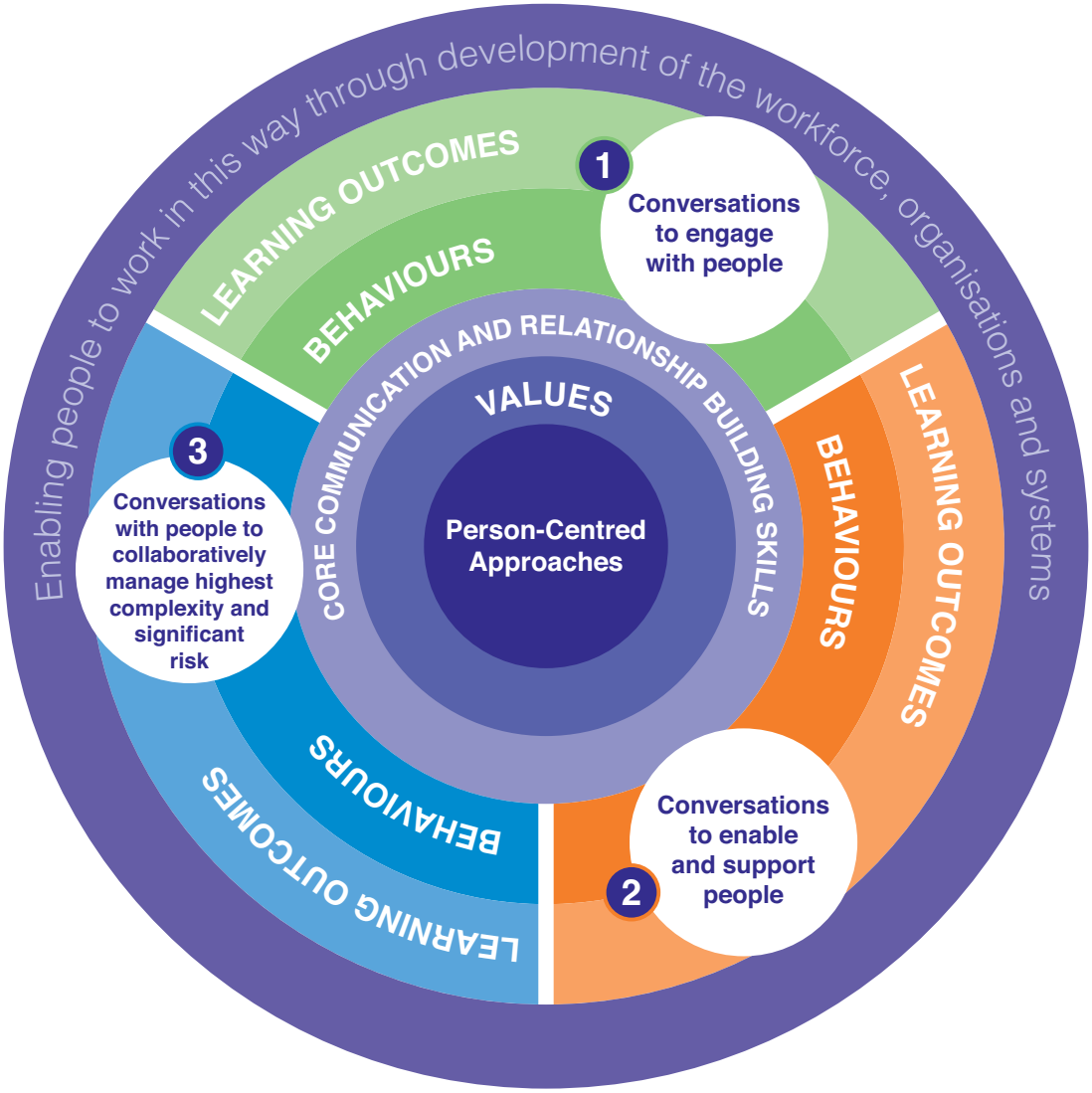

Person-Centred Approaches:

Empowering people in their lives and communities to enable an upgrade in prevention, wellbeing, health, care and support.

A core skills education and training framework

Skills for Health

skillsforcare

NHS
Health Education England

Acknowledgements

This framework was commissioned by Health Education England (HEE). Its development was led by Beverley Harden (HEE), with project management provided by Colin Wright (Skills for Health) and initial scoping research by Paula Knight (Skills for Care). The framework was written and compiled by Petrea Fagan, Anya de Iongh, Beverley Harden and Colin Wright.

The thinking for this work began with many valued conversations involving Em Rahman and colleagues within Health Education Wessex, alongside local people, Public Health, social care, housing, voluntary sector, academic and health colleagues.

Based on the principles of co-production, development of the framework involved the participation of a wide range of stakeholder organisations and representatives of people using health and care services. The stakeholder list compiled during development of the framework comprised approximately 300 individuals. We are particularly grateful to the members of the project steering group for providing their guidance, expertise and support during the development process and to Suzanne Wood (Improvement Fellow, The Health Foundation) for her guidance during the project. The steering group included representatives of the following organisations:

- Academic Health Science Network
- Carers Trust
- Coalition for Collaborative Care
- Health Education England
- Leadership Academy
- Local Government Association
- London Borough of Barnet
- National Voices
- New NHS Alliance
- NICE
- NHS England
- Public Health England
- Race Equality Foundation
- Royal College of General Practitioners
- Skills for Care
- Skills for Health
- The Health Foundation
- TLAP (Think Local Act Personal Partnership)

In addition, we would like to thank the many other people who provided comments and feedback on drafts of the framework during the project and particularly the 144 respondents to the online consultation survey.

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Addendum in 2020

The NHS Long Term Plan sets out the strategic national plan for the NHS over the next ten years. The Long Term Plan describes five major, practical changes to the NHS service model, one of which is:

> "People will get more control over their own health, and more personalised care when they need it"

Personalised Care will benefit up to 2.5 million people by 2024, giving them the same choice and control over their mental and physical health that they have come to expect in every other aspect of their life. A one-size-fits-all health and care system simply cannot meet the increasing complexity of people's needs and expectations. Personalised care is based on 'what matters' to people and their individual strengths and needs.

The approaches that have been brought together to form the new personalised care strategy have previously been referred to as Person-centred care. These approaches encompass a highly relevant range of activities and knowledge. The skills and competencies needed by the workforce to provide person-centred care are just as relevant and applicable to personalised care and shouldn't be viewed separately.

These are applied and integrated into the roles of people working across services and sectors such as health, social care, local authorities and housing, and across different types of organisations (e.g. public, not for profit and private). As described in the introduction of this Framework, much of this approach builds on previous ground breaking work in mental health and social care over many years, which mirrors the same fundamental values and skills that underpin person-centred approaches. The phrases are used interchangeably within the system, since they share the same core principles and evidence base.

The detail of the current policy for personalised care is contained within the Universal Personalised Care: Implementing the Comprehensive Model. The Comprehensive Model for Personalised Care is an all age, whole population approach, with different components that can support people relevant to their health and wellbeing. Acknowledging that people's health and wellbeing change over time, it is the universal and comprehensive provision of the components that builds cumulative benefits for people, their family and carers and communities.

The operating model to deliver personalised care defines six core activities that happen across health and social care services:

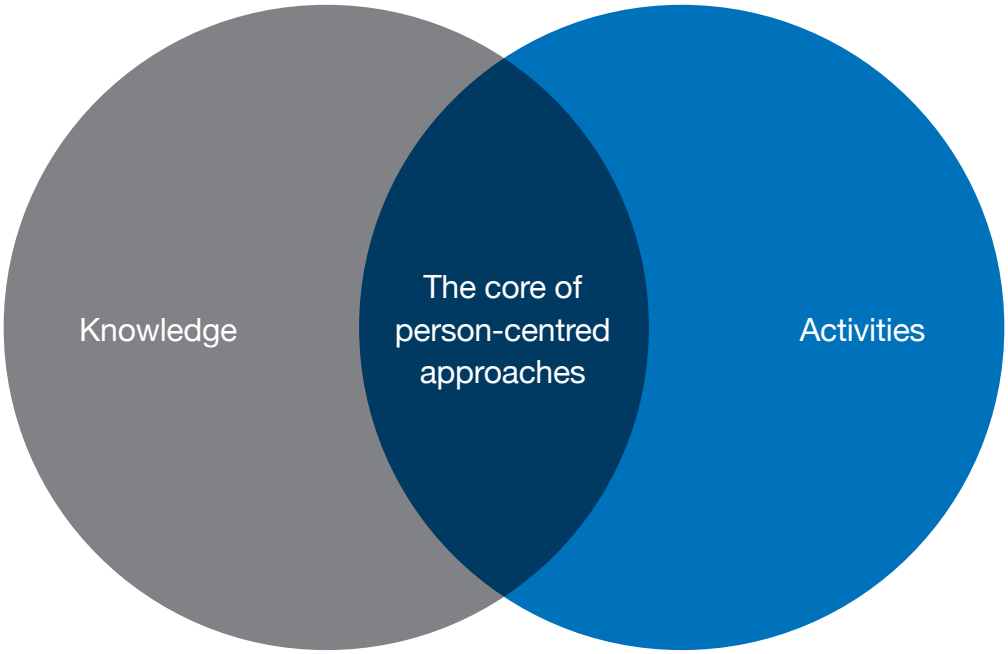
- shared-decision making
- personalised care & support planning
- self-management support
- social prescribing and community-based approaches
- personalised health budgets
- enabling choice.

These six core activities are facilitated by a number of enablers, including the workforce, which is directly supported by this Framework and the associated suite of resources. The ambition in the Long Term Plan is for personalised care at scale, so as many people as possible can benefit throughout their lives. This requires a step-change in workforce development around the outcomes described within this Framework.

The terms personalised care and person-centred approaches are used interchangeably throughout these resources. As the quote from Maya Angelou says "people will forget what you said, people will forget what you did, but people will never forget how you made them feel".

The social movement of person-centred approaches and personalised care will continue to evolve in the future, with its language naturally developing. The core skills that help people feel connected, engaged, enabled and supported remain consistent, whatever we may call them, and make this Framework highly relevant in today's world of Personalised Care.

The knowledge and activities of person-centred approaches that are enabled through this framework include:



The core of person-centred approaches

- Values
- Core communication and relationship building skills
- Conversations to engage with people
- Conversations to enable and support people
- Conversation with people to manage the highest complexity and significant risk

Enabling people to work in this way through:

- Development of the workforce
- Development of organizations and systems
- Supporting behaviour change

Knowledge – which may include the following:

- Social determinants of health
- Patient activation
- Quality improvement
- Technology to support health and wellbeing
- Health literacy
- Accessible Information Standard
- Patient and Public Involvement (PPI)
- Awareness of local services and resources
- Coproduction
- Asset-based approaches
- Looking beyond traditional health and care solutions
- Carer awareness
- Communities
- Prevention (primary, secondary and tertiary)
- Person-centred measurement & outcomes
- Statutory and mandatory regulation and governance
- Relevant policy

Activities – which may include the following:

- Shared decision making
- Social prescribing
- Care navigation
- Care coordination
- Advocacy
- Supporting self-management
- Care and support planning
- Health coaching
- Motivational interviewing
- Peer support
- Recovery
- Personal budgets/IPC
- Supporting behaviour change
- Signposting
- Advanced Care Planning
- Making Every Contact Count (MECC)
- Managing risk
- Working in partnership at individual and service level
- Integration of services across sectors
- Measuring impact at individual and service level

Contents

Forewords 05

Introduction 07

About this framework 09

Values 12

Core communication and relationship building skills 14

Step 1: Conversations to engage with people 16

Step 2: Conversations to enable and support people 21

Step 3: Conversations with people to collaboratively manage highest complexity and significant risk 28

Delivery of training, education and learning opportunities 33

Enablers for embedding a person-centred approach 42

Appendix 1: Communication skills 50

Appendix 2: Person centred approaches applied across a range of activities 52

Appendix 3: Tools to deliver training and development for the workforce 53

Appendix 4: Glossary of terms 55

Appendix 5: How the framework was developed 61

Appendix 6: Current relevant resources 62

Appendix 7: Reference list 70

Foreword from
Anya de Iongh

As someone living with long-term health conditions, person-centred approaches matter to me. I've been lucky to make a shift from being overwhelmed by my health, to feeling more confident, living well with my conditions, and working to support others with their self-management journeys. This has been a cumulative result of conversations with a range of different people, including peers, professionals, family and friends.

From my experience, conversations can make or break us.

- The person who reassured me by showing they understood that having to stop my hobbies to manage my physical conditions would affect my mental health.
- The doctor who left me feeling frustrated by listing all the various things I should be doing to help manage my condition, without stopping for a few seconds to acknowledge the effort I was already putting in.
- The physiotherapist who gave me confidence by co-designing an exercise programme with me so that it fitted around the rhythm and routine of my life.

These conversations can be too powerful to leave to chance. It shouldn't be by luck that some of us experience the shift to a person-centred approach. This is why I feel this framework is so important.

The creation of this framework itself has modelled the principles of person-centred approaches that we talk so much about. I've been involved as an equal partner to write this document, working closely with Petrea Fagan, Colin Wright and Beverley Harden. I am seen as more than my patient stories, with valued personal and professional expertise and experience to contribute.

Anya de Iongh is a patient leader and self-management coach

Foreword from
Clenton Farquharson MBE

I am passionate about person-centred approaches, which for me means:

- Control over the circumstances of my own life.
- Contact with other people that is meaningful and encouraging.
- Confidence to see myself as a strength, to be in a position to take actions and responsibility and to have a positive impact on those around me.

I work in the health and care system – I also live with an impairment and long-term health conditions. If I have learned anything about working in a complex, rapidly changing, health and social care system, it is that we all depend on each other to get things done.

Our quality of life, our happiness, our ability to bounce back when times are tough are directly related to the level we feel connected to others and can rely on them for support.

But people don't develop person-centred habits or behaviours just because they go to a workshop. In my experience, it is the ongoing quality of relationships that matters.

When health and social care workers know how to connect with me and my family, are able to listen and discover what's really going on beneath the surface, build trust and find ways to explore solutions together, then life outcomes can be transformed.

Clenton Farquharson is a citizen's leader, coproduction advocate and Social Justice campaigner

Foreword from
Professor Alf Collins

The conversations that frontline health and care staff have with people and carers can often seem inconsequential, but they can be a life event for the client. Every phrase, every word, every pause counts.

It follows that health and care workers should be mindful of what they say to people and carers. And given that many of the techniques that are used in person-centred conversations are skills that need to be learned, it also follows that we need to train our workforce to be more person-centred. National insight data reinforces this - we are not as person-centred as we think.

