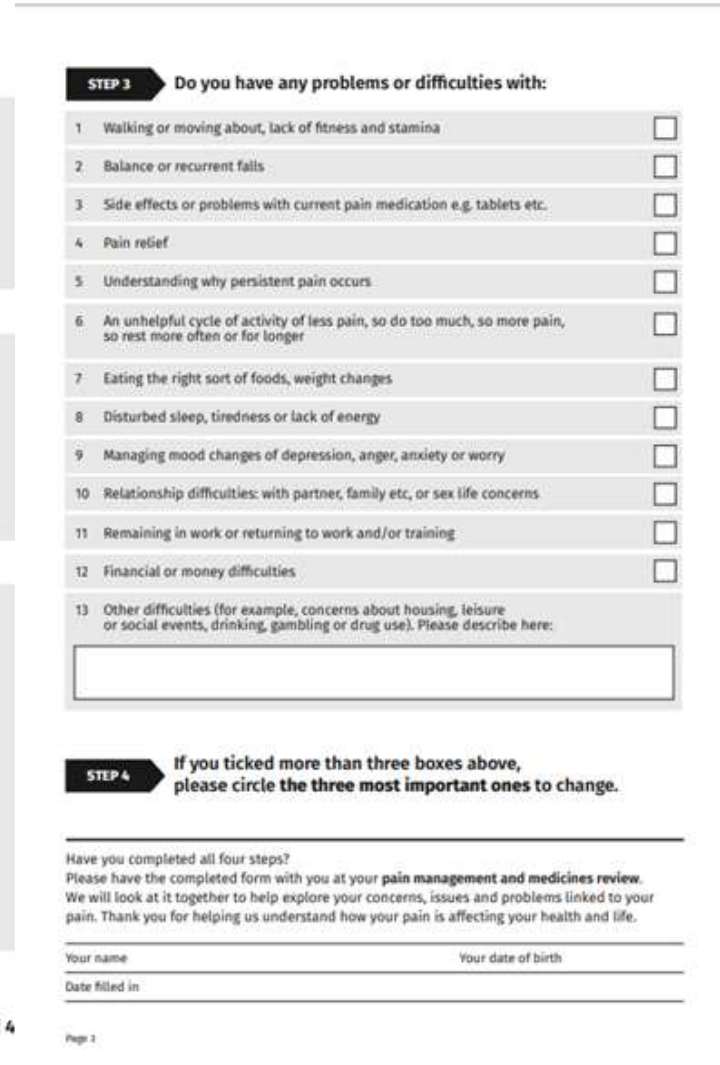
Now turn over for STEPS 3 and 4



STEP 3 **Do you have any problems or difficulties with:**

1 Walking or moving about, lack of fitness and stamina ☐
2 Balance or recurrent falls ☐
3 Side effects or problems with current pain medication e.g. tablets etc. ☐
4 Pain relief ☐
5 Understanding why persistent pain occurs ☐
6 An unhelpful cycle of activity of less pain, so do too much, so more pain, so rest more often or for longer ☐
7 Eating the right sort of foods, weight changes ☐
8 Disturbed sleep, tiredness or lack of energy ☐
9 Managing mood changes of depression, anger, anxiety or worry ☐
10 Relationship difficulties: with partner, family etc, or sex life concerns ☐
11 Remaining in work or returning to work and/or training ☐
12 Financial or money difficulties ☐
13 Other difficulties (for example, concerns about housing, leisure or social events, drinking, gambling or drug use). Please describe here:

STEP 4 **If you ticked more than three boxes above, please circle the three most important ones to change.**

Have you completed all four steps?
Please have the completed form with you at your **pain management and medicines review**. We will look at it together to help explore your concerns, issues and problems linked to your pain. Thank you for helping us understand how your pain is affecting your health and life.

