Personalised Care Institute

Curriculum

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Contents

Foreword

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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 well-being. People want:

- To be treated as a whole person by professionals they trust.
- To be involved in decisions about their health and care.
- To be supported to manage their own health and well-being, 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 healthcare oriented principles of person-centred care with the more social care oriented principles of personalisation in the Comprehensive Model for Personalised Care[1].

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 six 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 choice
6. Personal health budgets and integrated personal budgets

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 well-being, build community resilience, to 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 enables 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 multi-professional healthcare workforce.

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).

References
1. Universal Personalised Care: Implementing the Comprehensive Model. NHS England. London. 2019. www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf.

Acknowledgements

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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 different ways of approaching Personalised Care, and thereby:

1. Describe learning outcomes for individual practitioners to deliver care according to NHS England and Improvement Universal Personalised Care quality standards[1].
2. Inform 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 skill-sets needed within their teams to deliver Personalised Care.

The philosophy of the curriculum

The curriculum is based on the principles of Excellence by Design[2] and incorporates generic professional capabilities across the spectrum of the wider healthcare workforce.

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 than provide 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.

The learning outcomes in this document are intended to be applied to the role that delivers Personalised Care, rather than being defined by profession or assumed seniority. Thus, they 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 care workforce and community teams**. The curriculum provides a programme of learning for Personalised Care capabilities and guides personal professional development for registered professional groups such as doctors, nurses, physiotherapists, occupational therapists and pharmacists, and the wider non-registered health and social care workforce such as care coordinators, social prescribing link workers, health and well-being coaches.
- **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.

This Personalised Care curriculum builds on the core foundation of **Person-Centred Approaches: Empowering people in their lives and communities to enable an upgrade in prevention, well-being, health, care and support. Health Education England, Skills for Health and Skills for Care**[2] includes a greater level of detail on essential models and approaches, and the 'Six Components' of Personalised Care.

(See 'The Structure of the Curriculum' p. 14).

References
1. Universal Personalised Care: Implementing the Comprehensive Model. NHS England. London. 2019. www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf.
2. Generic professional capabilities framework. 2017. General Medical Council. London. www.gmc-uk.org/-/media/documents/Generic_professional_capabilities_framework__0817.pdf_70417127.pdf.

Table 1. The person-centred approaches framework:

The core of Personalised Care	Values Core Communication and relationship-building skills: understanding how the individual communicates 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 Inclusiveness: we are committed to fairness and equality, valuing diversity and cultural differences
Knowledge – which may include the following:	Social determinants of health Patient Activation Quality Improvement Technology to support health and well-being Health Literacy Accessible information Standards	Patient and Public Involvement Awareness of local services and resources Co-production 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 – connecting people to community support through social prescribing link workers 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[1,2,3]

Personalised Care has direct relevance to the wider workforce beyond the NHS, for example care homes, social care, local councils, and the voluntary sector. It enables all local partners to work together, building support around the person, based on 'what matters to me'. It builds on people's strengths and capabilities, sees them as partners in their own care and helps them to manage their health and well-being.

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. See Appendix 2.

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References:
1. Universal Personalised Care: Implementing the Comprehensive Model. NHS England. London. 2019. www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf
2. Excellence by design: standards for postgraduate curricula. General Medical Council. London. 2017.
3. Person-Centred Approaches: Empowering people in their lives and communities to enable an upgrade in prevention, well-being, health, care and support, Health Education England, Skills for Health and Skills for Care. 2017.

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' and building on assets of people and communities.

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

Deb's story

They are considered in the following terms:

Generic professional capabilities and values in Personalised Care

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 1 and 2 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 more 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 that support the provision of Personalised Care and its embedding into routine practice. They support the development of the skills and mindset shift required to build a change in the relationship between professionals and people to a more equal partnership, recognising that people are experts in their own health and well-being. 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 is intended for illustration of the potential of blended learning strategies. Learning methods will also need to be adapted to take account of pandemic restrictions.

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 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 using appropriate problems or case scenarios to trigger knowledge and understanding.	●	●	●
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	A small group of people who meet together regularly to discuss work-related issues or develop skills in an area of common interest. The approach helps them to share experiences, problem solve, learn new ways of working and test these in practice in a planned way.		●	●
Role play	Using a relevant scenario in a safe learning environment to test skills and approaches and to 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 topic.		●	●
Self-assessment	Comparing ourselves against defined criteria and making decisions about further learning needs and development.		●	●

Tool	Description	Level 1	Level 2	Level 3
Goal setting – team and individual	Collaboratively setting goals that are: • Meaningful and important to the individual. • Are able 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 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 skill.	●	●	●
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 and NHS Improvement.

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 PCI curriculum.

In order to be accredited by the PCI, training providers will need to provide evidence that their programme maps to the curriculum. The learning objectives they seek to deliver should meet the training standards, and demonstrate 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[1], 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[2] and the Heath and Care Professions Councils Standards for Education and Training[3]. 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

- Is evidence-based and designed on published evidence of benefit of Personalised Care and co-produced with patient and service users.
- Reflects 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.
- Integrates and 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 and profession specific e.g. risk communication, maternity, serious illness and end of life conversations.
- Takes account of health inequalities, equality and diversity and cultural factors.
- 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.
- Increase levels of specialist training that builds on basic training and equips professionals to provide the standard of personal care at the appropriate skill level of the PCI requirements.

References:
1. Health Coaching-Quality Framework. 2015. HEE. London. 2015.
2. Professional Standards (3rd edn). 2014. Academy of Medical Educators. Cardiff. 2014.
3. Standards of Education and Training. 2017. Health and Care Professions. London. 2017.

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.
- Practical – based on experiential learning with practical demonstrations and 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) and well-being tools e.g. ONS4 to assess service user impact and outcomes.
  - 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 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.

Additional resource:
Excellence by design: standards for postgraduate curricula. General Medical Council. London. 2017. www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/excellence-by-design

Programme of assessment

Key standards[1] of an assessment programme 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 detail 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.

References:
1. Excellence by design: standards for postgraduate curricula. General Medical Council. London. 2017 https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/excellence-by-design

Equality, diversity, and inclusion
(tackling health inequalities)

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

The move to a new model of Personalised Care delivery 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 for everyone, some of the models and approaches described in this curriculum may have a particularly positive impact on groups who are most impacted by health inequalities including: groups protected by the Equality Act 2010 such as BAME communities (protected groups), groups that traditionally have difficulty accessing healthcare such as vulnerable migrants (inclusion groups)and groups that live in areas of socio-economic deprivation. There is a significant overlap between these groups in practice.