But what are the skills of a person-centred workforce? And is there an underlying attitudinal or mind-set challenge to consider? Getting to the bottom of the challenge means asking people and carers what they want, and here the literature is remarkably consistent.

People want to be treated with dignity and respect. They want their care and support to be co-ordinated, so they only have to tell their story once. They want to be treated as individuals - not as a bag of body parts or problems. They want to talk about their priorities; not necessarily ours. They want to know about their options and what is known of the risks, benefits and consequences of all reasonable courses of action that are open to them. In short, they want to be supported to feel as in control as they would wish.

In other words, health and care workers should routinely make every contact count and always treat people with dignity and respect. They should support people to manage their own health and wellbeing through personalised care and support planning and self management support - which often means connecting people with their own sense of resourcefulness and with the assets in their community. And they should routinely share decisions by outlining all reasonable options and ensuring that all information is personalised, accessible and useful.

But don't all these ways of working overlap? Is there (for instance) much difference between making every contact count and health coaching or between shared decision making and personalised care and support planning? And if there are overlaps, shouldn't we ensure every professional possesses core skills, then teach more specific or advanced skills to specific segments of the workforce?

This framework is designed to address these questions. It is designed to support workforce leads to understand the knowledge, skills and capabilities of a person-centred workforce. It is designed to support them to identify the training needs of their workforce and to design training programmes accordingly.

The authors have done a splendid job of working with experts from a number of fields to identify the common themes and synergies across multiple ways of working but also to clarify those features of particular approaches that make them distinctive. We owe an enormous debt of gratitude to everyone who contributed to the document but we should extend particular thanks to Beverley Harden from HEE and Colin Wright from Skills for Health. Quite simply, this framework would never have been published without their expertise and their leadership.

Bev, Colin- thank you.

Professor Alf Collins
is a doctor, commissioner, researcher and national policy advisor in person-centred care.

Introduction

The value of a person-centred approach in health and care is increasingly recognised - much has been written about what it is and why it is important. However, it is less clear how to develop the workforce to put this into practice – *which is the purpose of this framework.*

Our aim here is to articulate what it means to be person-centred and how to develop and support the workforce to work in this way.

A person-centred approach puts people, families and communities at the heart of health, care and wellbeing. It means people feeling able to speak about what is important to them and the workforce listening and developing an understanding of *what matters to people*. It means working in a system in which people and staff feel in control, valued, motivated and supported.

We recognise that staff in health and social care services are often working under intense pressure and severe time constraints which may impact on practice and behaviour. However, the values and behaviours of being person-centred are about a fundamental approach.

This approach is about enabling the workforce to develop genuine partnerships with people, families, carers, communities and colleagues. This means that we can plan, design and deliver care and support with people and collectively plan and design services and systems. At each level, everyone's contributions are recognised and valued.

People's ability, confidence and willingness to manage challenges in their life, health and wellbeing will change over time (minutes or years). Person-centred approaches need to tailor and adapt to this, to support the person where they are.

A key part of a person-centred approach is about being 'community focussed' i.e. seeing the person in the context of their whole life and recognising that the most appropriate activity, treatment or support may be community based. Evidence confirms significant improvement in health and wellbeing when individuals and communities achieve a sense of purpose, hope, mastery and control over their own lives and immediate environment. When people feel a sense of control over the circumstances of their own lives and have contact with others that is meaningful and constructive, they can gain the confidence to take actions and responsibility.

This person-centred approach is not new. For many people already working in health and care, engaging in a meaningful way with people, families, carers and communities is part of their intrinsic motivation. It is seen in the development of 'personalisation' in the social care sector and is integral to established techniques and approaches such as care and support planning, health coaching, motivational interviewing, shared decision making, self-management support and coproduction[1]. A person-centred approach is underpinned by seeing prevention - engaging and supporting people to live healthier lives - as an on-going activity with people and communities, not a single event or intervention.

What is new in a person-centred approach is a shift from a values based argument, that this is the 'right thing to do', to the growing body of evidence (such as the recently published Realising the Value [2016] research and the National Voices Evidence for Person Centred Care [2017]) that it can lead to better outcomes and care for people and make better use of finite resources. Crucially, this approach is also now the focus of policy and legislation, notably the Five Year Forward View (Chapter 2), which emphasises the aim for *'a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health'*, together with the Care Act (2014) which aims to put people at the centre of their care and support and maximise their involvement.

In presenting this framework it would not be realistic to describe how a person-centred approach is implemented in every context or setting. On the contrary, *our aim is to distil best practice and to offer this as the core, transferable behaviours, knowledge and skills.* The person-centred approach described here therefore underpins other existing core skills frameworks such as those previously developed for dementia, learning disabilities, mental health and end of life care[2].

1. Definitions of person-centred activities and approaches are provided in the Glossary of Terms (Appendix 3)
2. Core Skills Education and Training Frameworks (CSTF)

We also recognise that working in a different way and changing behaviours and habits is not easy - and not simply about developing new skills and knowledge. Practice in the workforce is a complex combination of many behaviours, decisions and interactions between ourselves, communities, colleagues, people, families and carers. Behaviour change requires the necessary combination of workforce capability, together with the opportunity and motivation for behaviour change[3]. For change to 'stick' and become established, it also has to be supported by a system and culture within organisations that make it the easy thing to do. This is further explored in this framework through considering the 'enablers' for embedding a person-centre approach. This 'whole system' approach (as represented by the Year of Care House of Care Model[4]) recognises that a combination of elements need to be in place to deliver effective person-centred care. An authentic person-centred approach will also be seen in how staff interact with each other – and where managers adopt an enabling, 'coaching approach' to managing people.

The main audience for this framework is likely to be people in organisations with some level of responsibility for development of the workforce (e.g. commissioning, planning or delivering education, training and learning). It is hoped that staff delivering services and people receiving support or care may also find this framework helpful in providing clarity about the desired behaviours expected in a person-centred approach.

At its heart, being person-centred is not about being in a specific role or situation - nor dependent upon a level of seniority. It requires the right skills in the right place to enable the most effective and impactful conversations with people and carers using services.

3. Mitchie et al (2011), The behaviour change wheel: A new method for characterising and designing behaviour change interventions
4. Year of Care: House of care model

About this framework

Scope of the framework

This framework aims to distil best practice and to set out core, transferable behaviours, knowledge and skills. It is applicable across services and sectors (e.g. health, social care, local authorities and housing) and across different types of organisations (e.g. public, private and not for profit).

The framework particularly builds upon and learns from person-centred approaches with origins in the social care sector, dating back to the human rights movement for people with learning disabilities, which is now embedded in the 'personalisation' of services. It is not our intention to duplicate approaches already established in different sectors, but rather to describe that which is common and transferable between sectors and settings, to enable greater consistency of practice and more effective cross-sector working.

In describing conversations between the workforce, people and carers, we recognise the many connections and resources people may draw upon – the 'circles of support' in their community. This framework therefore includes being 'community focused' i.e. understanding the value and importance of community assets and resources. However, it is beyond the scope of this framework to describe the skills and knowledge specific to the practice of 'community development' – this is already described elsewhere in other frameworks and standards[5].

It is also recognised that a person-centred approach will be underpinned by existing core skills (e.g. in areas such as safeguarding, capacity to consent, information and professional governance, equality and diversity etc). These 'statutory/mandatory' subjects at different levels (appropriate to role) are also fully described in other frameworks6 and are not repeated here.

Structure of the framework

The framework begins with a description of values – which build upon the values set out in the NHS Constitution (2015)[7] and the value statements developed during the Realising the Value programme[8] in order to resonate with workforces in different sectors and settings.

Core communication and relationship building skills are next presented - relevant to the whole workforce, including communication between staff at all levels in an organisation.

Behaviours, knowledge and skills to put a person-centred approach into practice are then described in three 'steps':

Step 1: Conversations to engage with people

Step 2. Conversations to enable and support people

Step 3. Conversations with people to collaboratively manage highest complexity and significant risk

The appropriate step will depend upon the type of conversation needed in a particular situation – this is not necessarily dependent on a workers job role or level of seniority.

5. Community Development National Occupational Standards 6.Core Skills Education and Training Frameworks (CSTF)
7. NHS (2015), The NHS Constitution: The NHS belongs to us all
8. Realising the Value (2016), Realising the Value: Ten key actions to put people and communities at the heart of health and wellbeing

Behaviours and learning outcomes

Within each step, the framework provides *behaviours and learning outcomes*:

The behaviours aim to illustrate what people receiving care and support and their carers would see in practice. Behaviours are presented in two ways:

What is it?	i.e. examples of positive / desirable behaviour
What is it not?	i.e. examples of negative / undesirable behaviour

Learning outcomes then aim to describe the outcomes that would be expected from commissioned or delivered education and training for staff to be able to effectively work in person-centred ways i.e.

The learner will:

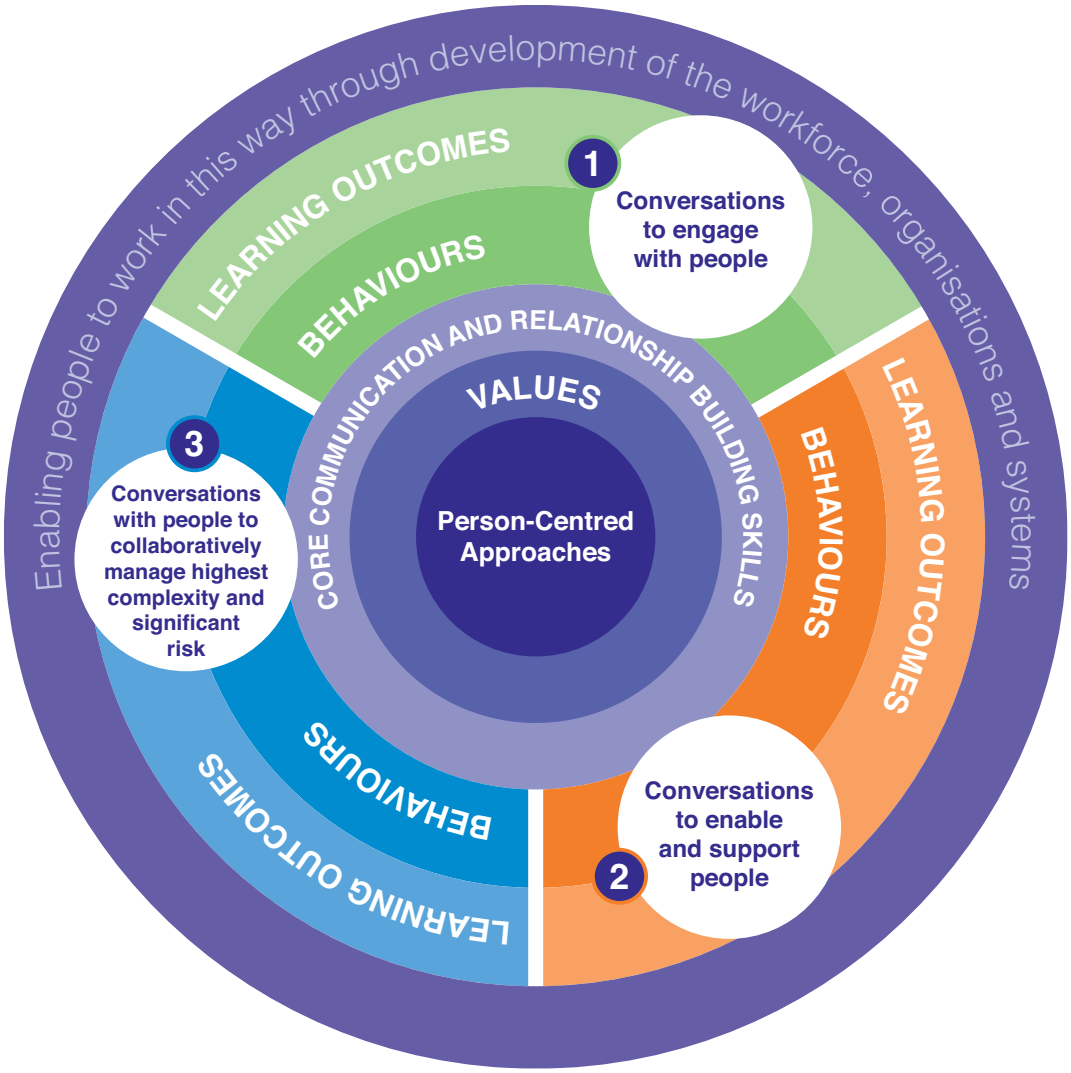
Be aware of…	i.e. has a basic awareness of a concept
Know…	i.e. remember previously learned information
Understand…	i.e. demonstrate a comprehension of the facts
Be able to…	i.e. apply knowledge and understanding to actual situations[9].

The learning outcomes for each step together indicate the minimum content for the design and delivery of teaching and learning. However, it is important to reiterate the scope of the framework is that which is common and applicable to all settings. Additional content may also be required for some roles and contexts.

Whilst training, education and the capability of individuals is important, this is not on its own sufficient. Long term behaviour change needs to be supported by the leadership and culture of the organisation – 'the way we do things around here'. This needs to provide both the opportunity and the motivation for behaviour change – and opportunities for reflection, review and development of skills. The 'enablers' for embedding a person-centred approach in the system and in organisations are described in the section of this document: 'Enablers' for embedding a person-centred approach.

9. This approach is derived from Bloom's Taxonomy (Bloom B, 1956)

Figure 1 below represents how the 3 steps build upon core values and communication and relationship building skills - and take place in the context of 'enablers' provided by the system and organisations.



Values

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

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

For everyone delivering, leading or managing services this can be summarised as follows:

- It is important to me to afford people dignity, respect and compassion, without judging them.
- I am interested in and want to understand people's perspective, their preferences and what's important to them and their carers.
- I see people as individuals beyond just their presenting (health, care or wellbeing) needs, 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.
- It is important to me to develop mutual trust in all my interactions with people, their carers and communities.
- I value and acknowledge the experience and expertise of people, their carers and support networks.
- I am committed to ensuring coordinated current and future care, support and treatment, through working together in partnership with people, teams and organisations.
- I value and acknowledge the importance of communities, social networks and community development to support people's health and wellbeing.
- I value collaborative involvement and co-production with people to improve the person-centred 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 person-centred 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 person-centred values might mean:

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

Core communication and relationship building skills

At the heart of person-centred 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. 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.

Behaviours

What is it that people and their carers would see?

1) Introducing yourself; 'Hello my name is…'
2) Really listening to me and hearing me
3) Asking open questions to explore and understand me, my personal situation, and what matters to me and my community
4) Acknowledging what I am doing already to manage, and reassuring me that what I am experiencing is understandable
5) Not judging me
6) Checking if there is something else I want to talk about
7) Giving me the opportunity to be an equal partner in how we guide and continue our conversation
8) Working with me and my carers in a way that means we can trust each other
9) Sensitively giving me an idea of how long we have available for our conversation

What is it not?