Your name Your date of birth

Date filled in

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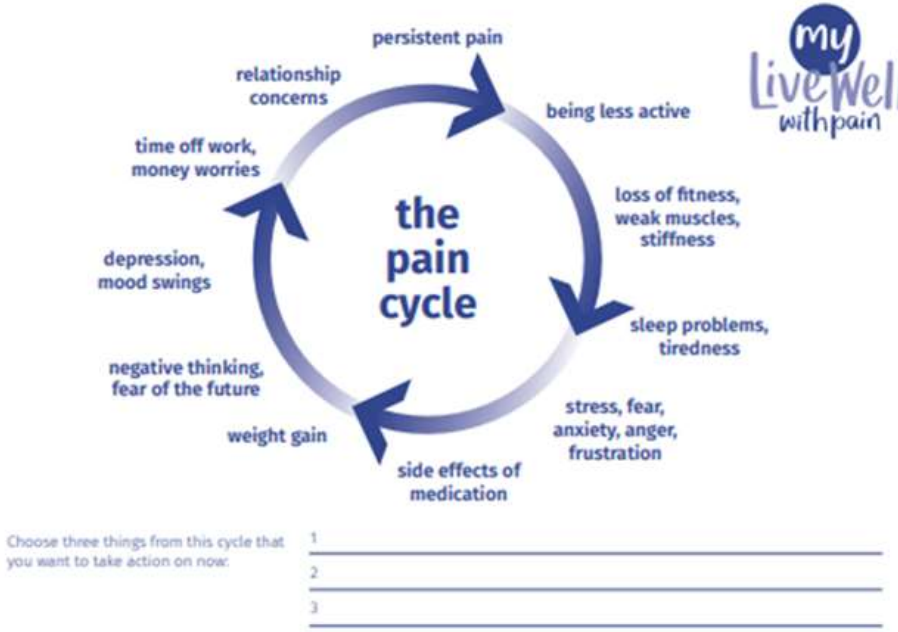
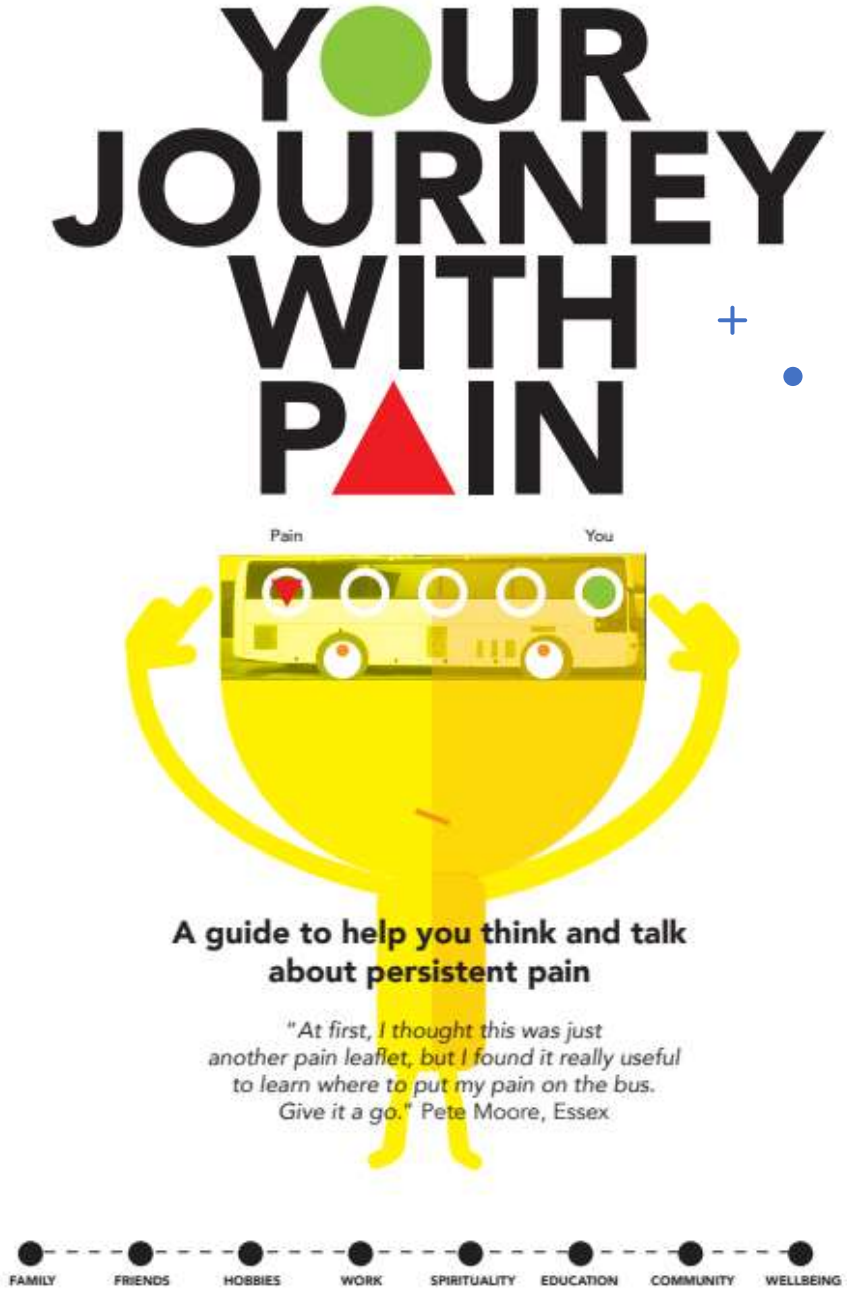
The Pain Cycle