The evidence base for the impact of personalised approaches on reducing health inequalities continues to grow. For example, people from lower socioeconomic backgrounds are disproportionately impacted by multiple long-term conditions and tend to have lower levels of knowledge, skills and confidence required to manage them well. Supporting them to improve their levels of knowledge, skills and confidence can result in better health outcomes, improved experiences of care and fewer unplanned admissions. Other beneficial outcomes in terms of reducing health inequalities, are seen for other components of Personalised Care such as shared decision making (particularly when tailored to health literacy), Personalised Care and Support Planning, social prescribing and asset-based approaches and the implementation of personal health budgets.

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.

References:
1. Excellence by design: standards for postgraduate curricula. General Medical Council. London. 2017 https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/excellence-by-design

The structure of the curriculum

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'[1].

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[2].

Curriculum	Core Capabilities	Models and Approaches	The 'Six Components' Level 3
		Range of consultation Models	

Personalised Care	• Generic professional capabilities
	• Values in Personalised Care
	• Capabilities in Personalised Care
	  · Core communication and relationship-building skills
	  · **Level 1** Capabilities to engage people
	  · **Level 2** Capabilities to enable and support people
		Health literacy skills	1. Shared decision making

		Motivational Interviewing	2. Personalised Care and Support Planning
		Making Every Contact Count	3. Social Prescribing and community-based support
		Knowledge, skills and confidence	4. Supported self-management
		Health Coaching	5. Enabling choice
		Supporting behaviour change	6. Personal health budgets and integrated personal budgets
		Personalised Care in remote and virtual Environments	

References:
1. Medical Education: Developing a Curriculum for Practice. Della Fish and Colin Coles. OUP. 2005.
2. A Global perspective on specialty medical curricula. Prof. Deborah Gill. UCL London. 2019.

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 Personalised 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)
- Learning outcomes specific to this model or approach
- Appropriate methods of teaching
- Standards for course providers.

The six components

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
- Outlines for learning and assessment strategies.

Core capabilities

The core capabilities are taken from **Person-Centred Approaches: Empowering people in their lives and communities to enable an upgrade in prevention, well-being, health, care and support, Health Education England, Skills for Health and Skills for Care. 2017.**

The framework describes the essential core capabilities common to all practitioners, and 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.

A story from practice:

Fran is a local authority support worker

Robin was referred by an occupational therapist following his discharge from hospital, just before Bank Holiday weekend. Robin had no family or friends, no telephone, no food and no way of getting out due to the operation he had undergone. Robin was reported as suffering poor mental health and generally in low mood. Due to his desperation Robin had put a letter in his window asking for help with his shopping. Unfortunately, this had resulted in someone taking his money and not returning with the goods.

I could not contact Robin as he had no phone, so I went to his home. I adhered to Covid-19 guidelines in place at the time (social distancing/outdoors).

We had a discussion as to how we could support him to buy a phone so he could communicate better in the future, but Robin did not want to do so at this time.

Robin spoke to me about his difficulties with low mood and loneliness. Robin felt that a referral to Mental Health Services would be supportive and asked that I complete this.

We talked about his passions, which include music and how he used to play in a band.

I contacted the local community responders and made a referral. I also spoke to the OT who had managed to get him a food parcel before the bank holiday weekend.

Robin stated he had some financial difficulties. He wasn't claiming attendance allowance and didn't know that it existed, we agreed that I would obtain the forms and we would start this process together.

Robin had enough medication for a couple of weeks since his discharge but had difficulties when he needed more. I suggested I could order this from his surgery for him next week and arrange for the pharmacy to drop off also, which Robin gratefully accepted.

Robin now has a process in place for food and medication. The outcome for Attendance Allowance is pending. Social Services may be providing some on-going support. I will continue to visit (following Covid-19 guidelines, social distancing etc.), until we manage to get all vital support needs arranged. I will discuss obtaining a phone with Robin to give him independence and options for on-going well-being calls.

We discussed the potential for links with music groups in the future.

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[3].

Additionally, there are profession-specific training requirements established by bodies such as the Health & Care Professions Council (HCPC)[4], the General Medical Council (GMC)[5], 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[6] 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 with 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:

Know:

- The Universal Model of Personalised Care.

Acknowledge:

- The boundaries of their 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.
- The implications of social determinants of health.
- 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).
- 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.
- An understanding of when it is appropriate to share information with carers, and do so.
- The professional and legal aspects of consent, capacity, and safeguarding.

Promote:

- Physical and mental health and well-being e.g. healthy eating, physical activity, and illness prevention.

References:
3. Core Skills Training Framework. Skills for Health. UK. 2018.
4. Health & Care Professions Council (2018). Standards of conduct, performance and ethics
5. Generic Professional Capabilities Framework. General Medical Council London. 2017.
6. NHS Constitution. Department of Health. UK. 2015.

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 that underpin high quality Personalised Care 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.

Being seen only as a **patient with symptoms** or separate conditions that need treating.	Health and care professionals believing **they have all the knowledge**, expertise and responsibility for your health and well-being.	Being **told** what is wrong with you and how your health needs will be met.
Shifts to...	**Shifts to...**	**Shifts to...**
Being seen as a **whole person** with skills. Strengths and attributes as well as needs to be met.	You and your health care professional **sharing knowledge** expertise and responsibility for your health and well-being.	Being valued as an **active partner** in conversations and decisions about your health and well-being.
Not having the information and support you need to make informed health and well-being choices and decisions.	A '**One-size-fits-all**' approach to meeting your health and well-being needs.	Feeling **powerless** against a complex health and care system.
Shifts to...	**Shifts to...**	**Shifts to...**
Having the information and support you need to make **informed choices and decisions**.	Having more **choice and control** so your health and well-being needs are met effectively in a way that makes sense to you.	Working in partnership with health and care professionals and **sharing power**.
Having to tell your story **again and again**.	Being asked "what's **the matter** with you?"	
Shifts to...	**Shifts to...**	
Only needing to tell your story **once**.	Being asked "what **matters** to you?"	