1) Asking open questions then not using the information to shape our conversation or your support
2) Being distracted, with your mind on other things during our conversation
3) Sitting or standing and using your voice in a way that shows you aren't listening or are annoyed by what I am saying
4) Assuming either of us has understood each other without asking and checking
5) Interrupting me
6) Using your body posture, voice or positioning to gain 'power' or advantage over me
7) Preferentially communicating with my carer or partner without asking me or because it feels 'easier'
8) Not giving me an idea of how long we have available for our conversation, and suddenly ending the conversation without warning, before I expect it

Learning Outcomes

What are the expected outcomes from effective person-centred workforce development?

The learner will be aware of:

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

Understand:

b) The value of really listening as an active process

c) Communication as a two-way process

d) The impact of conversations and different verbal and non-verbal communication styles for a person during the conversation and afterwards[10]

e) How to meet the communication and language needs, wishes and preferences of individuals

Be able to:

f) Confidently demonstrate the core communication skills for relationship building and information gathering (see Appendix 1 for full details):

- Using "Hello my name is…" to introduce oneself
- Using open ended questions to engage with the person
- Know when to use open and closed questions
- Checking if there is something else an individual wants to discuss
- Reflecting what the other person has said using their words
- Acknowledging the effort or achievement someone has made
- Letting the other person know you understand how they are feeling by being empathetic
- Helping someone feel that their experiences are normal and other people often feel the same
- Summarising what the person has said during the conversation
- Checking both parties have understood, and if needed, making the message more accessible
- Explaining so that the individual knows where the conversation is going
- Signposting to other relevant resources and information available
- Being aware of where the conversation is happening – for example, how the layout of the room or the level of privacy can affect the other person
- Checking if the person wants further information and how they want to receive that information before offering it
- Being aware of how eye-contact, gestures, facial expressions and our voice can be interpreted along with what we say
- Concentrating on the conversation at the time, making effort to hear and understand what someone is saying
- Feeling comfortable using pauses, silences and gentle cues such as nods as appropriate

The core of person-centred approaches are applied across a range of activities, as illustrated in Appendix 2.

10. Accessible Information Standard, NHS England

Step 1.
Conversations to engage with people

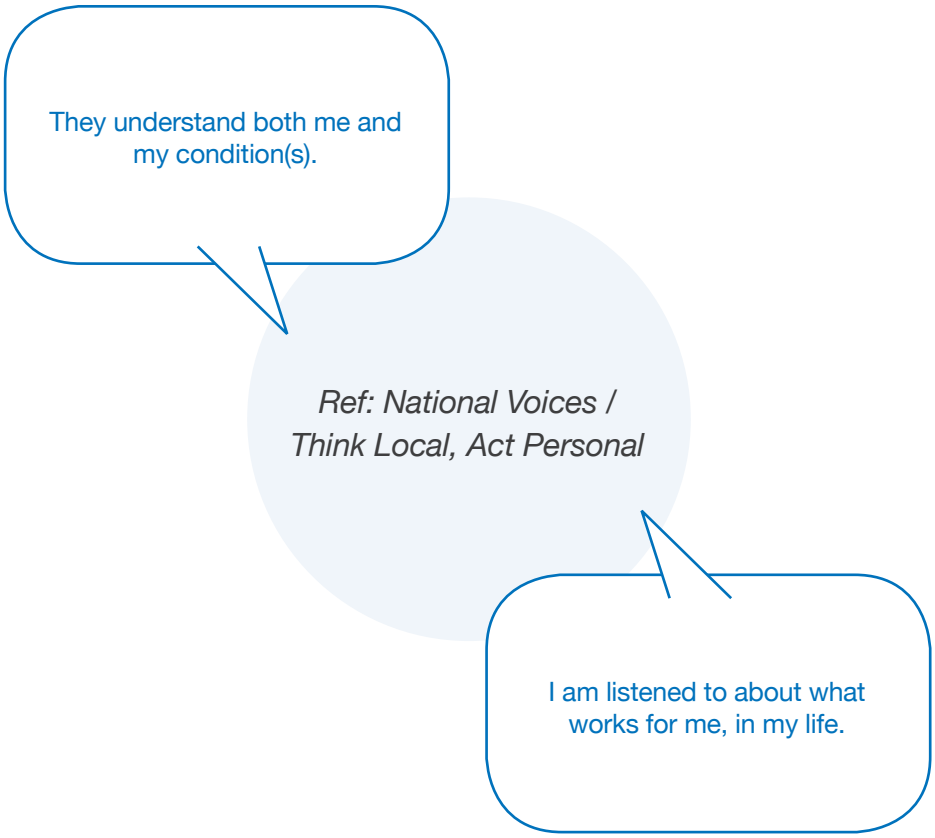
Overview

Step1 covers the baseline awareness, skills, knowledge and behaviours that everyone delivering services needs to have as standard to ensure consistent person-centred approaches.

Every conversation and interaction with people and carers should be enabling. It should create the optimum environment to engage them, supporting their development of self-awareness, belief in their ability to take action, and enable them to make decisions.

Enabling people within short episodes of contact is not always possible because of the complexity of some people's lives, but it is all too easy to disempower someone in a 5-minute conversation. No one should ever leave a conversation less empowered or enabled than they entered it.

This baseline of person-centred approaches acknowledges and respects that all conversations are two way and that the way in which the conversation is conducted can impact on all those involved and affected.



Step 1: Behaviours

What is it that people and their carers would see?

1) Being empathetic
2) Being interested in my life and community, and what matters to me
3) Seeing me as resourceful and capable
4) Explaining that you want to work together with me
5) Showing me respect and preserving my dignity
6) Allowing me to tell my story from my perspective – and providing my carer/family the space to do the same
7) Allowing me and my carer to gather the information I need and have the opportunity to ask questions
8) Being encouraging, acknowledging and respecting of the positive things I might have done/be doing
9) Helping me understand that some of my feelings are normal and I'm not alone with them
10) Recognising when I might need help to continue our conversation or noticing clues that might lead to further conversations
11) Helping me to make decisions and respecting these decisions
12) Sensitively bringing up topics I might find challenging
13) Using language and ways of working I can understand and follow

What is it not?

1) Assuming that you know what I might want or see as important without asking me
2) Assuming the first thing I mention is the most important or only thing that is important to me
3) You deciding what we need to talk about
4) Seeing me as just my problem/condition or just as a carer
5) Seeing me as incapable of making changes
6) Judging me and my choices
7) Focussing only on the medical perspective of my story
8) Starting with an assessment of me without understanding me and my perspective
9) Ignoring the value of my circles of support and community networks
10) Not allowing me to express my feelings, ideas and opinions

Step 1: Learning Outcomes

What are the expected outcomes from effective person-centred workforce development?

The learner will be aware of:

a) The strengths and resilience that people, families, carers and circles of support can have within themselves (strengths or asset based approaches)

b) The concept of co-production and its importance to individual health and care, and in wider service design

c) Person-centred care activities[11]

d) The importance of engaging and building rapport and relationships to create a safe environment where people and carers can share feelings, thoughts and ideas

e) Local resources relevant to the discussion to which people can be signposted

f) The importance of continually reflecting on whether services and process are optimal and opportunities to improve these further through coproduction

g) The impact that a range of social, economic, and environmental factors can have on outcomes for individuals, carers and their circles of support

Know:

h) How to sensitively introduce subjects that the person might find challenging

Understand:

i) When and how to refer a person onto more specialised, tailored or intensive sources of support

j) The importance of social networks and circles of support for individuals and their carers

Be able to:

k) Recognise the opportunity to have a conversation with a person and choose to take the opportunity

l) Identify what is important to the person both generally and in the context of a conversation

m) Use different communication styles and language depending on an individual's needs and understanding

n) 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

o) Set own goals to embed this approach into everyday conversations e.g. to identify a peer to work with once back in the workplace/community and think about what this means for the team.

NB. These are the common core learning outcomes which are applicable in all settings. Additional content will be required for some roles and contexts.

11. For example, care and support planning, health coaching, motivational interviewing, shared decision making and self-management support (see glossary of terms for further explanation)

Examples in practice:

Louise is a physiotherapist working in an acute hospital:

One of my patients was refusing to engage with treatment and had become quiet and withdrawn. She said she was too tired to mobilise so we spoke about her goals and how she felt - I listened carefully paying attention to the more subtle elements of the conversation. I found by expanding the conversation around her goals and what was important to her she became more animated and engaged. She said she felt like our talk was the single most enjoyable and useful experience since her admission.

Tony is a support worker at a discharge and reablement service:

I was taking a gentleman home from hospital after a fall. He had physiotherapy and was actually quite stable on his feet – but he was so low in mood. I offered to get him some shopping in, collect his prescription, connect him with some local groups – all of the usual things, but he kept saying there was nothing I could do for him and he didn't want to be a nuisance. So I asked, "if you could do anything right now, what would it be?" And he said "take flowers to my wife's grave". He was distraught the grave hadn't been tended. So I went and laid some flowers and then we built up to him going by himself. It taught me to be more open-minded and to listen more – not everyone wants to go to community groups.

Julie is an estate manager at a social housing provider:

We held a reminiscence session with residents and older members of a local Chinese community group. The discussions were based around important 'life' events including births, marriages and deaths. Some interesting comparisons were made between the cultures – for example, Chinese people traditionally wear white to a funeral. This was a great way to build awareness of each other's cultures, but also to explore thoughts and feelings about the end of life. We had a follow-up coffee morning and some of our residents decided they wanted to plan their funerals and use the session as a way to start a conversation with their families. They hadn't been able to find a way into such personal conversations before, but reflecting on how different everyone is gave them an opening.

Diane is a learning disability practitioner:

I often work with people who are described as having 'challenging behaviours'. There was a particular young lady who staff found very difficult to engage due to a high level of self-injurious behaviours and aggression to others. It was impossible for her to sit and engage in formal assessment, therefore one day we sat and I let her paint my nails. It was through this activity that we connected. I was able to find out a lot about her communication strengths and needs through this informal interaction. It helped to build a trusting relationship that lead to effective long-term support.

Hardeep is a volunteer at a community-based service:

I volunteer as a befriender and became worried that one man I visited was going to have a fall as he had became really unsteady. At first, I suggested he see his GP but he was cross about that. He was quite irritable really, which was unusual. When we explored what really mattered to him, it turned out he had been sold some sort of life insurance plan and was very stressed about it. He couldn't really afford it and he was very worried about having to go into care because he would run out of money. He wasn't sleeping or eating properly and that was making him unwell. We agreed to seek further information and I supported him to access Citizen's Advice and they sorted it out for him. He was back to normal in no time, but it could have gone really badly if we had not worked out the cause of the problem.

Yvonne is a social worker at a London local authority:

I worked with a woman in her late-70s who had stopped going out and was becoming increasingly isolated. Through person-centred conversations I realised the woman was having her hair washed by a carer, but the carer was not able to set her hair in the way that she liked and was used to. She felt this to be a very visible sign that she was unable to cope, which was the reason she had stopped going out. We talked about her care plan and agreed that it could be changed so the woman would have her hair washed and set at the local salon instead. Going to the salon restored the woman's dignity, which enabled her to once again become active in her community. It even had the additional benefit of being a very social activity in its own right.

Jackie is supporting her elderly parents to navigate health and care services:

My 83 year old mum was admitted to hospital and had been diagnosed with bowel cancer. My dad had recently been diagnosed with Parkinson's and was not coping well at home himself. The morning I arrived on the ward I found that dad had turned away the home care service when they arrived at his house and cancelled the care package. This was the last straw for me as we had worked weeks to secure the service and I knew that dad could not cope with caring for mum on his own. The hospital social worker found me in tears, took me into his office, gave me a cup of tea and listened whilst I ranted about how angry I was with my dad! After a while he said "your dad has lost a lot recently hasn't he? ….He has lost his health, his youth, his driving licence and his independence to name a few. Maybe the only control he feels he has left, is over who does and does not come into his house". This, for the first time made me see dad as a person rather than a problem. This shift in thinking allowed us to agree a plan that really took into account the wishes and needs of both mum and dad.

Step 2.
Conversations to enable and support people

Overview

This step focuses on supporting people, their carers and networks of support to reflect and build on their knowledge, confidence and skills to take control of their care, health and wellbeing. That might be through sharing expertise, preferences and decisions. This can be achieved through more in-depth conversations and changing the way services and systems support people.

In Step 2, the specific skills of Step 1 are further developed, in a way that is meaningful to the person's needs and workforce setting, and may involve use of models and techniques such as self-management support, shared-decision making and health coaching.