- Patients can take it away.
- Ask them to make notes around
- Can help them identify how they can make change



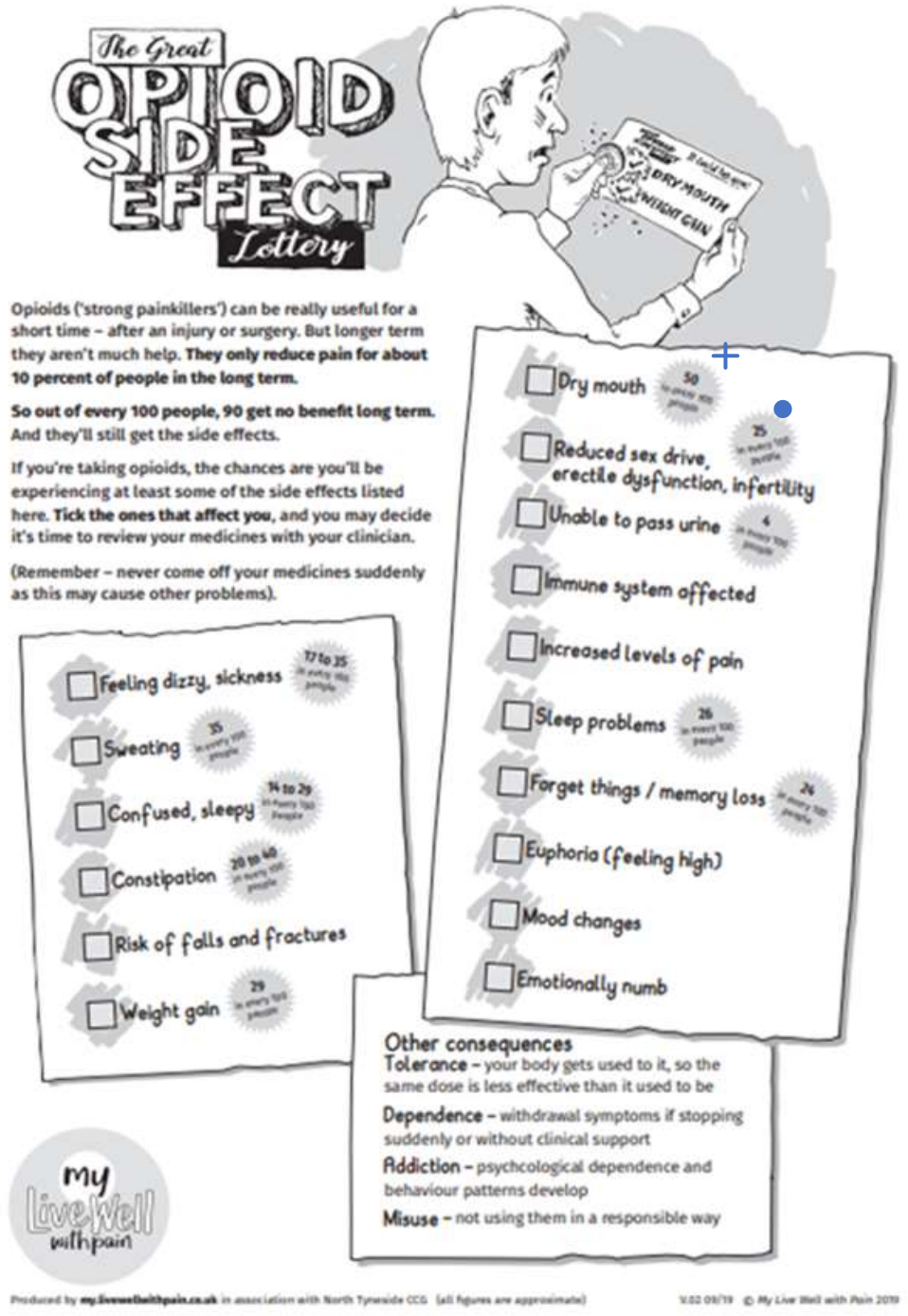
Your Journey with Pain

- 3 Week guide to help person centred care
- Patient completes it
- Talks about who is in control
- Daily journal
- Pain scores
- Goal setting