Additional resource:
From the Personalised Care Operating Model. NHS England.2019

A story from practice:

Jo is a social prescribing link worker

Bob is on the shielding program due to Covid-19. He has numerous health problems including Diabetes, leg infection and part of a limb removed. He has no family and cannot leave his chair due to his mobility. Bob was feeling very isolated, scared and depressed and the only person he would talk to would be the nurse who dressed his wounds.

Bob wanted someone to talk to on a regular basis to stop him feeling isolated and also to stop his mind from thinking the worst all the time. We could not provide Bob with home visits in the usual way, so I put a phone befriend service in place. They now phone Bob every few days and will chat to him about anything from football to the news to Bobs old job as a coal miner. I also ring Bob on a regular basis and text him to let him know he is not alone, and we are thinking of him.

Bob is in a much better place now. He says that he feels happier now. He told me that knowing he is going to be getting a call gives him something to look forward and it's just nice to know someone is there on the other end of the phone.

Bob said, "without the befriending service I would have cracked up a long time ago". Bob is now looking forward to the end of lockdown and would like to meet the befriender in person and consider other social outlets.

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 well-being) needs, and as individuals who have 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 well-being.
- 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, well-being 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 or 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 co-production 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:

1. Shared-decision making
2. Personalised Care & Support Planning
3. Social prescribing and Community-based support
4. Supported self-management
5. Enabling choice
6. Personal & 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, person-centred conversations, 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 we do this affects understanding, motivation and outcome. It is much more than gathering and sharing information and involves sharing power through partnership and asset-based approaches.

People may be using alternative forms of communication (aided or unaided AAC), and the impact this may have on their communication needs should be recognised.

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 afterwards.
- 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 Table 4).

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 conversation.
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, avoiding 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 feeling, process or 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.
De-mystifying health information	An awareness that the patient may have different assumptions. Being able to ask what the patient thinks are the Benefits, Risks, Alternatives, or outcome or Doing nothing (BRAN) and talking with them about what each possibility means, translating from the medical jargon to the patient's life and expectations.

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, including remote/digital environments, 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.

A story from practice:

Melody is a practice nurse in a local surgery

It had been about a year since our last review, although I'd actually seen Lesley quite regularly in clinic when she had come in with her partner, for whom she was the main carer. In that time, it was clear that, although it was a rewarding and important role, being a carer was having an impact on her own health too.

She wanted to get her review done today, to see if she could get her prescriptions better managed, but she was worried more generally about her partner.

I asked: "it sounds like you are providing lots of support for your partner, both practically and emotionally, and they seem to be finding it really valuable, but it is really important for all of us to have these things in our lives, so I am interested to hear what sort of support you get for yourself?"

Lesley hadn't wanted to ask for support because she was worried about being seen by others in the community as not being able to cope. Whilst this was causing stress, Lesley emphasised how important her community was to her.

I reflected that: "It's not an uncommon feeling for people who care for their partners, so you aren't alone". "Would it help if I gave you some examples of things that others have found useful in similar situations?"

I described local groups that were mainly for social activities and didn't necessarily need to be called a support group – like the walking group linked to the practice for example. When I mentioned this, I sensed a degree of apprehension so I made sure to reiterate that this is just an example, there are other similar groups out there, and that of course, she could decide to not follow-up any of them!

It felt like a review that had been useful for both of us.

"Information is given to me at the right times. It is appropriate to my condition and circumstances. It is provided in a way that I can understand."

"I am told about the other services that are available to someone in my circumstances, including support organisations."

"Taken together, my care and support help me live the life I want to the best of my ability."

From National Voices 'I statements'.

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.
- 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 co-production.
- 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 information technology 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.

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

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 personal 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 well-being.

Create:

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

A story from practice:

Jay is a junior doctor working in A&E

Having had a read of his notes before going to see Gordon, I had made an assumption about what the conversation would be about, but noticed the anxiety in his voice as I introduced myself, saying "Hello my name is Jay", and asked him how he would like to be addressed.

Rather than standing at the end of bed, I pulled up a chair to be on eye level with him and said "So, I've read your notes which told what has happened to you today. I want to know a bit more about what feels important to you right now, given everything that has happened?"

I had the full clinical history but knew it wasn't going to be the whole story. Although nervous as to what might be shared that could be beyond my scope to 'fix', I noticed how relieved he was to have just had the chance to share his concerns.

His chief anxiety was about losing his job and then the possible risk of losing his home. It was contributing significantly to the symptoms that had triggered their visit to A&E today. I picked up that this wasn't the first time he might have found themselves anxious about this particular set of circumstances, so enquired about what he had already tried.

"It sounds like you have had to manage symptoms such as these before, so I'd be interested if you could tell me more about what worked and what didn't work for you?"

He felt confident enough in our conversation to share that he was worried about needing follow-up medical appointments which would mean more time off work. I empathised, saying "I can see how difficult this must feel, with the challenge of having to balance going to work and needing to take care of your health."

I paused to allow a moment of reflection and for him to consider the effect that these conflicting demands could be having on him. We agreed that we would address the health concerns initially, but then touch on where he could get further support with his work issues.

After sharing my clinical concerns, we agreed between us to get as many tests completed during this visit to reduce the need for future visits. We arranged for follow-up to be by phone instead of face to face and supported him in making a self-referral to an employment support scheme.

Reflecting on this as I walked back to the desk, I realised how satisfied I was from such a conversation, and how it boosted my own morale during a busy shift.

Reflections from the service user's perspective:

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

"I tell my story once."

"I am always kept informed about what the next steps will be".

From National Voices 'I statements'.

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 including resources for those with communication difficulties.
- The implications of case law and The National Institute for Health and Care Excellence (NICE) guidance for consent and shared decision making.
- Models for patient activation, health literacy, and the Accessible Information Standard (AIS).

Know:

- The principles of behaviour change and 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:

- 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:
  - Understanding the outcomes that are important to them.
  - Explaining in non-technical language all the available options (including the option of doing nothing).
  - 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 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 by using 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.

Additional resource:
Person-Centred Approaches: Empowering people in their lives and communities to enable an upgrade in prevention, well-being, health, care and support, Health Education England, Skills for Health and Skills for Care. 2017

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 versus 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 group settings, difficult conversations, complexity, or barriers to communication.

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.