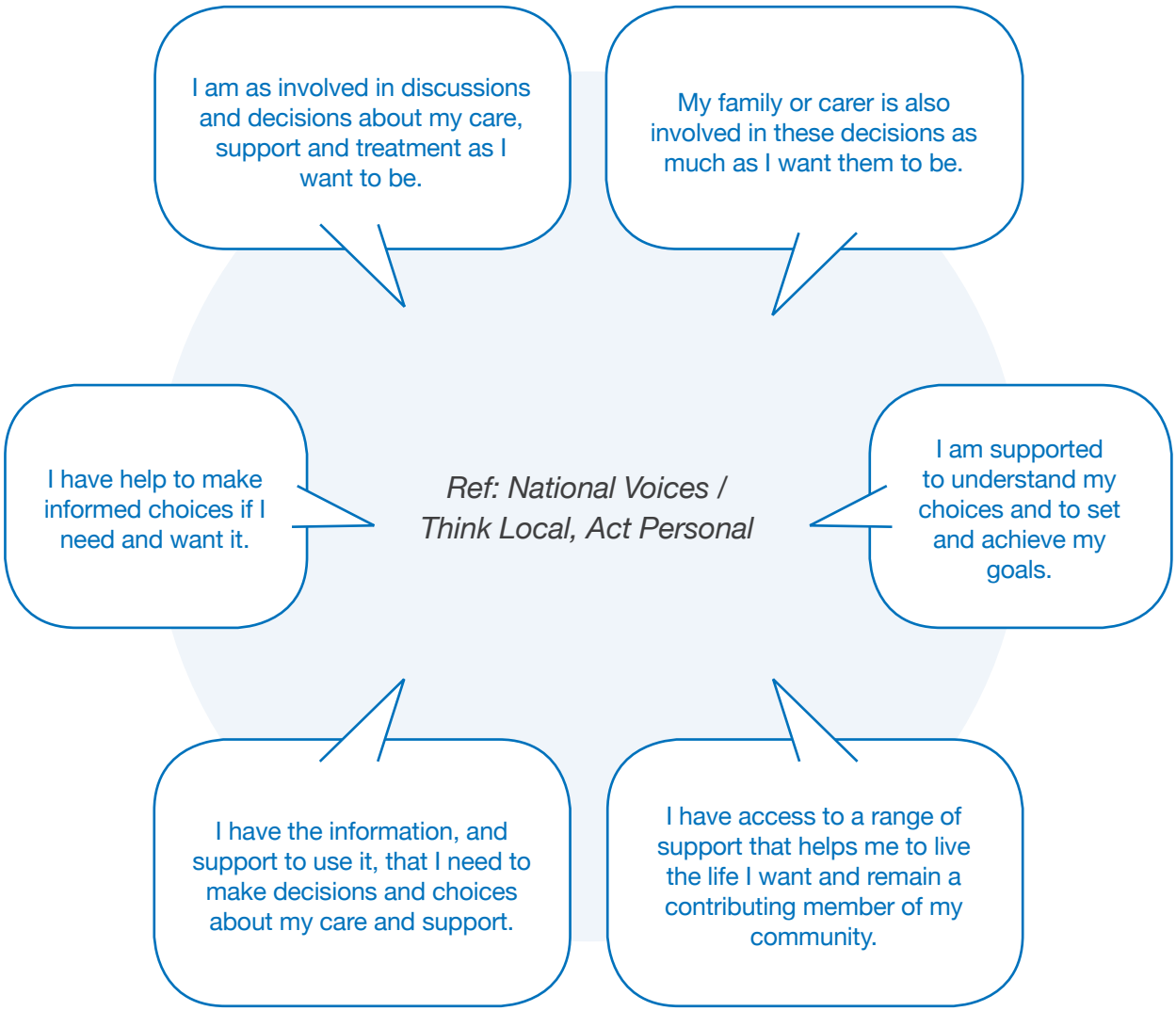
The skills in Step 2 enable coproduced agenda setting, agreeing priorities and anticipated outcomes, along with assessment and exploration of the person's current knowledge, skills and confidence around their health, care and wellbeing (their activation). It is important to be able to explore and understand these factors and the persons' starting point to offer support that is timely, appropriate and accounts for progress and setbacks the person might experience.

Then, decisions can be agreed collaboratively about care, treatments or choices in the context of people's lives, using appropriate information and acknowledging the preferences of all involved in the decision[12].

People can be supported to help translate their intention into action using evidence-based models such as action planning and goal setting, as well as identifying sources of support. The conversation may extend to a follow-up, to revisit and problem-solve any challenges that have arisen.

In addition to the use of the skills in Step 2 to enable and support people to be active partners in their own health and care, we can also use these skills of coproduction to create the foundation for broader engagement and involvement in development of services and quality improvement. This might mean seeking meaningful feedback from people using services, relatives, carers and communities beyond traditional satisfaction questionnaires and service delivery data. Evidence based models can be helpful to underpin these approaches, such as experience based co-design[13] and appreciative enquiry.
This is essential to ensure wider service and process changes can be made to facilitate the interactions and conversations detailed below.

12. NICE Shared Decision Making 13. Experience Based Co-Design, Kings Fund


I am as involved in discussions and decisions about my care, support and treatment as I want to be.
My family or carer is also involved in these decisions as much as I want them to be.
I have help to make informed choices if I need and want it.
Ref: National Voices / Think Local, Act Personal
I am supported to understand my choices and to set and achieve my goals.
I have the information, and support to use it, that I need to make decisions and choices about my care and support.
I have access to a range of support that helps me to live the life I want and remain a contributing member of my community.

Step 2: Behaviours

What is it that people and their carers would see?

1) Giving me the opportunity to work collaboratively with you to agree what we will talk about together
2) Working sensitively with me - whether I'm unsure, or feeling confident about what I can do
3) Supporting me to build on my ability and confidence to jointly solve problems around my health and wellbeing
4) Supporting me to understand what motivates me
5) Keeping a record of what care and support we have agreed that I need, which we review
6) Working in a coordinated way to support my continuity of care in partnership with different teams across organisations
7) Helping me to make the best decision for me in my life (about my health, wellbeing, care and support), by considering my options and using information I can understand
8) Helping me find out about other information or support that is meaningful to me
9) Helping me to find ways to access things I can do within my local community to support my wellbeing
10) Helping me to take positive steps towards achieving my goals and identifying how I can share them and review my progress
11) Supporting me to be more resilient and cope with set backs
12) Giving me and my carers the opportunity to tell you about our experiences of using your services and involving us in quality improvement

What is it not?

1) Ignoring my perspective and telling me what I will do
2) Using unnecessary technical language and jargon that I don't understand
3) Setting me things to do which I don't feel confident or able to do
4) Telling me the decision that you think is best for me, without considering my own goals, options and priorities.
5) Working in silos so I have to repeat myself to different teams
6) You 'fixing' me
7) Only collecting information about clinical/system outcomes and improving services based on these and a professionals' perspective
8) Judging me on the information I have shared
9) Ignoring someone who is speaking on my behalf when I'm unable to express my wishes
10) Not noticing when a formal advocate might be appropriate

Step 2: Learning Outcomes

What are the expected outcomes from effective person-centred workforce development?

Step 1 learning outcomes, plus the following

The learner will be aware of:

a) Key relevant and current policies around person-centred approaches

b) The different levels of prevention (primary, secondary and tertiary)[14]

c) The range of specific person-centred tools

d) The implications of case law and NICE guidance for consent and shared decision making

Know:

e) About models for patient activation, health literacy, and the Accessible Information Standard

f) About the principles of behaviour change

g) About established health coaching tools and techniques

h) The impact that a range of social, economic, and environmental factors can have on outcomes for individuals, carers and their circles of support

Understand:

i) That each person is an expert in their own life, along with their carer

j) The importance of values, mindset and motivation

k) The detail of different person-centred activities[15] and the skills in the context of these

l) The value and importance of preparation before interactions or conversations

m) The potential value and importance of non-traditional locations and settings for interactions or conversations

n) The importance of measuring person-centred outcomes

Be able to:

o) Support people to make plans to develop habitual behaviours

p) Find out the individual's priorities and what outcomes are important to them

q) Support people to integrate their ideas, opinions and perspectives into the conversation

r) Gather information that is meaningful for the individuals and their carers

s) 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[16]

t) 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

14. Care Act (2014) 15. For example, care and support planning, health coaching, motivational interviewing, shared decision making and self-management support (see glossary of terms for further explanation) 16. BMJ 2015;350:h1796: Clarifying the Montgomery judgement

u) Support people to self-reflect and understand the relationships and connections between their emotions, feelings and behaviours

v) Assess individuals' levels of activation and health literacy, modify conversation accordingly and support people in a way that develops these two factors

w) Coproduce and negotiate a shared agenda with an individual

x) Facilitate shared decision making using appropriate tools from a range of resources such as Ask Three Questions[17] and Patient Decision Aids (PDAs)[18]

y) Use action planning and goal setting models – including breaking goals into achievable chunks and identifying opportunities for follow up

z) Confidently support positive risk taking

aa) Recognise and sensitively explore ambivalence

bb) Coproduce care and support plans to meet current and future needs[19]

cc) Support individuals to identify and access support networks of family, carers and communities[20]

dd) Work in a coordinated and collaborative way with service users, circles of support, communities and organisations

ee) Signpost appropriately and effectively to information and support – including support that can help with use of technologies that meet needs and preferences

ff) Identify when formal advocacy might be appropriate and how to access advocacy services

gg) Be responsive to individuals' communication and information needs and support the use of accessible information where appropriate

hh) Use peoples feedback and person-centred outcomes to coproduce improvements in services with those who use them

ii) Identify opportunities to improve services and processes, and basic tools to facilitate improvement e.g. Plan, Do, Study, Act (PDSA)

NB. These are the common core learning outcomes which are applicable in all settings. Additional content will be required for some roles and contexts.

17. The Health Foundation: Ask three questions 18. NHS England: Right Care Shared Decision Making Programme
19. Year of Care Partnerships: Care and support planning – the process 20. GENIE tool (Southampton, Anne Kennedy)

Examples in practice:

Clare is a speech and language therapist working in the community:

I was working with a lady who had a brain tumour – she was gradually losing the ability to speak. Rather than introducing a standard communication chart we had a courageous conversation about the messages that would be important to her as her cancer progressed. These messages weren't about pain management or activities of daily living (as reflected on the standard chart); she wanted to be able to say thank you to her husband for looking after her and tell him that she loved him.

Together we designed a communication chart that was meaningful and grounded in her wishes and preferences.

Jane is a practice nurse in a local surgery

The health care assistant had asked me to see a young lady as her home blood pressures (BP) had come back borderline (but normal). We discussed the BP and as part of this I asked about lifestyle - and indeed she smoked a lot. I was tempted to give her a lecture, but stopped and decided to take a motivational approach. I asked her how important stopping smoking was to her. She graded it 5/10.

I took a step back and we talked about what was important to her. She had a lot of stresses at home (her husband had just been diagnosed as bipolar) and the smoking helped this. We explored further and then decided together that it wasn't the right time to talk about stopping smoking. Instead, she said she would find a plan to manage her stress more helpful.

Simon is a medical specialist in a hospital:

I was referred a man who had an enlarged prostate that was causing him some troubling symptoms. At the beginning of our conversation he said he was very keen to 'get rid of it' as he had two friends with prostate cancer and he did not want to 'suffer' like them. After hearing about his thoughts I suggested that we went through the various option available to him. After discussing the pros and cons of each option and what they meant to him he actually decided that he would rather watch and wait as the potential risks of surgery might mean a reduction in the quality of life in the areas that were important to him.

Julie is a health coach:

A particular lady was a regular attender at the GP Practice. Her father lives with dementia and she was desperate for carer support. Listening to her, it became clear that she felt lonely & isolated – we agreed goals for her to meet new friends. I supported her to join a local support group and a healthy walking group and she now volunteers with the local dementia group 'memory lane'. After building a relationship, she revealed she couldn't read so we agreed a referral to 'Easy Read'. She recently described being able to read as 'life changing' and has set new goals to lose weight and set up her own support group for middle aged people to share days out.

This lady is now usually smiling, grown in confidence and has improved her relationship with her father.

Denise is a health and wellbeing officer at a social prescribing service:

I worked with a woman in her 70s who had asthma, diabetes and depression and had been to see her GP ten times in three months. She was struggling to cope and was very anxious she would have to go into care and would be separated from her dog. I worked with her to manage her piles of paperwork and connected her with a money advice service who found she wasn't claiming everything she was entitled to. I also linked her with a physiotherapist and OT who helped her to adapt her home and find safer ways of using her bathroom and kitchen. All of this helped her to grow in confidence and now she goes to a knitting group and is socialising again. She now visits her GP much less frequently and hasn't been to see him at all in the last three months.

Sally is Alex's Mum:

When I was asked to create a support plan for my son I decided to match person-centred planning tools to each of the seven essential criteria. We used a "what is working and not working" to help us identify what we wanted to change and achieve, and then we focused heavily on my son's circle of support to contribute to answering all of the other criteria. By using his circle of support it manages and maintains his support evenly without the control resting on my shoulders. I recognise that as Alex's mum I may not always be the best person to make decisions for him. Getting the best life for Alex is of paramount importance and it is an onerous task. By forming a circle of support it spreads the responsibility and it ensures that Alex's best interests are kept at the focus of everything.

Cally is managing her dialysis:

My renal unit were great! They had done some interesting thinking about how to develop a more centred approach to patient care for the people they were supporting on peritoneal dialysis. Apart from periodic monitoring by a doctor, patient care was primarily nurse led with a named nurse system.

Coming into hospital regularly could be a stressful experience for those of us who were managing our dialysis at home so the unit introduced home visits. What could take up a whole day for patients was reduced to an hourly visit once a month with a nurse who knew you well. My named nurse Wendy was fantastic. She was keen to know what was important to me. I was determined to manage my health problems rather than them manage me and apart from keeping up as a mum, wife and friend it was important to me that I continue to work. Wendy really got that and bent over backwards to adjust the way I dialysed so I could continue to travel with my work. I felt she saw me as a person and not just as a 'patient' with kidneys past their sell by date!

Audrey is supporting her son with his care and support plan:

The role of Care and Support planning in helping people with long term health conditions stay well and enjoy their life to the full is at the heart of person-centred care. In my family both my husband and I live with long term health issues but we don't need a formal 'Care and Support Plan' to manage our health, stay well and live full lives. However, our son with learning disabilities, who has very complex health needs, does have a formal 'Care And Support Plan', to make sure all aspects of his support join up and promote his well being. What is important to him is as important as what is important for him.

We use his social care Personal Budget to 'positively promote his wellbeing' (wellbeing as defined in the Care Act 2014). This includes attending a range of community-based groups where he dances, plays sports and gets peer support as part of an attempt to lose weight. All these activities actively support the better management of his health problems and have resulted in significantly better health outcomes than where previously hoped for. Not only that, he has a great network of friends and feels part of his community.

