# Personalised Care in Action: A Guide for All

Personalised Care means putting people at the centre of their care, so they have choice and control over the way their care is planned and delivered, based on ‘what matters’ to people.
Delivering personalised care involves supporting choice, shared decision making, and self-management, providing social prescribing, enabling the use of personalised care and support plans and the effective use of personal health budgets.
NHS England » Universal Personalised Care: Implementing the Comprehensive Model

Personalised care is seen as being “business as usual”, meaning that it is expected to be both part of organisation strategy and an established part of service delivery.

**This guide helps colleagues in operational, clinical, and support roles understand how to deliver personalised care. It provides information about the key aspects of personalised care, what personalised care looks like and gives examples of how to put this into practice.**

There are areas where further information is embedded in the document, hover when you see *(i)* within the document.

## Personalised Care – A Guide For Colleagues Who Delivering Care.

Personalised care can be demonstrated when we;

- put people at the centre of their care,
- support individual choice and control over the way care is planned and delivered,
- use a strength based approach,
- engage effectively with people who need care or interventions,
- support self-management,
- strengthen links with community assets,
- support long term condition management.

| Aim | Primary Driver | Staff behaviours | Examples of how to put into practice |
|---|---|---|---|
| **Offer choice and work in partnership** | Offer choice | Listen to and **understand the impact of health inequalities** and personal circumstances. | Ask **open questions** and use professional curiosity.<br>“Tell me more about…?”<br>“How do you feel about getting to that clinic/appointment?” |
| | | Accept & respect others without judgement, and with compassion. | Focus on **what matters to the person**.<br>Why ask what matters? |
| | | Work flexibly to find a solution to increase access and attendance. | Offer virtual appointments at accessible times, to help fit around someone’s working or caring responsibilities. |
| | | Work in a **trauma informed** way. | **Reflect back** what they say without judgement.<br>“That sounds like it was a challenge…?” |

| Aim | Primary Driver | Staff behaviours | Examples of how to put into practice |
|---|---|---|---|
| **Support shared decision making (SDM)** ***(i)*** | Adopt a strength-based approach | Use a strength-based approach, showing respect for people's values, preferences, experience, and expertise. | **Explore strengths**.<br>"What is important to you about…?"<br>"How do you like to make decisions?" |
| | | Use **open questions** to explore what motivates people. | Uncover what drives people.<br>"What matters most to you?" |
| | | Work with people to identify their positive drivers and work together with them to explore options available. | Use **exploring questions** that help build a professional relationship with people.<br>"What would you love to do that you can't do now because of your situation?" |
| | Share information about treatment options, risks and benefits, in a health literate way to support decisions | Share knowledge and best practise in a health literate manner to support the persons thinking and ideas. | "What do you think about those options, which do you want to explore in more detail?"<br>Remember to **check understanding** with health literate techniques. |
| | | Explore risks, benefits and challenges. | Use decision support tools e.g.<br>• 'BRAN' (What are the **B**enefits, **R**isks, **A**lternatives and if I do **N**othing?) BRAN<br>• 'Ask 3 questions' Ask 3 Questions<br>• |
| | | Explore options together to support the person to make the right decision based on their preferences. | Encourage people to **consider several options**.<br>"How might we adapt this to take this/that into account?"<br>"What are your initial thoughts about …?" |