Opiate lottery Side Effect.

- Helps to highlight side effects and open up discussion around medication.
- Often many never considered
- Visual
- Hearing from another perspective



The Reality.

- Many patients are demotivated- not ready to change
- Imagine being a patient with chronic pain. This must be “hocus pocus”
- Wont look at resources, wont engage.
- How do we manage this?

- What about medications?
- Do we change them?

Case Examples.

45 yr M, Chronic back pain. Under pain clinic (biomedical approach). 40mg Zomorph BD, Oramorph PRN. Slow medication reduction. More clarity to engage. Supported to approach pain team. Now looking for work.
58 yr F, Fibromyalgia, ME, Depression ? Personality disorder. Prev high dose opiates, Gabapentinoids. Mental health a barrier, explored physical health problems too. Just had both knee's replaced.
42yr F, Chronic back pain, under pain clinic (biomedical). On 10mg Zomorph BD, about 2 litres oramorph a month, 75mg Pregabalin BD. Joined us recently.

Case Examples.

53yr F. Widespread pain, back pain, endometriosis (hysterectomy). In excess 600mg Morphine daily. Threats to sue.

36yr M Back pain, Injecting Zomorph for pain??

Person-centred care in summary

- Listen
- Understand
- Time
- Empathy
- Understand x2- you may never agree in relation to medications- use judgment.

The Personalised Care Roles.

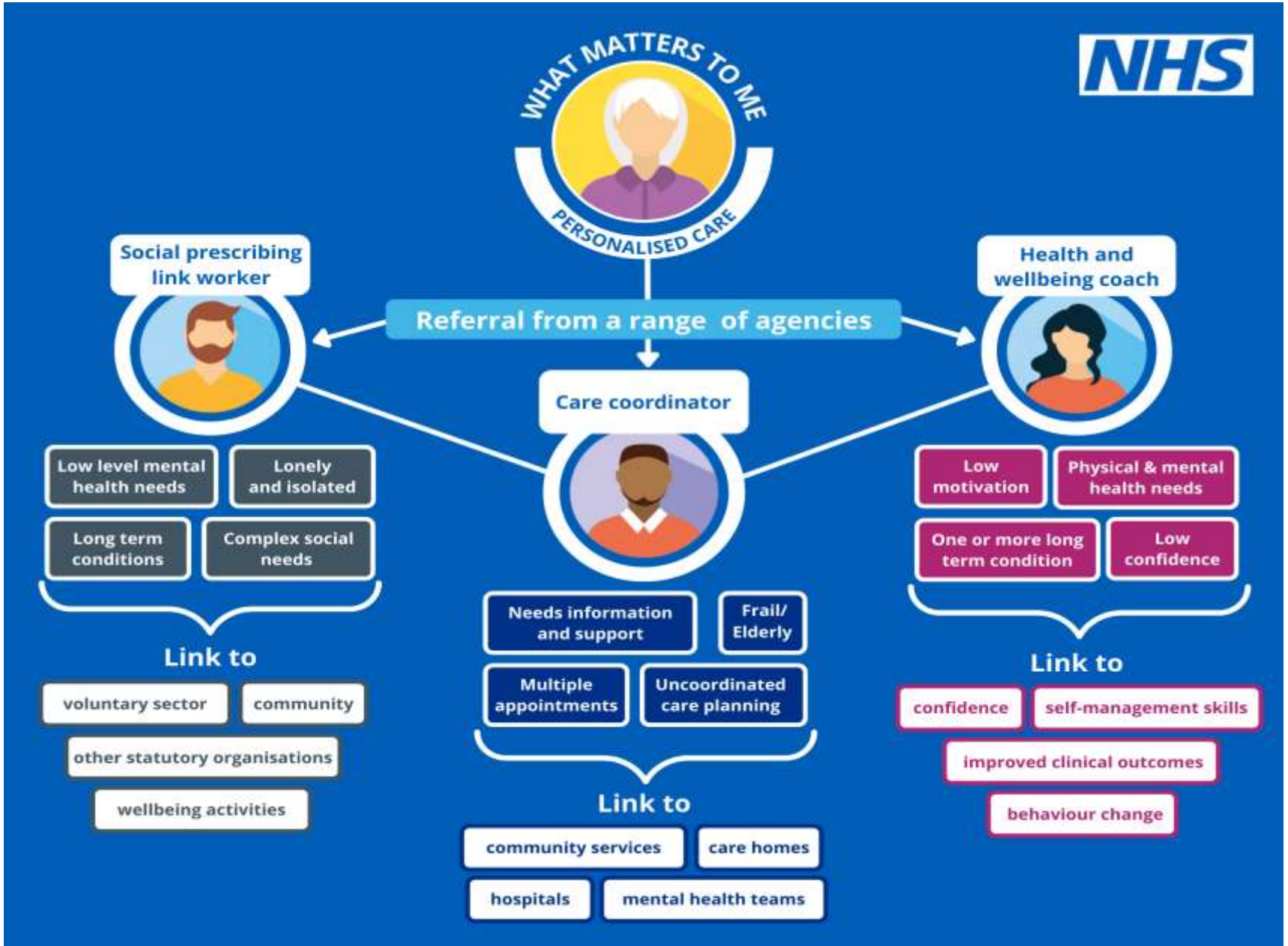
Dr Caroline Gibson **MBChB DFSRH MRCGP DipBSLM/IBLM MInstLM**