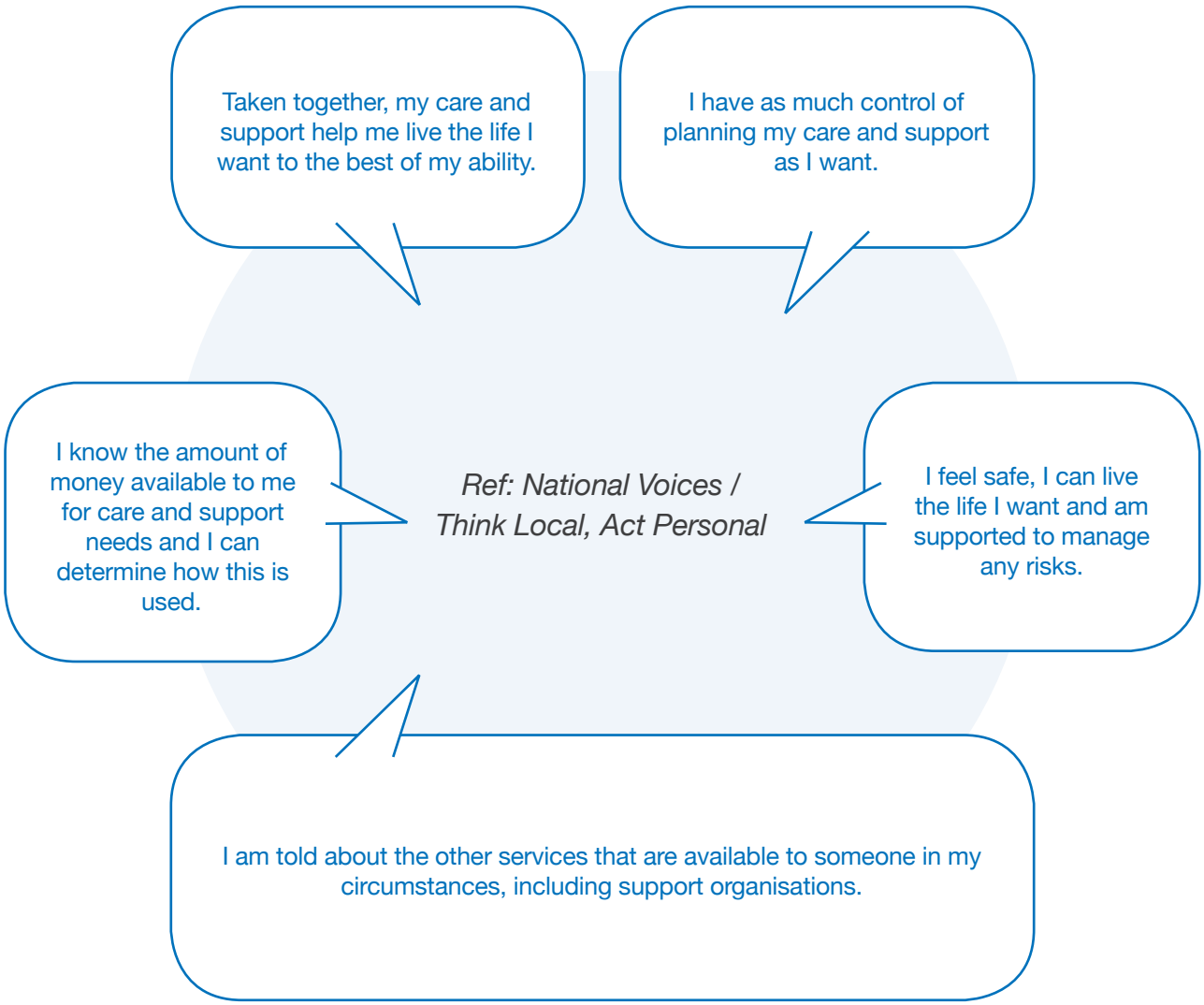
Step 3.
Conversations with people to collaboratively manage highest complexity and significant risk

Overview

Step 3 applies the content of Step 1 and 2 in situations when we are working with people who have the highest complex interplay between their physical and mental health and social circumstances. This is where decisions carry significant risk for individuals and there is likely to be tension between professional and personal preferences.

People with complex needs now make up a significant proportion of health, social care and local authority activity - and caseloads of the majority of the workforce. Building on steps 1 and 2, the skills, knowledge and behaviours within step 3 are concerned with when that complexity is at its greatest and most challenging. These interventions and interactions may be one off conversations with highly specialised practitioners, long-term packages of support and care, or advocacy support to navigate these. The issues of mental capacity (Mental Capacity and Deprivation of Liberties Safeguarding) may also add to the complexity and perception of competing agendas at this stage.

In order for person-centred approaches to work for people seamlessly, in these most complex of situations, service delivery must be integrated across networks of relevant organisations and commissioners.


Taken together, my care and support help me live the life I want to the best of my ability.
I have as much control of planning my care and support as I want.
I know the amount of money available to me for care and support needs and I can determine how this is used.
Ref: National Voices / Think Local, Act Personal
I feel safe, I can live the life I want and am supported to manage any risks.
I am told about the other services that are available to someone in my circumstances, including support organisations.

Step 3: Behaviours

What is it that people and their carers would see?

1) Helping me or my recognised representative balance my preferences and decisions with my highly complex medical and care needs, now and in the future
2) Helping me and my carer understand risk in the context of my life, and supporting me to understand and manage the consequences
3) Giving me, my family and carers the support we seek to identify and access services, information and resources in our community
4) Enabling me to access and use technologies to meet my needs and preferences
5) Helping me live with the complexity of the social, environmental and welfare aspects of my life
6) Discussing and helping me understand and navigate the complexity of funding my care and support using a budget
7) Negotiating with and coordinating other services in partnership with me, or on my behalf based on my preferences and care plan
8) Positively acknowledging my potential and desire to have meaning in my life

What is it not?

1) Not trusting me to have a role in decisions on complex issues
2) Seeing me as 'your client/patient' solely in the context of your service
3) Dismissing my need to take positive risks
4) Looking at and solving my problems in isolation of the rest of my life

Step 3: Learning Outcomes

What are the expected outcomes from effective person-centred workforce development?

Step 1 and 2 learning outcomes, plus the following

The learner will be aware of:

a) The tension between supporting prevention/self-management, providing care in an acute context and enabling quality of life

b) Implications of support and care for other services and people who are involved with supporting that individual and their personal network

Know:

c) Principles of coproduction as applied to individual's complex situations, within organisations, intra-organisations and across sectors

Understand:

d) How care and support planning might incorporate the use of personal health budgets, individual budgets and direct payments

Be able to:

e) Work in a coordinating way with an individuals' family, carers, advocates and network of professionals

f) Support positive risk taking and shared decision making when there is significant complexity or severity relating to the situation or consequences

g) Coproduce care and support plans with people and carers who have complex contexts to their lives to facilitate positive changes to meet current and future needs

h) Support people to understand positive risk and shared decision making by exploring consequences of actions and not taking actions, including, when frame shifts from curative to palliative, and there is a clear negative risk

i) Confidently work with personal health budgets, individual budgets and direct payments

j) Negotiate and enable access to other services with individuals in complex situations

k) Support development of resilience and capacity in support networks or communities to provide or support sustainable resources

l) Identify opportunities to improve services and processes across organisations

m) Confidently work in this way in compliance with the Mental Capacity Act / Deprivation of Liberty Safeguards - relevant to the context of one's role

NB. These are the common core learning outcomes which are applicable in all settings. Additional content will be required for some roles and contexts.

Examples in practice:

John is a GP in an inner city surgery:

I am working with a lady in her early forties with depression/anxiety and substance misuse who is fuelling her partner's drug habits by street begging and daily calls to A&E/999.

Rather than criticising her behaviour, I am seeing her weekly in order to gain a degree of confidence before thinking how we might work with a mental health therapist. The therapist could then help her think how, in the first instance, she can be supported in managing her anxieties rather than calling out the emergency services. The mental health therapist would also work with her in exploring what would help boost her self-confidence and self-esteem and to facilitate access to a voluntary self-help group suitable for her circumstance.

Ramai is an anaesthetist working in hospital operating theatres:

We know most people get through surgery uneventfully, however for some undergoing surgery may be life changing or even life ending. I remember one gentleman was offered a knee replacement, but due to his other conditions the surgery had high risk of complications. We spent time speaking about what mattered to him, his values and preferences, and then about the risks and benefits if he underwent surgery. Giving him the time to think about his values, he said walking the dog was important to him as especially as he had recently lost his wife. He understood he was at high risk of complications after surgery but wanted to proceed. If he developed a complication, he did not want prolonged treatment or life support. To him, an active and independent lifestyle was most important to him.

Solent NHS has co-designed and co-produced learning resources:

One of the requirements of the Accessible Information Standard (NHS England, 2015) is for organisations to review the ability of their workforce to support people with communication and information needs and to implement the training and/or an awareness programme. Solent NHS Trust (a community and mental health trust) co-designed and co-produced an 'Accessible Information Awareness' film to educate healthcare staff across their organisation.

A number of focus groups were run with people living with communication and information needs to find out about their first-hand experiences. Key messages were then incorporated in the film which aimed to win the hearts and minds of staff across the Trust. One of the courageous patients agreed to share his story on camera. Keith who suffered a stroke in his 40s, highlighted what it is like to acquire communication needs later in life and gave a number of simple suggestions about how staff can help. Keith also took an active role in reviewing early cuts of the film during the editing process.

There is open access to the film on the Trust website and it is now used by a number of organisations nationally. Not only has it been valuable tool in raising awareness locally, but it has also acted as a catalyst for a range of quality improvement initiatives and innovations related to accessible information."

Katie is managing her long-term conditions:

I have a number of long-term conditions, one of which is Addison's disease. The way I work with health professionals changed for me following a very bewildering and frightening visit to A&E where, because staff didn't know about my complicated health conditions, assumptions were made during the triage process which led to treatment being delayed and consequently my life was in danger.

After this visit to A&E my carer and I decided that we wanted to work with professionals to help them understand about me as a whole person and what matters to me, so we spoke to someone from the Patient Advice and Liaison Service (PALS) who worked with us and the A&E consultant to generate a care plan for any future A&E visits. My carer and I both have a paper and electronic copy of the plan, which is also on the A&E computers so it is instantly accessible to A&E staff, which means my Addison's can be dealt with without delay.

My clear and straightforward care plan has been welcomed by ambulance crews and A&E staff as they can provide me with the high level of care they strive for. I now benefit from having much better relationships and interactions with the medical professionals who care for me. I feel like we are equals in my care and we work as a team.

Delivery of training, education and learning opportunities

The 3 steps described above outline the desired learning outcomes which will guide the content of education, training and follow-up. The method of education and delivery of training is not prescribed and will need to be tailored to local needs.

Importantly, this is more than just education. Person-centered approaches require a significant behaviour change for workforces. Achieving successful implementation across whole organisations requires clear and strong leadership, together with systems and process that support this way of working.

Essential additional underpinning principles are described below.

Behaviour change

To achieve and sustain positive impact for workforces who are adapting and/or adopting new ways of working, recent research[21] suggests that taking a behavioural approach (including capability, opportunity and motivation) to supporting people is more successful than isolated training.

Development of capability must simultaneously be supported with the right processes, system and opportunity together with locally relevant incentives, which build those intrinsic and extrinsic motivations.

The principles of behaviour change are essential to understand, whatever methodology is used to deliver the training or education. There are factors that can impact the ability of staff to learn and their motivation and confidence to implement new skills and behaviours. These include psychological, social, economic and cultural factors within their lives and working environment.

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

Figure:
Michie et al. Implementation Science 2011, 6:42

Ref:
The behaviour change wheel: A new method for characterising and designing behaviour change (23 April 2011)

21. Realising the Value (2016). Supporting self-management

Co-producing training

The active involvement of people and carers with experience of using services and managing health conditions is central to effective training on person-centred approaches[22].

Sessions should be co-designed to model person-centred approaches and to meet learning outcomes.

As well as articulating the experiences and perspectives of people using services, co-production demonstrates the wider positive strengths, contributions and impact that they can make.

Individuals may contribute by sharing their story (either in person, or through a medium such as video or podcast) while others may wish to actively co-deliver theory and techniques as much as possible.

There are valid steps along the way to achieving co-production, such as engagement, involvement, participation and consultation[23].

When developing models for co-delivery, it is important that these include:

- Robust mechanisms for feedback
- HR process including development and support
- Remuneration
- Boundaries between dual roles of patient and educator, collaborator and service provider

Reflective practice

To develop person-centred behaviours and approaches, it is important for individuals to take time to think about what they are doing and how they are doing things and the impact this has on other people. This draws on an individual's experiences, knowledge, values and feedback (and evidence where appropriate) to analyse and identify opportunities to change their thoughts and behaviours[23].

Examples of how this might be achieved include:

- keeping a diary
- talking to peers,
- focusing on specific events,
- informal or formal mentoring[24]
- local role specific activities such as Schwatrz rounds
- listening and acting on feedback from people who have used service and their carers

22. "It is important to recognize that how people train is as important as what is taught. Education should include training that is co-designed and co-delivered by people with lived experience, in community settings" (Realising the Value 2016, pg 34)
23. OpenLearn: Health Sports & Psychology/Bringing your learning together in reflective practice 24. Chartered Society of Physiotherapy: Keeping a CPD portfolio

Continuous Improvement

Continuous improvement is a principle that runs through everything we do. Embedding person-centered care will require improvements in how some services are designed, delivered and reviewed. The opportunities for improvement need to be identified, developed and evaluated in partnership with people who deliver and use those services[25].

A continuous feedback loop is an essential component of this.

Training and development for person-centred approaches can be a component of quality improvement projects, and the principle of quality improvement should be included in training to enable staff to drive this agenda.

Values-based approaches to workforce recruitment and development

The foundation for a strong person-centred workforce begins with attracting, recruiting and developing individuals who embody the values as described at the start of this document[26]. It is important that the organisation commits to:

- ongoing support to build the person-centred skills, behaviours and motivations of its workforce
- continually seek feedback and involvement from people who use services for ongoing improvement
- supporting staff with these approaches in the context of professional revalidation

Examples of how this might be achieved include induction programmes, mandatory training, appraisals, local initiatives, campaigns, networks and opportunities for ongoing development.

Methods for delivering training

All members of the workforce need to be trained in the core relationship building and communication skills. It is important to stratify the workforce to identify those for whom the following steps are appropriate.

At each step, the mindsets of behaviour change (e.g. COMB[27]), coproduction, continuous improvement, values based approaches to workforce development and reflective practice, should be all considered.

All steps should be grounded in real life examples and complexity to experience the importance and impact of these conversations.

25. Health Quality Improvement Partnership: Social care and quality improvement and NHS Improvement: Quality improvement
26. Health Education England: Values based recruitment and Skills for Care: Finding and keeping workers
27. Michie S, Atkins L & West R (2014), The Behaviour Change Wheel: A Guide to Designing Interventions, Silverback Publishing

Delivering Step 1

The baseline nature of Step 1 means that it is important to make the training available, appropriate and accessible to the majority of the workforce. This includes clinical, non-clinical, qualified and non-qualified, and those who might not traditionally be offered training opportunities.

At Step 1, training might focus on scalable blended approaches such as e-learning and interactive exercises to experience using these skills. Workforce development and reflective practice can support follow-up for these individuals.

Delivering Step 2

Step 2 covers many of the key activities of person-centred approaches and should be considered the level at which the majority of staff who have more focused conversations with people should be trained.

Training at this level would be using blended approaches of real-life examples, face to face experiential learning, with integrated follow-up and ongoing learning through, for example, team action learning sets and mentoring.

Experiential learning tools such as role-play should enable people to experience the conversation from both perspectives. This would use their own personal real-life scenarios, to experience the personal impact, and workplace scenarios, to experience what its like applying the skills in role.

The greater scope and intensity of the content at this point means practice and coaching approaches are important.

Delivering Step 3

Training, education and learning opportunities in Step 3 focuses on supporting people delivering services to feel confident in applying the person-centred skills in highly complex situations with significant risk. Training at this level takes into account the broader system, might be delivered across organisations, and make use of opportunities beyond formal learning environments.