How to learn this approach

Learning method	Description	Level 1	Level 2	Level 3
e-Learning	Using electronic resources 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	Writing structured reflections 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.			●

How to learn this approach

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 and interactions with self-assessment and feedback on a range of models. Observed real life and simulated consultations assessed against published criteria. • 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.

Making Every Contact Count

Definition and introduction

Making Every Contact Count[1] (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 well-being.

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 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 well-being; 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 care team has a role. See figure 1.
- The 'Five Ways to Well-being'[2] introduces the concept of well-being and describes how a set of evidence-based actions to help improve people's well-being 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.

Figure 1: Behaviour change interventions mapped to NICE Behaviour Change: Individual approaches.

References:
1. Making Every Contact Count. NHS England. 2014
2. Five Ways to well-being. A report presented to the Foresight Project on communicating the evidence base for improving people's well-being. New Economics Foundation. 2008.

Learning outcomes specific to utilising this model or approach

Level 1

The learner will:

Be aware of:

- National health and well-being resources that are available for signposting – e.g. NHS Choices, One You, Every Mind Matters, Good Thinking. Covid-19 resources such as PHE mental health resources.
- Local support and resources available through local authorities e.g. housing, smoking cessation.

Know:

- What is meant by well-being and how health and well-being are linked.
- The main sources of information about key health and well-being messages.
- What to consider when providing information or signposting.

Level 2

In addition to Level 1, the learner will:

Know:

- The scale of impact of different interventions can have on health, including: the five core elements of MECC: Stop smoking models, Physical activity guidelines; Alcohol guidelines; 'All our health' guidance on health improvement and Mental Health promotion.
- Brief intervention and behaviour change skills e.g. 3 step approach to MECC conversations – (Ask, Advise, Assist).
- The 'Five Ways to Well-being'.

Understand:

- What MECC is and who it is for, and understand the difference between objective measures of health and the subjective nature of well-being.
- Appropriate opportunities for starting a conversation about health and well-being.
- Models of open questioning and how to use them.

Be able to:

- Describe what 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 Well-being' model.

Level 3

In addition to Level 1-2, the learner will:

Be able to:

- Demonstrate their own professional development and support others as a future MECC champion at home or in the workplace.

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.		●	●
Recording and role play	Use 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	The capability for self-directed study such as reading around a topic, reflecting on experience and searching for evidence are important aspects of learning as an adult.		●	●
Multi-source feedback	Feedback from colleagues and patients is essential to evaluate and develop learning needs.		●	●
Small group, multi-professional, and peer learning	Peer learning has a powerful influence on enhancing professional development. It provides the opportunity to share experiences, learning together, and encourages groups to be self-directed.			●
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	• Clearly articulates the principles of MECC and covers the evidence base offering data on the scale of impact on health with different interventions (e.g. smoking cessation) 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 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.

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 also related to the ability to find and apply health-related information using digital technology and electronic sources (digital health literacy). It 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.

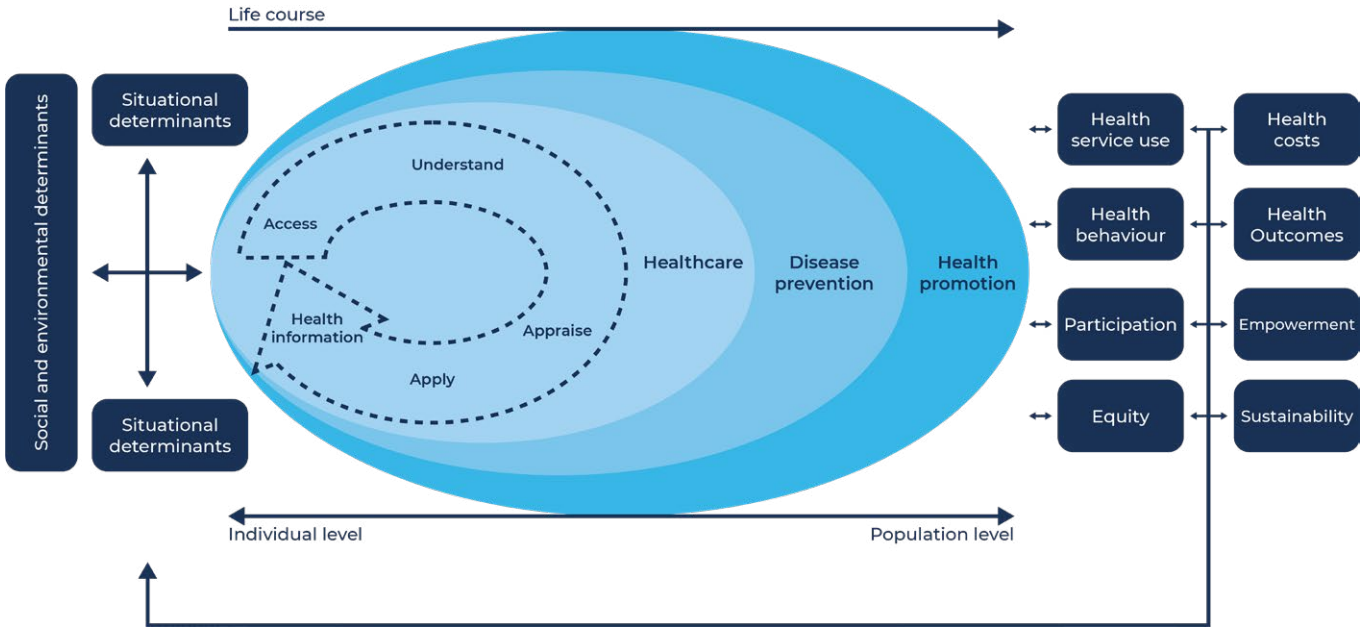
Key elements of the model(s)

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.

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]



Source: Sorensen et al. 2012

References:
1. NHS The Health Literacy Place | Home [Internet]. [cited 2020 Jun 2]. Available from: www.healthliteracyplace.org.uk/.
2. Sørensen K, Van Den Broucke S, Fullam J, Doyle G, Pelikan J, Slonska Z, et al. Health literacy and public health: A systematic review and integration of definitions and models. Vol. 12, BMC Public Health. BioMed Central; 2012. p. 80.
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.

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 the whole organisation.

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, 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.
- National quality standards for health information, including quality mark schemes.