| Aim | Primary Driver | Staff behaviours | Examples of how to put into practice |
|---|---|---|---|
| **Support self-management *(i)*** | Adopt a strength-based approach. (Start with a 'what's strong' mindset, not 'what's wrong') | Assume people will know what will work best for them. | "What ideas do you have?"<br>"What has worked for you in the past?" |
| | | Use **professional curiosity** to explore what they already know about their health and care, and what is realistic/possible. | "When did this start?"<br>"What has worked well before?" |
| | | Appreciate, acknowledge, and **affirm positive steps** already taken. | "It sounds like you have done a lot to manage your problem already". |
| | Build self-management skills and connect people to peer support | Build peoples **knowledge, skills, and confidence** to self-care. | "It's great that you do (x)…, how would you feel about doing (y)…?"<br>"How would you feel about trying this, I'm here if you need some support?"<br>"What would work best for you?" |
| | | Use **health literate approaches** to support self-management. This involve sharing written information, a website link, written bullet points, or talking through the process. | Give **information in small amounts**.<br>"How can I best share information with you?"<br>"What way would be best for you to take this information away with you?"<br>Check understanding as you go, (use 'chunk and check' technique) |
| | | | Use **'teach back'** to check you have given information in a way that has been understood<br>"To make sure I have explained this well, could you tell me how you will…."<br>"To make sure I have been clear, can you tell me what will do….."<br>"We've gone over a lot of information. What have you found most important?" Teach Back - The Health Literacy Place What Is Teach-Back? |
| | | Explore **local peer support** opportunities. | Explore what is available locally.<br>"How do you feel about hearing other people's experiences of this condition?"<br>"How would you feel about coming to the diabetes education group?" |
| | Clarify and agree a self-management plan | Empower people to take ownership of their own health and care as far as possible, this may need a stepped approach. | **Agree person-led goals** that are stated in the person's own language.<br>"I will dress the sore on my leg myself every other day."<br>"I will make my own breakfast before 11 each morning." |
| | | | Agree what they are going to do, **how they will do it.**<br>"What option most appeals to you? When will you start to do that?"<br>"What will you do tomorrow?" |

| Aim | Primary Driver | Staff behaviours | Examples of how to put into practice |
|---|---|---|---|
| **Support social prescribing and social connection** ***(i)*** | Understand the benefits of and use social link-workers | Build knowledge of local resources in order to **signpost to community groups** and peer support. | Know what social connection resources are available locally, and how to refer people to them. |
| | | | Set **realistic expectations** and explain the role of social connectors to the people you are working with. |
| | | | Explore with people what is available in the local area.<br>"I know other people I have supported have had similar concerns; how would you feel if I put you in touch with a local group?" |

| Aim | Primary Driver | Staff behaviours | Examples of how to put into practice |
|---|---|---|---|
| **Personalised care and support planning (PSCP)** ***(i)*** | Facilitate structured conversation(s) with people about;<br>• what matters to them<br>• how they can manage their health<br>• what support they need | Make people central to developing and agreeing their personalised care and support plan.<br>• Understand what is possible and available.<br>• Decide who needs to be involved in the plan. | **Develop a care and support plan** that belongs to the person.<br>"Who would you like to be involved in this conversation?"<br>"What is most important to you to manage your health and wellbeing?"<br>"How helpful is this plan to you?" |
| | | Take a person-centred, strength-based approach. Acknowledge preferences, skills, and experiences. | Focus on what matters to them, and paying attention to needs and wider health and well-being.<br>**Explore past experiences** and what works well.<br>"How do you manage your condition/well-being when you are feeling well, and when you are feeling OK?" |
| | | Include self-management and crisis management plans. | Explore past experiences and **what could be improved**.<br>"How do you manage your condition/well-being when you are feeling unwell?"<br>"What strategies would you be OK trying?" |
| | | Agree **health and wellbeing goals** and how they will be achieved. | "What would good look like?"<br>"How will you know if you have achieved it?" |
| | Ensure that the PCSP is shared with all relevant partners (particularly at times of crisis) | Create a **plan that is shared** across partners and can be accessed easily particularly at times of crisis. | "How will you share your plan with other health and care services?" |
| | | Review the plan on a regular basis. | Agree a suitable review date. |
| | | | Agree who will review the plan with the person. |
| | | | Plans can be reviewed by different people at different times that are relevant and applicable to the persons health and well-being. |

## Guide to delivering personalised care for operational leaders.

Operational leads facilitate the delivery of personalised care. This can be demonstrated when ;

- people who use the service, are at the centre of their care,
- individuals have choice and control over the way care is planned and delivered is supported,
- staff use a strength-based approach and support self-management when appropriate,
- services have strong links with relevant community assets,
- services support long term condition management.