Trudi is a health coaching trainer:

"I am continually moved by the willingness of clinicians to reflect on their clinical practice, identify opportunities to improve their communication skills and to try something new all for the benefit of their patients. This is irrespective of where they are in their career from students to those with many years of experience. I recall one nurse whose feedback at the end of the course was: "I have been qualified for 40 years – I thought there was nothing else to learn. But this changes everything." A humbling moment for me as a Health Coaching trainer."

Implementation

There are a range of challenges to implementing effective training and development programmes. Some key factors to consider, with suggested practical tips and evidence for overcoming operational challenges and supporting workforces through the behaviour change are presented in the table below.

Factors to consider	Learning and evidence
Effective leadership to enable person-centred care beyond isolated services or small patches of good practice	Small pockets of change are possible but for successful up-scaling across organisations, having key leaders actively engaged is critical. These leaders might be clinical, non-clinical, local or national. Part of the leader's role might involve: • Aligning organisational values to person-centred approaches, making it a priority. • Giving 'permission' and resources to workforces. • Demonstrating that the organisation values workforces that work in this way. • Motivating workforces to work in this way. • Modelling the values and behaviours of person-centred approaches. • Holding the system to account with meaningful outcomes.
Making person-centred approaches important and relevant to the workforce	• Acknowledging individuals' own lived experiences of using services themselves or supporting close family or friends. • Sharing evidence of positive impact for people who use services. • Using stories to demonstrate its importance and relevance (including local, national, professional and pathway-specific examples). • Showing how these approaches can support workforces with the challenges they identify in their roles and settings. • Demonstrating how this way of working contributes to codes of conduct, revalidation, appraisal and continual professional development. A useful framework for considering this is the Easy, Attractive, Social and Timely (EAST) model[28].

28. Realising the Value (2016), Supporting self-management

Factors to consider	Learning and evidence
Deciding who to train/ develop	• Core skills and basic application of values and behaviours are important for the whole workforce and whole teams. • Start with those who have the most opportunity to use the skills in their role. • Work with pathways where people who use services and their support networks have the greatest opportunity to benefit, and reallocating resources to enable this if needed. • Stratify your workforce when deciding which teams and groups to develop further with extended and specific skills (such as shared decision-making or health coaching). • Train whole teams together for the best outcomes. • For those developing further skills, start with individuals, teams and pathways who self-select, this gives the greatest opportunity for sustainable and embedded change.
Deciding who to develop as trainers and educators?	Successful trainers and educators should have: • Content knowledge and expertise. • Facilitation and training skills. • Their own experience of using the skills that they can draw on, to maximize peer-to-peer influence[29]. • Local credibility and respect. • Ability to sustain the training over time. • Time to commit to training delivery and development[30].
How best to enable staff to access to training and development?	• Using existing opportunities such as pre-timetabled sessions, protected learning times and continual professional development. • Making training locations convenient and conducive. • Offering flexible timings, in terms of length of training and time of day, to accommodate staff routines. • When training whole teams at the same time is not possible, consider part-team approaches, and/or training jointly with other relevant teams/services to maintain duty cover[31]. • Using these ways of working within team meetings and day-to-day working routines to embed learning and follow-up[32]. • Using commissioning as a lever to facilitate staff training[33]. • Making training mandatory[34]. • Weave through all training within the organisation to reinforce these skills.

29. Page 12 Ideas into Action: person-centred care in practice HF Oct 2014 30. University of Southampton (2015): Wessex Making Every Contact Count (MECC) Pilot, Evaluation Report 31. University of Southampton (2015): Wessex Making Every Contact Count (MECC) Pilot, Evaluation Report
32. The Health Foundation (2013): Sustaining and spreading self-management support 33. University of Southampton (2015): Wessex Making Every Contact Count (MECC) Pilot, Evaluation Report 34. University of Southampton (2015): Wessex Making Every Contact Count (MECC) Pilot, Evaluation Report

Factors to consider	Learning and evidence
Workforce health literacy levels	• Ensure sessions account for the range of different individual levels of health literacy within the workforce • Through the sessions, support individuals with the opportunity to reflect on how they might develop and increase their own health literacy
Making training timely and impactful	• Divide the training in to chunks with time to practice between and bring experiences back to subsequent sessions. For steps 2 and 3, total contact time is likely to be equivalent to approximately two days. • Consider what preparation is appropriate for organisations to do before offering training. • Consider what preparation is appropriate for participants to do before attending training. • Ongoing support and follow-up is essential for application of learning and continued development. This may be through formal or informal mechanisms. • Include examples of quality improvement tools[35] to enable staff to make improvements that allow them to work in person-centred ways
Getting middle managers on board	• All managers need to hear about the benefits and how these interventions link with wider strategic priorities to establish shared understanding and motivation[36] • Active support from senior leaders • Acknowledge the associated behaviour change this requires of them and their teams, and supporting them to manage this • Enable them to establish a sense of local ownership[37] • Effective regular communication and briefings to confirm understanding and address concerns[38] • Encourage them to participate in ongoing training and development and involve them in the design and evaluation of training[39]
Permitting time for e-learning activities	The organisation needs to understand and decide when staff will do e-learning and how they will access it. This might be within work time or outside, and using internal or external devices.

35. NHS Improvement: Better healthcare, transformed care delivery and sustainable finances 36. The Health Foundation: Ideas into action: person-centred care in practice (page 9) 37. The Health Foundation: Ideas into action: person-centred care in practice (page 10) 38. University of Southampton (2015): Wessex Making Every Contact Count (MECC) Pilot, Evaluation Report 39. University of Southampton (2015): Wessex Making Every Contact Count (MECC) Pilot, Evaluation Report

Factors to consider	Learning and evidence
What is the best environment for training?	• Use room layouts that facilitate interactive and experiential working. • Consider the benefits of learning new skills away from workplace to provide team-building opportunities. • Consider the convenience of training on site in terms of travel times. • Structure rooms and session to minimise impact of team hierarchy. • Match the experience of facilitators to the needs and experience of the group. • Ensure the physical environment is safe and accessible for all including lay tutor. • Ensure the process delivers a positive experience for the lay co-facilitator, before, during and after sessions.
Overcoming further barriers for professional engagement	Common barriers may include preconceptions about roles, "we are already doing this", concerns about risk and lack of knowledge of wider support services. Strategies to overcome these include: • Give people the opportunity to explore their professional identify. • Acknowledge existing strengths and assets. • Explore challenges and develop learner-led agenda. • Use interactive and experiential learning in order for the individual to experience the impact of this way of working ('light-bulb moment'). • Focus on "how can we help you do it better?" • Mitigate concerns by sharing stories and evidence from peers. • Signpost to voluntary organisations as a single point of access[40]. • Allow for those learning new skills to develop quickly and those changing behaviours might need more time and support. • Make sure all team members give permission not barriers for these approaches.

40. The Health Foundation: Ideas into action: person-centred care in practice (page 9)

Factors to consider	Learning and evidence
How to upscale training and facilitation	• Establish the right model, such as train the trainer programmes across organisations, develop capability and capacity in teams and pathways or commission external providers. • Consider external experts to kick-start with local people to continue the programme. • Establish where ownership for these programmes sit within the organisation. • Decide if an intensive course or action learning approach within the role, or a combination of the above is most appropriate to train facilitators. • Plan how to release staff to deliver training. • Ensure a sufficient pool of trainers to mitigate for service pressures, leave and turn-over. • Quality assure around a core set of values, principles and content. • Provide networks for ongoing support and development for trainers/facilitators.
How to evaluate training	• Understand the right outcomes to measure that are meaningful. • Measure quality, self-reported longitudinal reflections. • Measure application and impact for service users. • Include a combination of person, workforce and system-centric measures.

‘Enablers’ for embedding a person-centred approach

The following section is about the system and organisations as the ‘enablers’ which provide Opportunity and Motivation for behaviour change.

Each of the enablers described below aims to highlight why a person-centred approach is important for a different audience and provides a number of ‘challenge questions’ to encourage reflection on the extent to which person-centred approaches are understood, being adopted and how such approaches could be further embedded, utilising the behavioural change approach. The roles of people using services and communities are also important enablers. These people and groups can fulfil any of the roles that are listed below, as well as influence directly in their own right[41].

The lists of challenge questions are not exhaustive, but are offered here as indicative examples to prompt further reflection.

You may wish to select and review the enabler/s which best describe you and your role.

Enablers

- System leaders
- Leaders and managers in organisations
- Human resources and organisational development
- Commissioners of services
- Commissioners of education and training
- Education and training providers
- The wider system e.g. Regulators, Royal Colleges, Professional Bodies

It is also crucial to consider how impact is measured, ensuring that outcome measures take account of what matters to service users at individual, community and population levels in addition to clinical, service and efficiency measures[42]. This should form part of continuous quality improvement programmes.

The implementation of a person-centred approach will have further implications for workforce planning/ service design. However, the competences specific to the practice of workforce planning and design are beyond the scope of this framework.

Imagine if we were able to harness the breadth of prevention opportunity of the estimated 300 million contacts each year between people and professionals in the NHS alone (Kings Fund 2015) - a fraction of our wider shared opportunity.

41. Realising the Value, Spreading Change 42. Measuring what really matters Helping measure person-centred care

System leaders

This is for you if you are …

Providing national and/or system leadership, perhaps as part of sustainability and transformation planning teams or at a local level working to deliver improvements in health and wellbeing for defined populations.

What's in it for me?

- Achieving better engagement of people, communities and staff with health and wellbeing and the ambitions of prevention[43]. Ensuring that services support people to make positive changes, which evidence shows leads to better outcomes and reduces demands on health, care and support systems[44].
- Investing in our people, to recruit, retain and support resilience of our wide workforce including carers and community assets.

Indicative challenge questions:

- How am I working in equal partnership with people who use services and their carers in my role, sharing choice, control and strategic decisions together?
- How does my leadership pay attention to, clearly communicate and acknowledge the importance and value of a person-centred and community focussed approach and the fact that this is everyone's responsibility? Have we set actions and clear goals to move us towards our shared vision?
- How am I leading the system to be person-centred and community focused? Do I role model this approach and make it the easy and right thing to do?
- How do I communicate to others the impact of being person-centred in how we work with people in the context of their communities both within the populations we serve and the people and staff who work for or with us? E.g. for building engagement and resilience.
- How do I articulate the broad prevention agenda and ensure it is central to everything we do?
- How are we able to measure and evaluate what matters to people in order to drive improvement, evidence impact and support meaningful development of these approaches?
- How are we building workforce capacity and capability and committing time and resources to work in this way across our system?
- Are we giving the system permission to improve and co-produce pathways to work in this way? Are we promoting and rewarding this improvement using system levers?
- How are we coordinating efforts across the system to enable access to timely support e.g. accessible health information, health literacy, activation levels, navigation services and other interventions?
- How am I ensuring that the system looks broadly at its strengths e.g. libraries, leisure centres etc and enables people and communities to have more involvement in and control over decisions that affect them?

43. Prevention at primary, secondary and tertiary levels – see glossary of terms
44. Realising the Value (2016): Ten key actions to put people and communities at the heart of health and wellbeing

Leaders and managers in organisations

This is for you if you are…

A leader or manager responsible for delivering services. For example, you may be a care home manager, health sector or local authority manager, housing lead, divisional director, practice manager, manager in a private company or the voluntary sector.

What's in it for me?

- A clear response to the voices of people using services and better outcomes for people who access services by focussing on what matters to people.
- Ensuring that investment in staff training supports sustainable behaviour change and improvement in services.
- Helping to use resources in more sustainable ways, supporting the mismatch between available resources and demand for services.
- Building collective responsibility and improved staff engagement, resilience, motivation and retention through a more facilitative and integrated way of working.

Indicative challenge questions:

- How do we coproduce a shared vision in equal partnership with those who use services and those who deliver services to enable a person-centred way of working - and are we clear what it will feel like for those providing and receiving services when we are achieving it, so we can we agree specific actions and clear goals?
- How does my leadership role model and clearly communicate the value of a person-centred and community focussed approach and the fact that this is everyone's responsibility?
- Do I see myself, our service, staff team, connected services, those who access services and their carers as resourceful and capable of embracing this transformation, and do we see the benefits to be greater than the efforts to achieve it?
- How can we build on existing assets/resources to develop a person-centred approach?
- Have I understood the skills needs of my teams and met these needs appropriately? Have I put in place support for their personal behaviour change and ongoing developmental needs?
- How am I enabling the service to develop, learn and embed these skills together, across sectors, to build shared purpose? How am I engaging people within this?
- How do I foster a culture in my service which values, promotes, motivates and helps sustain a person-centred and community focused approach?
- How do I give permission and create the environment that makes person-centred approaches the habitual way the system and people work.
- How do key staff and teams work together to coordinate people's involvement in their support and care?
- How do we as an organisation communicate the ambition to work in partnership with people to improve wellbeing and resilience?
- How do I engage effectively with representatives of those using services?

Human resources and organisational development

This is for you if you are…

Responsible for human resources, leadership development and/or organisational development in an organisation. For example, you may be a human resources or organisational development, leader, manager or director.

What's in it for me?

- Improved staff engagement, resilience and motivation, helping with recruitment and retention.
- Ensuring that the workforce have the skills, abilities, confidence and attitudes needed to deliver services relevant to sustainable health and care now and in the future.
- Improving the capacity and skills of the workforce to assist people and themselves to make positive behaviour changes to improve their own health and wellbeing within the workplace and into the community.

Indicative challenge questions:

- How am I working in equal partnership with people and their carers to share decision making and power in this area of work e.g. how do we create opportunities for those using and delivering services in the co-design and co-delivery of services?
- How can I be sure that managers at all levels are clear about the importance of a person-centred approach both in how they role model and manage/support their workforce and volunteers in a person-centred way?
- How do I ensure that staff are trained to meet the learning outcomes set out in this framework and offer staff adequate time to practice and continue their learning?
- How do I recruit people with the mindset, values and attitudes for a person-centred and community focussed approach?
- How is person-centred and community focussed practice recognised, encouraged and supported through our supervision, action learning, service improvement, appraisal or revalidation processes as a developmental opportunity?
- How can we build on existing assets/resources to develop a person-centred approach?
- How do we ensure that our organisational culture – 'the way we do things around here' – reflects person-centred and community focussed approaches?
- How does the organisation support staff to positively and proactively manage risk to support this approach?
- How does our organisational development/training strategy emphasise the skills needed for quality improvement and co-production?
- How are staff given the opportunity and kept motivated to change and sustain behaviour until the new way of working becomes the default and habitual?
- How are we using a person-centred approach to develop healthy workplaces, improve workforce health literacy and improve staff to staff conversations?