Know:

- What is meant by health literacy and other relevant types of literacy including digital health and eHealth 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-judgemental 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 access to care and high-risk situations where the ability to understand health information may be impeded (e.g. Covid-19 restrictions, hospital discharge and clinic visits; 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, Accessible Information Standard (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 and 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 useful.

Be able to:

- Use a non-judgemental 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 or low digital health literacy including digital health literacy, and those with specific health or cultural needs (e.g. disability, illness, language, diet 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.
- Address the capability of staff in their organisation to support patients' health literacy needs (including their own health literacy needs).
- Address the health literacy needs of staff in their organisation to support the health literacy needs of patients.
- 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.

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.	●	●	●
Recording and role play	Use 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	The capability for self-directed study such as reading around a topic, reflecting on experience and searching for evidence are important aspects of learning as an adult.		●	●
Multi-source feedback	Feedback from colleagues and patients is essential to evaluate and develop learning needs.		●	●
Small group, multi-professional, and peer learning	Peer learning has a powerful influence on enhancing professional development. It provides the opportunity to share experiences, learning together, and encourages groups to be self-directed.			●
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.

Additional Resources:
Health Education England. Health Literacy Toolkit. 2018. Available from: 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: www.healthliteracysolutions.org/home.
Making it Easier – a health literacy action plan for Scotland 2017-2025. Available from: 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[1]. 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[2]. 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[3].

Key elements of the model(s)

- 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 licensed product from Insignia™ and consists of 13 questions, about a person's perspective on managing different aspects of their health and well-being. 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)[4].
- People with different levels of knowledge, skills and confidence may need and want different things from their healthcare, so the services offered. 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[5].
- The Universal Personalised Care model expects these interventions to increase the level of knowledge, skills, and confidence. This can lead to a reduction in GP appointments (9%) and A&E attendances (19%)[3].

Stephen's story

Level 1	Disengaged and overwhelmed	Individuals are passive and lack confidence. Knowledge is low, goal-orientation is weak, and adherence is poor.	**Their perspective:** *"My doctor is in charge of my health".*
Level 2	Becoming aware, but still struggling	Individuals have some knowledge, but large gaps remain. They believe health is largely out of their control, but can set simple goals.	**Their perspective:** *"I could be doing more".*
Level 3	Taking action	Individuals have the key facts and are building self-management skills. They strive for best practice behaviours, and are goal orientated.	**Their perspective:** *"I am part of my health care team".*
Level 4	Maintaining behaviours and pushing further	Individuals have adopted new behaviours, but may struggle in times of stress or change. Maintaining a healthy lifestyle is a key focus.	**Their perspective:** *"I am my own advocate".*
		Increasing level of activation	

Image source: Image: PAM Implementation Quick Guide NHS England (2018)

References:
1. Patient Activation and PAM FAQs NHS England. 2020.
2. Supporting people to manage their health: an introduction to patient activation. Kings Fund. 2014.
3. Universal Personalised Care: implementing the comprehensive model. NHS England. 2019.
4. Patient Activation Measure. Insignia Health. 2020.
5. Understanding and using the patient activation measure in the NHS. Webinar. Health Foundation. 2018.

Learning outcomes specific to utilising this model or approach

Level 1

The learner will:

Be aware of:

- Knowledge, skills, and confidence within 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'.
- How this approach should be adapted to support individuals with communication difficulties (either expressive or receptive).

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.

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 their usage.
Reflective practice / supervision	Follow-up face to face workshops, 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.

Supporting behaviour change

Definition 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.
- 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).

Knowledge and skills

All the factors that lie outside the individual that prompt the behaviour and make it possible

Conscious goals and decision-making as well as habits and emotional responses

These factors interact to produce behaviour

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

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 or 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-judgemental, 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 and 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.

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	The capability for self-directed study such as reading around a topic, reflecting on experience and searching for evidence are important aspects of learning as an adult.		●	●
Multi-source feedback	Feedback from colleagues and patients is essential to evaluate and develop learning needs.		●	●
Small group, multi-professional, and peer learning	Peer learning has a powerful influence on enhancing professional development. It provides the opportunity to share experiences, learning together, and encourages groups to be self-directed.		●	●
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.

Additional resource:
Michie, S., Atkins, L., & West, R. The Behaviour Change Wheel. A guide to Designing Interventions. 2011.

Motivational interviewing

Definition and introduction

Motivational interviewing (MI) 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 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[1].

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 in 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 (Rollnick 2012)[2]:
  - 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 skill sets 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.
- How this approach should be adapted to support individuals with communication difficulties (either expressive or receptive).

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.
- 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 by ensuring correct understanding of the scale of health change possible.
- Reflect on alternative approaches to increasing individual's intrinsic motivation – undertaking behaviour change conversations in contexts of highest complexity and significant risk.

References:
1. www.rcn.org.uk/clinical-topics/supporting-behaviour-change/motivational-interviewing. Rollnick et al. 2008. Page updated 03/08/19. Accessed 26/05/2020
2. Motivational Interviewing: Helping People Change. 3rd Edition. Miller & Rollnick 2012

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	The capability for self-directed study such as reading around a topic, reflecting on experience and searching for evidence are important aspects of learning as an adult.		●	●
Multi-source feedback	Feedback from colleagues and patients is essential to evaluate and develop learning needs.		●	●
Small group, multi-professional, and peer learning	Peer learning has a powerful influence on enhancing professional development. It provides the opportunity to share experiences, learning together, and encourages groups to be self-directed.			●
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, of 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

Definition 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 well-being goals'[1].

Key elements of the approach

- Coaching is a client-led approach for change through the utilisation of the individual's own resourcefulness potential. The process of health coaching is to support people to identify and grow their internal resources, so that they can improve and maintain their health and well-being.
- Its approach is to build awareness, responsibility and develop confidence to manage health and reduce dependency on services.
- Health Coaching[2] involves a partnership between the practitioner (coach) and the individual, agreeing topics on which to focus and outcomes that matter to the person.
- It requires a mindset in which people and practitioners are acknowledged as experts in their own right. Recognising when and how practitioners use their expertise and the capability the person has in their own life and the central role they have in terms of self-managing their own health and well-being.
- Health Coaching can involve exploring the person's experiences, situation and perspective to help them identify barriers and their own solutions and plans to achieve their goals. Challenge and motivation may be needed, and support is tailored around the capabilities of the person and their assets within the context of their life and support networks.
- It also involves breaking down goals into manageable steps and encouraging commitment using a structured approach and recognised tools.