Regional Mentor for Health & Wellbeing Coaches, NEY
Personalised Care team, NHSE/I

18th November 2022

NHS England and NHS Improvement

The personalised care roles in primary care



Personalised Care Roles in Primary Care roles

Ways of working

- Proactive outreach to cohorts and patients who may benefit from personalised care interventions
- Work as part of the multi-disciplinary team to ensure patients receive the right support from the right professional
- Receive referrals from multiple agencies
- Give people time over several sessions to offer a person-centred conversation based around asking, “what matters to you?”
- Work with other personalised care roles and the wider MDT to ensure people are supported by the right service at the right time.

Social Prescribing Link Workers	Health & Wellbeing Coaches	Care Coordinators
Take an all-age, whole population approach and work with people who are lonely, have complex social needs, low level mental health needs and long term conditions (LTCs) Help people to identify issues that affect their health & wellbeing, and co-produce a simple personalised care and support plan Support people by connecting them to non-medical community-based activities, groups and services that meet practical, social and emotional needs, including specialist advice services and the arts, physical activity, and nature Use coaching and motivational interviewing techniques to support people to take control of their own health and wellbeing Support accessible and sustainable community offers by working with VCSE organisations, local authorities and others to identify gaps in provision and deliver activities and groups to meet population needs.	Work with people with physical and/or mental health conditions, people with LTCs and those at risk of developing a LTC. Encourage and support people to self manage their condition, by helping them develop knowledge, skills and confidence. Use coaching skills and models of behaviour change and positive psychology to develop personalised goals for patients and guide them on how they can meet these goals. Focus on improving clinical outcomes and setting personalised goals. For example, supporting patients to lower their blood pressure, reduce weight, and manage glucose levels. Support people to manage or change their health related behaviour, enabling them to make better short and long term choices for their physical and mental health and wellbeing.	Work with people experiencing frailty and people with LTCs, to help them co-ordinate and navigate their care across health and care services. Help people to identify issues that affect their health & wellbeing, and co-produce a simple personalised care and support plan Support people to understand and manage their condition, ensuring changing needs are addressed. Provide coordination and access to existing services and support access to other appropriate services.. Prepare patients for follow-up clinical conversations with primary care professionals. Help to reduce confusion, keep people informed and enable people to have choice and control over their health and care.

Health and Wellbeing Coaching
– what is it and how to get the best out of the role?

What is it?	
Health coaching is a supported self-management (SSM) intervention	Behaviour change
What matters to them	Active participants
1-to-1 or group health coaching (at least 6 sessions)	Personal choice and positive risk taking

Ensuring a safe and effective service	
4 day PCI approved health coaching training	Reimbursed at Agenda for Change Band 5
Monthly supervision	eLearning
Safeguarding	Line management

Who might want to be referred to a health coach?