Commissioners of services

This is for you if you are…

Commissioning services at local, regional or national level - for example working for a Clinical Commissioning Group (CCG), a local authority, health and wellbeing board, or NHS England.

What's in it for me?

- Ensuring that the contacts across health, social care, local authorities, blue light services and beyond support people to change behaviours, enabling better engagement with health and wellbeing, better outcomes and reduced demand on health, care and support systems.
- Minimising the costs (financial and personal) of preventable illnesses and dependency, inappropriate admissions and prescribed medication.
- Encouraging innovation to meet local and national targets around the different activities within the public health, long term conditions and integration agendas.
- Creating collaborative and mutually beneficial relationships with and between communities and service providers.

Indicative challenge questions:

- How do we develop a people and community-focussed vision within our system to enable a radical upgrade in engaging people in their health and wellbeing?
- How do I enable our system, workforce and population to understand the benefits to people's lives, outcomes and demand that are possible by supporting people to better participate in prevention, managing their own health and wellbeing within their community?
- How am I engaging people to develop, learn and embed these skills together, across sectors, to build shared purpose and a common way of working across teams and reduce boundaries?
- How am I leading, role modelling and building the skills and mechanisms to support genuine coproduction of services with people and communities?
- How do we commission to support and encourage person-centred and community focussed approaches? E.g. do contracts motivate, incentivise, and measure outcomes to meaningfully drive change? Do we train people in the concept of community development?
- How can I commission services in ways which create the environment for person-centred and community focussed approaches to be the system default and the right thing to do, enabling this to become the habitual way the system and people work?
- How are we coordinating efforts across the system to enable access to timely support e.g. carer identification, accessible health information, health literacy, activation levels, navigation services and other interventions?
- How can I enable collaboration between agencies and organisations such as local government, voluntary sector, health and housing organisations to improve the coordination of support through developing person-centred ways of working together?
- How could we better use technology to engage and support people and communities?
- How could I better commission for measurement and evaluation of real outcomes for people and communities, not just that which is easy to measure?
- Do I state in my service specifications that staff should be trained and supported in behavioural change to the relevant learning outcomes described in this framework?

Commissioners of education and training

This is for you if you are …

Commissioning education or training at local, regional or national level - perhaps working for an organisation such as a Clinical Commissioning Group (CCG), local authority, NHS Trust, CCG/GP federation, care organisation or implementing a Sustainability and Transformation Plan.

What's in it for me?

- Developing a future workforce with the skills, knowledge, behaviours and habits that will be needed by employers to transform services.
- Increasing workforce confidence to translate intention and knowledge into action and use evidence-based skills, models and approaches to achieve behavioural change.
- The opportunity over time to have national virtual learning to reduce duplication, enabling employers to focus on the effective delivery of the experiential training.

Indicative challenge questions:

- How do I commission training which is part of an organisational strategic approach? Am I commissioning providers to tailor interventions to the contextual needs of the services and ensure effective experiential learning?
- How will I use this framework to stratify the learning needs of the workforce and ensure that education and training commissioned has evidence-based content and methods of delivery?
- How do I ensure education and training commissioned is itself person-centred e.g. considers training participants' characteristics, abilities, health literacy and experience?
- How am I engaging with and involving people and carers, in the development and delivery of training interventions and strategies?
- How do I enable teams to train together, across settings and professions to build shared purpose, share language and relationships
- How do we best use peer to peer learning and ongoing support alongside supervision, appraisal or action learning to support and sustain behavioural change?
- How do we recognise the culture within the environment of work and the established 'norms' (the 'hidden curricula') which may prevent these skills being put in to practice - if there are issues, how are we responding to these?
- How do we weave quality improvement training through the interventions to empower people to take more control - and reducing the 'hassle factors' for people?
- How do I ensure that training is evaluated in terms of sustained outcomes (e.g. changes in knowledge and behaviour over time) and impact for people who access service?
- Do I engage with education providers (and for National commissioners – professional bodies/ Royal Colleges), to ensure that a person- and community-centred approach is embedded in their curricula and standards?
- How do I commission training to be reflective of the local services and needs of people who may be marginalised or hard to reach, or with specific needs? Everyone deserves good conversations and these may be further developed and extended in more specific contexts e.g. end of life care and personalised commissioning.

Education and training providers

This is for you if you are:

A provider and/or developer of education or training - perhaps a trainer, lecturer, subject matter expert, instructional designer or curriculum designer.

What's in it for me?

- Developing a future workforce with the skills, knowledge, confidence, behaviours and habits that will be needed by employers, aligning with national policy.
- Ensuring that workers have the skills, abilities and attitudes needed to develop self-care, meet individual needs, outcomes and aspirations and support behaviour change – which translates into better health, well-being and outcomes for people, families and carers.

Indicative challenge questions:

- What do I understand by a person-centred and community focussed approach and the tools and practices to deliver it? How can I use this framework to modernise how we deliver training and education?
- How do I embed person-centred values, knowledge and skills in the curriculum / training programmes?
- How do I co-produce and/or deliver training with people and/or carers who use services?
- How do I offer appropriate support to people and/or carers during and after co-facilitated training?
- How do I ensure trainers are skilled in person-centred approaches?
- How do I ensure that experiential learning gives learners the opportunity to understand and reflect on their values, how they work and their professional identity?
- How do I ensure that learners are supported to apply and develop new skills in the workplace – recognising the reality of the work environment and the challenges to embedding this way of working?
- How do I ensure training and education meets the needs of a workforce with a range of individual levels of health literacy?
- Do I deliver education and training that genuinely meets the learning outcomes set out in this framework?
- How do I support learners to build action plans, goals, and form habits that will support this to become a habitual way of working?

The wider system e.g. Regulators, Royal Colleges, Professional Bodies

This is for you if you are:

Working within the wider system, such as the Care Quality Commission (CQC), NHS Improvement, General Medical Council, Healthcare Professions Council or Nursing and Midwifery Council, perhaps as part of a registration or inspection team. You may be working within a Professional Body or Royal College.

What's in it for me?

- Ensuring that professionals and services meet the standards relating to person-centred and community focused care
- Ensuring compliance with the CQC fundamental standards of care and regulations, in particular that everybody has the right to expect Person-centred care: *'You must have care or treatment that is tailored to you and meets your needs and preferences'*
- Ensuring providers of services work in partnership with people, making any reasonable adjustments and supporting people to understand and make informed decisions about their care and treatment options, including the extent to which they may wish to manage these options themselves.

Indicative challenge questions:

- How are people who use services and those important to them involved as partners in the development and regulation of services?
- How do we incorporate the behaviours and learning outcomes in this framework as part of our standards or curriculum?
- How do we understand the impact of the 'hidden curriculum' or organisational culture upon this way of working in practice?
- How might education or service providers evidence how they stratify and train their workforce to reflect the values and steps in this framework?
- How is a person-centred and community focussed approach part of revalidation or re-registration processes with professional regulators?
- How do services measure and evaluate real outcomes for people, not just processes or service outputs i.e. what matters to people, not just that which is easy to measure?

Appendix 1:

Communication skills

The following table provides a description of the core communication and relationship building skills:

Skill	Description
Hello my name is…	Clearly introducing self, role and setting the scene for the conversation[45].
Use of open ended questions	Open ended questions are questions that cannot be answered with a yes or no. They invite broader responses during information gathering and allow the person to share their broader thinking and perspective. They also create a more equal conversation. 'tell me more about…' 'how was that…' 'what are you doing that you find helpful?...' 'when do you notice that?...' 'who supports you in your day to day life?...'
Use of open focused questions to closed questions (cone)	Knowing how and when to move from open exploratory questions to ones that are more focused around a particular topic or subject. Understanding the place and value of closed questions.
Screening	Checking if there is 'something else' or 'anything else'. There are many contexts when screening is helpful and can be used, for example, when exploring what is important, agenda setting and exploring importance and confidence.
Reflection	Using words to let the other person know you have heard what they have said. Non verbal body language and facilitative cues are not enough on their own. Using the person's language helps them feel heard, builds rapport and ensures that the person is an active partner in the dialogue. It is also very powerful to have your own thoughts and words reflected back.
Empathy	A deep reflection and using words to let the person know you understand or are trying to understand how it is for them emotionally. It is a complex skill however there are some key guiding principles including taking the other person's perspective, staying out of judgement, recognising emotion and communicating what you notice[46].
Affirmation	A positive statement and acknowledgement of the effort or achievement somebody has made, offering emotional support or encouragement. E.g. 'you told me you tried to change before, that shows great determination'.
Normalisation	An acknowledgement that the [for example] feeling, process, symptom is normal and other people report similar experiences. It helps the person feel validated, that they are not alone and that the worker has experience of working with people like them.

45. The Hello Name Is… campaign

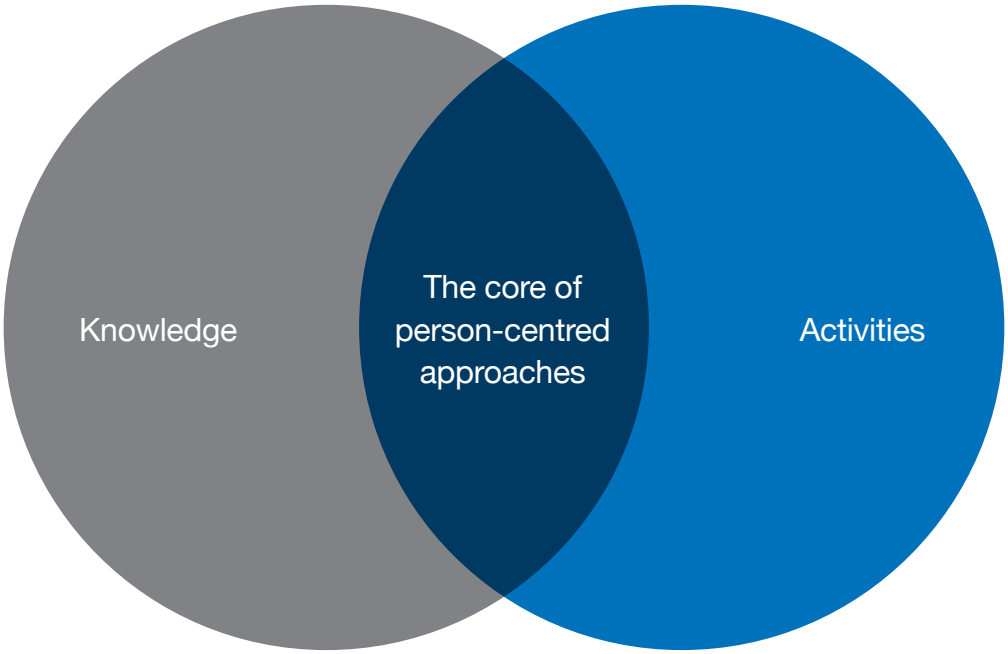
46. Ref: Hojat M et al, (2011), Physicians' Empathy and Clinical Outcomes for Diabetic Patients, Academic Medicine, Vol. 86, No. 3 / March 2011

Skill	Description
Active listening	Being present psychologically, socially and emotionally, making a conscious effort to hear and understand what people are saying. Active listening requires the listener to feed back 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[47]
Environmental awareness	How the room, chairs, tables, desk etc are arranged. Who is taking part, where the conversation is taking place, how public or private it is for example. Understanding the impact of the environment on an individual and adapting for this.
Ask before advising	Before giving information checking what the person knows, what they would like to know, that they would like to receive the information and how they would like to receive it.

47. Silverman et al (2005), Skills for Communicating with Patients, Third Edition

Appendix 2:

Person-centred approaches applied across a range of activities



The core of person-centred approaches

- Values
- Core communication and relationship building skills
- Conversations to engage with people
- Conversations to enable and support people
- Conversation with people to manage the highest complexity and significant risk

Enabling people to work in this way through:

- Development of the workforce
- Development of organizations and systems
- Supporting behaviour change

Knowledge – which may include the following:

- Social determinants of health
- Patient activation
- Quality improvement
- Technology to support health and wellbeing
- Health literacy
- Accessible Information Standard
- Patient and Public Involvement (PPI)
- Awareness of local services and resources
- Coproduction
- Asset-based approaches
- Looking beyond traditional health and care solutions
- Carer awareness
- Communities
- Prevention (primary, secondary and tertiary)
- Person-centred measurement & outcomes
- Statutory and mandatory regulation and governance
- Relevant policy

Activities – which may include the following:

- Shared decision making
- Social prescribing
- Care navigation
- Care coordination
- Advocacy
- Supporting self-management
- Care and support planning
- Health coaching
- Motivational interviewing
- Peer support
- Recovery
- Personal budgets/IPC
- Supporting behaviour change
- Signposting
- Advanced Care Planning
- Making Every Contact Count (MECC)
- Managing risk
- Working in partnership at individual and service level
- Integration of services across sectors
- Measuring impact at individual and service level

Appendix 3.

Tools to deliver training and development for the workforce

The following table lists a range of tools that can be used to deliver training at each step of this framework. Many of these activities can happen at any step, but we have highlighted the steps where they are most likely to occur.