< >

References:
1. Health Coaching: Implementation and Quality Summary Guide and Technical Annexes. NHSE/I. March 2020
2. 'A better conversation'. The Health Coaching Coalition (2016): irp-cdn.multiscreensite.com/0856eb26/files/uploaded/A_Better_Conversation_Resource_Guide.pdf.

Key Health Coaching Principles (Adapted from Olsen, 2014)		
Principles or mindset	Purpose Belief Partnership Focus on benefit for the person Purpose Belief Partnership Focus on benefit for the person	• To improve the health and wellness of patients. • That people are resourceful and have potential to self-manage. • The active participation of both patient and clinician. • Thereby providing a tailored or personalised approach.
Behaviour change skills	Goal setting Movement Creating insight Empowerment 'Case-based discussions'	• Goal clarification, based on a person's preferences rather than professionals. • Helping people assess where they are and how they would like to move forward, a recurring process where action is taken. • Through health education, reflective inquiry, client identification of barriers and strategies and self-awareness. • Is perceived as a consequence of health coaching.
Clinical skills	Integration	• Builds on the skills of the coach, e.g. clinical skills or lived experience if a lay person or peer.

Learning outcomes specific to utilising this model or approach

Level 1

The learner will:

Know:

- The principles and concepts of health coaching.

Understand:

- The use of approaches that focus on strength and positive emotions.
- Health behaviour and barriers to change (cognitive, emotional, behavioural, etc.).

Level 2

In addition to Level 1, 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.).
- 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.

Be able to:

- Apply a coaching mind-set to maximise the effectiveness of conversations.
- Build safety in the conversation to support openness, honesty and willingness to engage.
- Use effective questions to raise awareness and provide supportive challenge.
- Apply a range of directive and non-directive communication approaches.
- Convey expertise, ideas and challenge to support individuals while leaving them in control.
- 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.
- Work constructively with resistance in a non-judgemental way.
- Gather meaningful feedback from service users and people using services.

Level 3

In addition to Level 1-2, 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.
- Apply health coaching approaches in a wide range of situations on a consistent basis.

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	The capability for self-directed study such as reading around a topic, reflecting on experience and searching for evidence are important aspects of learning as an adult.		●	●
Multi-source feedback	Feedback from colleagues and patients is essential to evaluate and develop learning needs.		●	●
Small group, multi-professional, and peer learning	Peer learning has a powerful influence on enhancing professional development. It provides the opportunity to share experiences, learning together, and encourages groups to be self-directed.		●	●
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. Health Coaching: Implementation and Quality Summary Guide and Technical Annexes. NHSE/I. March 2020
2. 'A better conversation'. The Health Coaching Coalition (2016): https://irp-cdn.multiscreensite.com/0856eb26/files/uploaded/A_Better_Conversation_Resource_Guide.pdf. Accessed May 2020

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), 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 situation 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,
  - when 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 the preference of the individual should be taken into account.
- Consent in this context includes agreement for video consultation, confirmation of participants and 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 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 opportunities, means of access, and processes for booking virtual interactions 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

In addition to Level 1, the learner will:

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 or 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

In addition to Level 1-2, the learner will:

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 and 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.

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	The capability for self-directed study such as reading around a topic, reflecting on experience and searching for evidence are important aspects of learning as an adult.		●	●
Multi-source feedback	Feedback from colleagues and patients is essential to evaluate and develop learning needs.		●	●
Small group, multi-professional, and peer learning	Peer learning has a powerful influence on enhancing professional development. It provides the opportunity to share experiences, learning together, and encourages groups to be self-directed.		●	●
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 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.