| Aim | Primary Driver | Leaders Behaviours | Examples of how to put into practice |
|---|---|---|---|
| **Services offer choice and work in partnership** | Services enable choice whenever possible. | Service leads understand the needs of the population they serve, and the impact that the social determinants of health can have on individuals. | Service leads **engage** with community groups and service users to understand the needs of the populations and challenges they face accessing services. |
| | | | Service leads **enable** services to be delivered within local communities.<br>E.g. delivering a podiatry education group in a local mosque or offering pulmonary rehab services to homeless people within a local community centre. |
| | | | Service leads **encourage** appointment times to be offered relative to individual needs e.g. to reflect local bus timetables or offering evening clinics to enable people to have a service after they finish work. |
| | | Services leads work collaboratively with staff and patients/service users to understand how service delivery can be delivered in a flexible way. | Service leads **model** open listening skills to understand the challenges staff and patients have to both deliver and receive services. |
| | | | Service leads **adopt** a strength based approach and enable to staff to offer services in flexible ways. |

| Aim | Primary Driver | Leaders Behaviours | Examples of how to put into practice |
|---|---|---|---|
| **Services support shared decision making (SDM)** ***(i)*** | Service leads ensure that shared decision making (SDM) approaches are supported as part of routine service delivery. | Service leads ensure that staff have the **skills** to facilitate shared decision making approaches. | Staff access **Quality Conversations** training. |
| | | | Staff are aware of the impact of **Health Literacy** and adjust the information they share accordingly. |
| | | | Shared decision making forms part of service reviews. |
| | | | Shared decision making is a regular topic for in- service training. |
| | | | Staff know how to work in a trauma informed manner. |
| | | Service leads embed SDM into service delivery, using resources such as **Decision Support Tools** (DST's) or BRAN/Ask Three Questions BRAN Ask 3 Questions | All staff have access to relevant resources for their service. |
| | | | Documentation systems encourage staff to record use of SDM approaches. |
| | | Service leads model using a strength-based approach. | Service leads take an **asset-based approach** (a 'what's strong' mindset) supporting staff to identify solutions to challenges. |

| Aim | Primary Driver | Leaders Behaviours | Examples of how to put into practice |
|---|---|---|---|
| **Services support self-management whenever appropriate** ***(i)*** | Service leads see self-management a key approach to service delivery whenever appropriate. | Service leads ensure that staff have the **skills** to facilitate self-management. | Staff are supported to access **Quality Conversations Self-management** training. |
| | | | Staff consider the impact of Health Literacy and adjust the information they share accordingly when they support self-management. |
| | | | Supporting self-management, goal setting, and health coaching are part of in-service training. |
| | | Service leads ensure that use of **self-management resources** are part of routine service delivery. | Self-management tools and resources are easily accessible to both staff and patients considering inequalities and health literacy needs. E.g. information both digitally and on paper, is provided in a health literate manner and in a range of necessary languages. |
| | | | Documentation systems encourage staff to record use of self-management support, to enable this to be audited. |
| | | Service leads encourage goal setting and use of health coaching approaches. | E.g. leaflets about ward service inform patients and their families that they support a strength based approach to discharge planning. |
| | | Service leads ensure that any relevant local peer support group or education group is utilised. | Staff are aware of local groups and know how to refer on to them. E.g. community nurse refers to local chair-based activity groups when relevant, social worker links person into local gardening group. |

| Aim | Primary Driver | Behaviours | Examples of how to put into practice |
|---|---|---|---|
| **Support social prescribing and social connection** ***(i)*** | Service leads ensure use of local social prescribers and community connectors are part of routine service deliver whenever appropriate. | Service leads ensure that staff know about, and know how to refer to, local social prescribing services and any relevant wider community connection staff. | Service ensures key staff member keeps up to date with geographically relevant social prescribing services, community groups and other related support. |

| Aim | Primary Driver | Behaviours | Examples of how to put into practice |
|---|---|---|---|
| **Personalised care and support planning (PCSP)** ***(i)*** | Service leads ensure that people who would benefit from a personalised care and support plan have one. | Service leads enable staff to have adequate time to **develop and document** a personal care and support plan when relevant. (E.g. for people with on-going long-term health or care needs.) | People who need them to have a PCSP which include;<br>• what matters to them,<br>• how they can manage their health,<br>• what support they need. |
| | | PCSP are reviewed within and appropriate timescale. | Up to date PCSP are documented within individual health and care records. |
| | Service leads ensure there's a **process** to share PCSP with relevant partners. | Service leads are assured that PCSP are shared with relevant partners as agreed by the patient. | PCSP are **shared with relevant partners**, people know that they can use them to offer consistent support, particularly during times of need or a clinical flare up.<br>Reducing Preventable Admissions to Hospital and Long-term Care |