- People with chronic pain (including patients waiting for surgery)
- People where long term condition reviews have identified a need for additional help with self – management for conditions such as: type 2 diabetes, COPD, asthma and hypertension
- People identified at being at risk of developing a long term condition, for example through health checks (such as people identified as having pre – diabetes)
- People wanting help with weight management/obesity, smoking or alcohol issues
- People struggling with managing their health
- People with low level mental health issues, including anxiety

Feedback from GPs & healthcare professionals for Health and Wellbeing coaches

“It's so frustrating to see the same patients time and time again, who have made no progress with my advice from the last time I saw them of losing some weight/ reducing their alcohol consumption/stopping smoking or doing exercise. This is where HWBC can take some of the pressure off your consultation.”

- GP

“Trying to cram lifestyle advice into a 10 minute appointment is impossible! Knowing that I can refer on to a HWBC who can have that conversation for me is so reassuring”

- GP

“Some patients just need the extra support to help increase their motivation, and this takes time, patience and understanding. Health coaches help with that and provide support and continuity”

- ANP

Patient experience of coaching:

“I would advise anyone who gets offered this service to take advantage of as it helped me a lot I was a bit tearful when I first went to my first session but my confidence and enthusiasm grew on each session I feel much better and more confident to continue moving forward to do more with my time.”

“This coaching is essential and provides the patient with confidence and support after a life changing event such as a heart attack in my case.”

“I went to the park for the first time in 10 years”

"My health coach has supported me over a short few months but already I feel a huge difference in my mental health and well-being. Her positive attitude and support and advice has gone such a long way and I look forward to the future."

‘When I come to clinic, and I really like the staff, I always feel like I’m being judged. I don’t feel that with you’

‘Thankyou very much for all your help listening to me. I have my confidence back and I have made changes to my life to make things better…Thankyou’ – COPD patient

Care Coordination
- what is it and how to get the best out of the role?

What is it?	
Proactive identification	Timely, efficient, and patient-centred
Personalised care and support plan	Time, capacity, and expertise

Ensuring a safe and effective service	
PCI accredited care coordination course PCI accredited two day health coaching course	Reimbursed at Agenda for Change Band 4
Supervision	eLearning
Safeguarding	Line management

What GPs who have a care coordinator at their practice said:

“The Care Co-ordinator role has really helped navigate the myriad of complex needs of our frail and palliative care patients. Having the role, has streamlined the care process and helped organize our care in a way that the patients, relatives care home and practice staff find satisfactory”

- GP

“Our care co-ordinators have been invaluable in helping to organise our patient flows within the PCN, especially helping to organise our Care Home residents for ward rounds and MDTs. Could not have done it without them!"

- Clinical Director (GP)

Who might want to be referred to a care coordinator?

- People with complex long term conditions in need of information or support
- People with multiple health conditions needing support to access services
- People who have multiple hospital appointments, experiencing high appointment burden
- People with multiple hospital admissions or unplanned attendances
- People experiencing frailty and other LTC

Patient's experience of care coordinator support:

"Excellent, fantastic resource for patients, knowledgeable and helpful."

"Thank you for all you've done, always someone to fall back on"

"I appreciate you being there and listening to me"

"God knows what we've of done without you, I mean it whole heartedly, it was a light"

Social Prescribing Link Workers

- **Address the wider issues** that affect people's health & wellbeing
- **Take a person-centred approach**, **to identify what matters to the person**
- **Connect people to:**
- practical, social and emotional support within their community; and
- activities that promote wellbeing e.g. arts, sports, natural environment; and
- positive people, positive places and positive things
- **Identify and nurture community assets** by working with partners such as VCSE, local authorities and health
- **Tend to work with** people experiencing loneliness, complex social needs, mental health needs or multiple LTCs

For more information

To talk to someone who can help you to introduce health and wellbeing coaches and care coordinators into your practice, email:

england.personalisedcarenortheastyorkshire@nhs.net

Or for more information about these roles, visit:

NHS England » Supported self-management
https://www.england.nhs.uk/personalisedcare/supported-self-management/

For more information about social prescribing, visit:

https://www.england.nhs.uk/personalisedcare/social-prescribing/