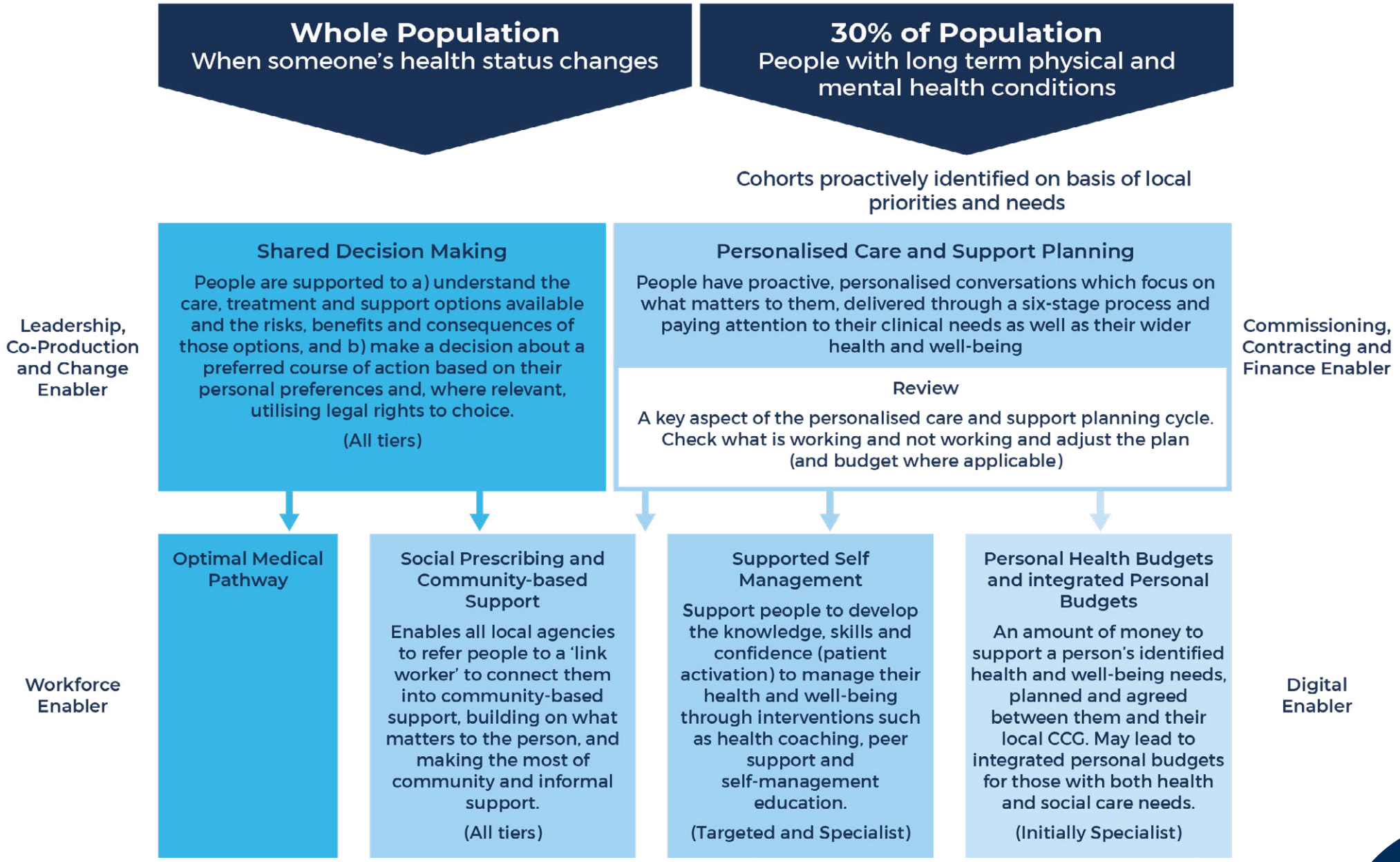
The six components of Personalised Care

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.

Personalised Care Operating Model



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:

1. Ethical standard – support for autonomy.
2. Moral principle – patents want to be more involved.
3. Professional code of conduct, especially consent.
4. 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 knowledge of 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.

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:

- The 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 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 needs at present and in the future. They include social needs 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.

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	The capability for self-directed study such as reading around a topic, reflecting on experience and searching for evidence are important aspects of learning as an adult.
Multi-source feedback	Feedback from colleagues and patients is essential to evaluate and develop learning needs.
Small group, multi-professional, and peer learning	Peer learning has a powerful influence on enhancing professional development. It provides the opportunity to share experiences, learning together, and encourages groups to be self-directed.
Supervision and mentoring	Provides the means of monitoring professional progress, role-modelling, and facilitating reflective practice and giving formative 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 Shared Understanding and Shared Decision-making. • 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.

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 can be considered as a six-step approach[1]:

1. Context – an overview of the health and social care setting.
2. Preparation – a discussion between equals cannot take place, unless each understands the purpose and process of Personalised Care and Support Planning.
3. Conversation – a structured conversation between the person, involving the people, family, peer supporters and health /social care practitioner they know best.
4. Record – The record is 'the Personalised Care and Support Plan' owned by the individual.
5. Making it happen – Coordinating and supporting a complex mix of actions agreed in the conversation.
6. Review – a critical opportunity to reflect and make further changes and decisions. Personalised Care and Support Planning is not a one-off event but a continuous process of discussion and review reflecting the ongoing changes and priorities in a person's life.

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 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:

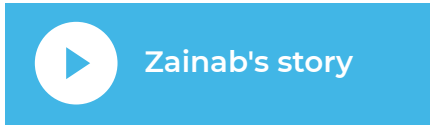
- How to prepare for the role of engaging in support planning.

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.



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References:
1. www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/context/ (July 2020).

How to learn this component

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	Feedback from colleagues and patients is essential to evaluate and develop learning needs.
Small group, multi-professional, and peer learning	Peer learning has a powerful influence on enhancing professional development. It provides the opportunity to share experiences, learning together, and encourages groups to be self-directed.
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 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.

3. Social prescribing and community-based support

Definition and introduction

Social prescribing[1] connects people to community groups and services, enabling people to manage their health and well-being, developing skills and confidence. 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 social prescribing link workers who operate at the heart of primary care. They provide support to people by giving time, focusing on what matters to most to the person, building a shared plan with them and introducing them to community groups and services, including taking them to introductory sessions, where needed. By spending time with a person, link workers 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.

NHSE/I has worked with partners to co-produce the core elements which make social prescribing work at a local level.

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References:
1. Universal Personalised Care: Implementing the Comprehensive Model. NHS England. London. 2019. www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf

Descriptors of professional behaviours:

The Social prescribing link worker should:

- Give time to people, listen, build trust and focus on what matters most to the person, building support around their priorities.
- Create a shared plan with the person about what community groups and services link workers will connect people to, including how they will be introduced, to ensure maximum take-up of support.
- Work with local community groups, Voluntary, Community and Social Enterprise organisations and other local partners to make the most of local community assets and build a diverse menu of community activities to connect people to, including providing basic safeguarding guidance and ensuring that voluntary sector partners are confident to refer people back to the NHS in emergency situations or where there are concerns about people.
- Work with all local partners, including local authorities, police, fire service, job centres, primary care and secondary care and others to recognise people who would most benefit from social prescribing and enable easy referral and self-referral of these priority people and communities, to reduce health inequalities.
- Use the ONS4 well-being tool and other tools to capture individual levels of knowledge, confidence and skills at regular intervals to assess impact.
- Work collaboratively with local commissioners and voluntary sector partners to identify gaps in community support and find creative ways to work together to nurture local community assets.
- Understand the structure of the local healthcare system, including the various roles, responsibilities and organisations within it, applying this understanding to improve the quality and safety of the care you provide.
- Facilitate appropriate support that is realistic and avoids dependence by utilising appropriate support groups and agencies targeted to the needs of the person and/or his or her family and 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:

Know:

- How local services and community activities can be accessed and use this understanding to inform your referral practices.

Understand:

- The role of social prescribing link workers in connecting people to community support.
- The importance of effectively utilising and supporting social and community networks.
- How social prescribing link workers can work with partners to nurture local community assets, spot gaps in provision and encourage voluntary sector partners to develop new community support.
- How working alongside local partners can encourage a local 'systems' approach which joins up services and integrates support around the person.

Be able to:

- Give people time, listen, build trusting relationships and value what matters most to people.
- Proactively address factors that have an impact of social and environmental factors on health.
- Support resilience and capacity in community networks, nurturing community projects, including ensuring that local grant funding and development support is available to develop new groups.
- Work with partners to use population health data to identify people who will most benefit from social prescribing, in order to reduce health inequalities.
- 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.
- Support local voluntary and community organisations to be confident in referring people back to the NHS in emergency situations and where there are concerns.

How to learn this component

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	Feedback from colleagues and patients is essential to evaluate and develop learning needs.
Small group, multi-professional, and peer learning	Peer learning has a powerful influence on enhancing professional development. It provides the opportunity to share experiences, learning together, and encourages groups to be self-directed.
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 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.

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 well-being.

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.

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.

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	Feedback from colleagues and patients is essential to evaluate and develop learning needs.
Small group, multi-professional, and peer learning	Peer learning has a powerful influence on enhancing professional development. It provides the opportunity to share experiences, learning together, and encourages groups to be self-directed.
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 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.

5. Enabling choice including legal right to choice

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. All providers should 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 patient choice is being implemented within their Clinical Commissioning Group (CCG), and put improvement plans in place to address areas that need strengthening; all opportunities to extend choice beyond existing standards are explored and implemented.

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.
- Ensures shared understanding of what the problem is and the benefits, risks and alternatives, including of doing nothing.
- 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:

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.

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.
Multi-source feedback	Feedback from colleagues and patients is essential to evaluate and develop learning needs.
Small group, multi-professional, and peer learning	Peer learning has a powerful influence on enhancing professional development. It provides the opportunity to share experiences, learning together, and encourages groups to be self-directed.
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 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.

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 well-being 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[1].

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 disabilities 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 well-being 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 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.

Descriptors of professional behaviours: capabilities in enabling choice

The practitioner:

- Understands and works confidently with personal health budgets integrated budgets and direct payments.
- Exemplifies the importance of collaboratively agreeing and measuring Personalised Care 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

- 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.

References:
1. www.nhs.uk/using-the-nhs/help-with-health-costs/what-is-a-personal-health-budget/

How to learn this component

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.

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.

Appendix 1: Glossary of terms

Term	Definition
Action learning set	A small group of people who meet together regularly to discuss work-related issues or develop skills in an area of common interest. The approach helps them to share experiences, problem solve, learn new ways of working and test these in practice in a planned way.
Advance Care Planning	This offers people the opportunity to plan their future care and support, including medical treatment and end of life care, while they have the capacity to do so. It can be done in a number of different ways and usually involves a conversation between people, their families/ carers and health and social care professionals.
Capability	The ability to perform or achieve certain actions or outcomes. Capabilities are flexible and adaptive in a wide range of real-life, complex settings (as opposed to competencies). Capabilities also reflect the extent to which learners can generate new knowledge and continue to improve their performance.
Care coordination	The deliberate organisation of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.
Care navigation	A person-centred approach that uses coordination, signposting and information to help patients and their carers move through the health and social care system in as smooth and integrated way as possible, to ensure that unmet needs are met. The term is sometimes used interchangeably with “care coordination”.
Case-based discussion (CbD)	A structured oral discussion to assess professional judgment in a clinical case. It is a component of workplace-based assessment.
Co-production	A way of working that involves health and care service users, carers and communities in equal partnership, and which engages groups of people at the earliest stages of service design, development and evaluation.
Competencies/competences	A set of defined, discrete knowledge, skills, behaviours and attitudes that are learned and assessed in specific situations. These terms are often used interchangeably.
Health coaching	An approach based on 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 well-being goals.
Health Education England (HEE)	Non-departmental government body responsible for providing leadership and co-ordination of education and training for the health workforce in England.
Health literacy	People having the appropriate skills, knowledge, understanding and confidence to access, understand, evaluate, use and navigate health and social care information and services.

Term	Definition
Human factors principles	The environmental, organisational and individual characteristics that influence behaviour and outcomes at work. They include learning styles, behaviours and values, leadership, teamwork, the design of equipment and processes, communication, and organisational culture. Through a better understanding of these principles, changes can be made that result in a reduction of human error and higher quality care and patient safety.
Integrated Care System (ICS)	In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. ICSs have evolved from Sustainability and Transformation Partnerships (STPs).
Learning outcomes	The detailed knowledge, skills and behaviours that a learner will be expected to achieve and demonstrate on completion of training.
Making Every Contact Count (MECC)	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 well-being.
Motivational Interviewing (MI)	This is based on eliciting people's intrinsic motivation to change their behaviour and improve their health, rather than it being imposed externally.
Patient activation	'Patient activation' describes the knowledge, skills and confidence a person has in managing and taking action regarding their own health and care. The words of this definition are now more commonly used than the term "patient activation" itself.
Personal Health Budget (PHB)	An amount of money to support a person's health and well-being needs, which is planned and agreed between the person (or representative), and their local NHS team. Personal health budgets are a way of personalising care.
Personalised Care and Support Planning	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.
Positive risk-taking	Weighing up the potential benefits and harms of exercising one choice of action over another. Based on this, plans and actions should be developed that reflect the positive potentials and stated priorities of the service user (i.e. a strengths approach). In a positive risk-taking approach, decision making should be balanced, defensible (but not defensive) and collaborative.
Problem-based learning (PBL)	Learning about a topic using appropriate problems or case scenarios to trigger knowledge and understanding. The main outcome is learning from the problem, not necessarily solving it.
Quality Improvement (QI)	The use of methods and tools to continuously improve quality of care and outcomes for patients.
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.
Self-efficacy	This is about a person's confidence in undertaking a particular behaviour and their beliefs about their capabilities. Self-efficacy beliefs are cognitions that determine whether health behaviour change will be initiated, how much effort will be made, and how long the change will last in the face of obstacles and failures.

Term	Definition
Shared Decision Making (SDM)	A collaborative process through which people are supported to understand and make decisions about their care, based on evidence-based, good quality information and their personal preferences.
Social determinants of health	The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.
Social prescribing	A means of enabling GPs and other healthcare professionals to refer people to a range of non-clinical services in order to address their emotional and social needs. There are many different models for social prescribing, but most involve a link worker or navigator who works with people to access local sources of support.
Strengths-based (or asset-based) approaches	This approach focuses on the strengths of a person (including personal strengths and attributes, along with social and community networks), rather than their deficits, to empower and aid their health and well-being.
Supported self-management (SSM)	This is about proactively identifying a person's knowledge, skills and confidence in managing their own health and well-being, and then providing the support to enable them to do so.

Appendix 2: 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:

Term	Definition	Commonly used verbs
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

Table 2. Modified Bloom's taxonomy of learning[1]

References:
1. 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.