Tool	Description	Step 1	Step 2	Step 3
E-platforms	Using web-based or electronic tools to deliver training, such as e-learning models, remote coaching and accessing information and resources.	●		
Videos of communication skills	To clearly demonstrate what good communication does and doesn't look like. The video format also makes it replicable and scalable teaching tool.	●		
Problem-based Learning	Learning about a topic from solving a problem as described in a prompt.		●	●
Reflective group work	Feeding back in groups to enable individuals to hear and learn from others perspectives and experiences, supported by trained facilitator to manage dynamics and interactions.		●	●
Action learning sets	Exploration in small groups, reflecting on challenges, exploring and problem solving new ways of doing things, and testing them in practice in a planned way[48].		●	●
Role play	Using a relevant scenario in a safe learning environment to test skills and approaches, receive feedback from other learners or facilitators. This should include opportunities for re-rehearsal. Role play can be highly stressful for some learners, it requires skilled facilitation and is more appropriate as a means of 'trying out' than as a means of testing learners.		●	●
Mentoring	Formal or informal support from someone with more experience or knowledge of a topic[49].		●	●
Self-assessment	Objective way to identify gaps for further learning and development.		●	●
Goal setting – team and individual	Collaboratively setting goals that are • meaningful and important to the individual • use a robust process to support individuals to translate intention into action • broken down into achievable chunks • followed up, to enable constructive debrief so the individual can move forwards.		●	●

48. Skills for Success: The Health Library Staff Development Framework / Introducing Learning Sets 49. CIPD: Coaching and mentoring

Tool	Description	Step 1	Step 2	Step 3
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.		●	●
Modeling coaching approaches	Facilitation of groups and training sessions should model the coaching and asset-based approaches, using the values and tools described in this document.		●	●
Team and pathway-based training	Evidence shows that greatest impact is achieved when teams/pathways are trained together, with shared understanding, purpose and goals. This can be within or across organisations.		●	●
Co-delivery and co-faciliation	Delivering training in equal partnership with people and their carers who have experiences of using services, to model the principles of person-centred approaches.		●	●
Shadowing and watching others	Using pre-existing services to shadow and see person-centred 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[50]	●	●	●
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.	●	●	●

50. Kolb D. A. (2014), Experiential learning: Experience as the source of learning and development

Appendix 4.
Glossary of terms

Term	Definition
Advocacy	Advocacy supports and enables people who have difficulty representing their interests, to exercise their rights, express their views, explore and make informed choices. In doing so, people can make informed decisions, have a voice, express choices and take control of situations in their life[51].
Accessible information	Information presented in a format that is easily used and understood by its intended audience. In the context of health and social care, the Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with health and social care services[52].
Activation	A person's knowledge, skill and confidence for managing their own health and health care.
Active participation	A way of working that recognises an individual's right to participate in the activities and relationships of everyday life as independently as possible; the individual is regarded as an active partner in their own care or support, rather than a passive recipient.
Advance Care Planning	The voluntary process of discussion between an individual and their care providers to make clear the individual's wishes regarding their ongoing care in the context of anticipated deterioration of their health with loss of capacity to make decision or communicate wishes in the future.
Advance decision	A decision, made by the individual, specifically related to the refusal of medical treatment in certain circumstances to come into effect when the individual has lost capacity to give or refuse consent to treatment.
Asset-based approach	A way of working that considers the strengths, resources and potential of individuals and communities.
Best interest decisions	A decision made on an individual's behalf because they no longer have the capacity to make the decision themselves. A best interest decision is based on the individual's previously expressed wishes and preferences and should be the least restrictive option available.
Carer	In the context of this framework, a carer is someone who spends a significant amount of their time providing unpaid support to a family member or friend.

51. Ref: Older People's Advocacy Alliance 52. NHS England: Accessible Information Standard

Term	Definition
Care and Support Planning	Care and support planning is a defined process which helps people set their own aims, and then secures the support and care that are needed to achieve them. It is the key that unlocks person-centred, coordinated care. It is about working with a care and support partner to think about: • what is important to you • things you can do to live well and stay well • what care and support you might need from others Care and support planning is for anyone who has health and care needs over time[53].
Care navigation	The assistance offered to people and carers in navigating through the complexity of health and social care systems to overcome barriers in accessing quality care and treatment[54].
Circles of support	The community around a person (which may include family, friends and other community members), who are not paid to be there but help somebody accomplish their personal goals in life.
Coproduction	At the level of individuals, services and systems, co-production means professionals and citizens sharing power to plan, design and deliver support together… recognising that everyone has an important contribution to make to improve quality of life for people and communities[55].
COM-B	A model of behaviour change whereby behaviour (B) occurs as the result of interaction between three necessary conditions; capabilities (C), opportunities (O) and motivation (M). • Capability - to have developed the required skills and knowledge • Opportunity - to be supported by a system and organisations where a person-centred approach is recognised and valued. • Motivation - linked to personal values and making behaviours become habitual[56].
Community	A group of people sharing the same location, interest or identity.
Health Coaching	Enabling a person to maximise their own health through raising individuals' awareness and responsibility for their own health. Key characteristics include a focus on a person's goals rather than what professionals think they should do; empowering people to take ownership and responsibility for their health; and helping people plan and break down their goals into manageable steps[57].

53. National Voices: Care and support planning 54. Health Education England: Care Navigation - A Competency Framework 55. Think local act personal: Co-production
56. Mitchie et al (2011), The behaviour change wheel: A new method for characterising and designing behaviour change interventions
57. Realising the Value (2016): Ten key actions to put people and communities at the heart of health and wellbeing

Term	Definition
Health literacy	The WHO defines heath literacy as "The personal characteristic and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health". There are a number of different levels of health literacy as follows:- **Functional health literacy** – sufficient basic health literacy skills in reading and writing to be able to understand everyday health information of follow instructions **Interactive health literacy** – more advanced health literacy skills which can be used to be actively involved in decisions about health and care over time, and in changing circumstances. For example making a decision about your preferred treatment **Critical health literacy** – more advanced skills which can be used to be applied to critically analyse information, and to use this information to exert greater control over life events and situations. For example, identifying a lack of green space in their community and researching and then taking action to improve the situation (Nutbeam 2000[58]). It is important to consider the health literacy of people using services and people delivering services.
Informed Consent	An individual must give permission before they receive any care, support or treatment. For consent to be valid, it should be given voluntarily, be based on accurate information including risks and benefits, and the individual giving consent must have the capacity to do so.
Lasting power of attorney	Anyone who has the capacity to do so may choose a person to take decisions on their behalf should they subsequently lose capacity.
Mental capacity	The ability to make your own decisions based on an accurate understanding of information, retaining the information long enough to make a decision, weighing up information and communicating a decision.
Making Every Contact Count (MECC)	An approach to behaviour change that utilises the millions of day to day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations[59].
Motivational interviewing	A method based on facilitating and engaging a person's intrinsic motivation in order to change behaviour. It is a goal-oriented, person-centred counselling style for eliciting behaviour change by helping people to explore and resolve ambivalence.
Patient Activation Measure (PAM)	A tool that enables healthcare professionals to understand a person's activation level, or their level of knowledge, skills and confidence to manage their long-term condition[60].
People	In the context of this framework, people are those receiving support or care.

58. Nutbeam, D. (2000) Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century, Health Promotion International 59. Health Education England: Making Every Contact Count (MECC) 60. NHS England: Patient activation

Term	Definition
Personalisation	Recognising people as individuals who have strengths and preferences and putting them at the centre of their own care and support. Personalised approaches involve enabling people to identify their own needs and make choices about how and when they are supported to live their lives[61].
Personalised care and support planning	A collaborative process which helps people set their own aims, and then secures the support and care that are needed to achieve them, considering what is important to the person; things the person can do to live well and stay well and what care and support the person might need from others[62].
Personal Budgets/ Integrated Personal Commissioning	Money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local clinical commissioning group (CCG).
PDSA – Plan do study act	A model for improvement that helps teams plan their chosen intervention, test it on a small scale and then review it before deciding how to proceed[63].
Prevention	Providing or arranging services that reduce needs for support among people and their carers, and contributes towards preventing or delaying the development of such needs. The Care Act (2014) describes prevention at three levels: • primary prevention - to stop care and support needs from developing among those who do not have them • secondary prevention - for people at increased risk of developing needs, which could involve adaptations or short term provision of services that prevent deterioration • tertiary prevention - for people with established needs to help improve independence[64]
Integration	Planning and delivering services, care and support for individuals and communities based on their needs, rather than from an organisational perspective[65]. This involves working across organisational and health boundaries, to include housing, transport, libraries, environment and other public services.
Recovery	The belief that it is possible for someone to regain a meaningful life, despite serious mental illness[66].
Self-management support	When health professionals, teams and services (both within and beyond the NHS) work in ways that ensure that people with long-term conditions have the knowledge, skills, confidence and support they need to manage their condition(s) effectively in the context of their everyday life[67].

61. Coalition for Collaborative Care (2016), Personalised care and support planning handbook 62. National Voices: Care and support planning
63. The Kings Fund: Model for improvement 64. Care Act (2014) 65. The Kings Fund: The evidence base for integrated care
66. Mental Health Foundation: Recovery 67. The Health Foundation: A practical guide to self-management support

Term	Definition
Shared decision making	Shared Decision Making starts with the conversation between the person receiving care and the person delivering care. It puts people at the centre of decisions about their own treatment and care by: • exploring care or treatment options and their risks and benefits • discussing choices available • reaching a decision about care or treatment, together with their health or social care professional or support worker. Benefits of shared decision making • Both people receiving and delivering care can understand what's important to the person, when discussing choices and options • People feel supported and empowered to make informed choices and reach a shared decision about care • Health and social care professionals can tailor the care or treatment to the needs of the individual For people receiving care this means care and support should take into account their needs and preferences. People delivering care need to understand the importance of balancing professional judgement and expertise with the needs and wishes of people receiving care. There are a number of health literate support tools to support this process in the clinical environment [68]. Enabling patients and citizens to be active participants in their health and healthcare is a critical goal for the NHS in England. Shared Decision Making is 'a process in which clinicians and patients work together to select tests, treatments, management or support packages, based upon clinical evidence and the patients informed preferences. It involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing patients' informed preferences'. Shared Decision Making occupies the middle ground between traditional clinician-centred practice, where patients rely on their doctor or clinician to make decisions about their care, and consumerism where patients have access to information and make their own choices. In Shared Decision Making there are two sources of equal expertise that come together to enable better decisions – clinician and patient. In Shared Decision Making the patient's knowledge and preferences are taken into account, alongside the clinician's expertise and the decisions they reach in agreement with each other are informed by research evidence on effective treatment, care or support. This clinically leads to better decisions and outcomes for both the patient and clinician.

68. Implementing shared decision making in the NHS: lessons from the MAGIC programme, BMJ (2017;357:j1744)

Term	Definition
Shared decision making (continued)	Shared Decision Making may include the use of decision aids when there is more than one option and neither is clearly better, or when options have benefits and harms that people value differently. Decision aids may be pamphlets, videos, or web-based tools. They state the decision, describe the options, and help people think about the options from a personal view (e.g. how important are possible benefits and harms). [69] In addition to the clinical reasons to undertake Shared Decision Making, from an ethical perspective it is important to ensure that patients have unbiased and clear information on options, benefits and harms. It is the right thing to do. A recent landmark case, Montgomery v Lanarkshire Health Board [2015][70] has focused the legal requirements to undertake Shared Decision Making. The importance of a patient's right to make their own decision has been advocated in legal cases before, but the Montgomery case confirms that the need for 'informed consent' is firmly part of English law. This ruling recognises a growing appreciation for patient's self-determination and ability to understand the consequences of a particular treatment. Clinicians now have a clear duty to take reasonable care to ensure that patients are aware of material risks. Shared Decision Making is a key way of ensuring this[71]. NHS England, Clinical Commissioning Groups and providers have duties to deliver shared decision making that are covering the respective legislation: • Heath and Social Care Act 2012, section 13H and 14U[72] • Health and Social Care 2008, Regulation 9 Regulations 2014[73]
Supporting behaviour change	To encourage people to adopt a healthier lifestyle by, for example, stopping smoking, adopting a healthy diet, being more physically active, better blood sugar control or adherence to medicines[74].
Social prescribing	Connecting people to non-medical sources of support in their local community that may help meet particular needs, or that can help to prevent worsening health for people with existing long term conditions and reduce costly interventions in specialist care[75].
Workforce	All staff including unpaid and voluntary staff
Year of Care - House of Care Model	The Year of Care was a pilot programme sponsored by The Department of Health and Diabetes UK which demonstrated how to deliver personalised care for people living with long term conditions (LTCs) using diabetes as an exemplar. Pilot sites developed the Year of Care 'House' as an enabling framework. The House of Care with its walls, roof and foundations acts as a metaphor, emphasising that collaborative care planning cannot easily take place without addressing all of the practice and organisational infrastructure that surrounds it[76].

69. Decision aids to help people who are facing health treatment or screening decisions 70. The Supreme Court Judgement: Montgomery v Lanarkshire Health Board
71. NICE guidelines: Shared decision making 72. Health and Social Care Act (2012) 73. Care Quality Commission: Regulation 9 – Person-centred care
74. NICE Guidelines 75.Coalition for Collaborative Care (2016), Personalised care and support planning handbook
76. Year of Care Partnerships: Care and support planning/The House

Appendix 5.

How the framework was developed

An initial stakeholder event, attended by over 50 delegates, was held in June 2016 to build a shared understanding and common language for the project and to learn from current and previous activities.

A literature review was then undertaken to identify key references, resources and significant themes or issues for consideration – further references and resources continued to be identified during the project (see Appendix 6 Current relevant resources and Appendix 7 Reference list).

Based on the principles of co-production, a number of iterations of the framework were developed, guided by a steering group comprising a range of stakeholder organisations and representatives of people using health and care services.

A wider stakeholder list was also established to include a more diverse range of organisations and individuals that wished to be kept up-dated on development of the framework and to provide comments or feedback as part of the consultation process. By the end of the project this stakeholder list comprised approximately 300 individuals.

During January and February 2017, an online consultation was conducted to obtain feedback on the draft framework – with 144 respondents. Based on analysis of the survey outcomes and other feedback received through emails and discussions, a final draft of the framework was developed for approval by the project steering group in April 2017.

Appendix 6.

Current relevant resources

The following resources are listed in alphabetical order, grouped into three categories:

- Guidance and learning resources
- Frameworks and standards
- Policy and legislation

Guidance and learning resources

Better conversation: Better health

Better conversation: Better health offers a set of resources available to download and use on health coaching.

Choosing Wisely UK

Choosing Wisely UK is part of a global initiative aimed at improving conversations between patients and their doctors and nurses. The Choosing Wisely principles encourage patients get the best from conversations with their doctors and nurses.

Coalition for collaborative Care, A Co-production Model

An alliance of people and organisations committed to making person-centred, collaborative care the norm. It offers a Co-production Model which describes five values and seven steps to making this happen.

Community Health and Learning (CHL) Foundation

A health literacy delivery organisation, offering information and a range of resources available for download. The national evidence based health literacy course, Skilled for Heath, co-created by DH, BIS and ContinYou can be accessed from this web site. It covers a wide range of primary and secondary prevention topics and is aimed at people with lower levels of health literacy

E-learning for Healthcare (e-LfH)

E-learning programmes providing national online training content for the healthcare profession. A wide range of programmes are available including:

- Accessible Information Standard
- Building Community Capacity
- Personal health budgets
- Personalised Care Planning
- Shared Decision Making
- Supporting Self Care

Health Foundation: Person-centred Care Resource Centre

Learn about Person-centred care or find resources from The Health Foundation and its recommendations from around the web.

Health literacy

Resources for practitioners who are interested in building the evidence base for Health Literacy and information, research papers and publications are available on this web site.

Health Literacy Universal Precautions Toolkit (Agency for Healthcare Research and Quality):

This toolkit was developed, in the US, to guide primary care practices in making simple changes to their environments and strategies for communicating with patients that can improve comprehension of health information among patients of all health literacy levels.

Making Every Contact Count

Making every contact count (MECC) is an approach to behaviour change that utilises the millions of day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations. This website provides resources and information to support people and organisations implementing MECC and has been developed with multi-agency input at local, regional and national level.

National Voices

National Voices is a coalition of health and social care charities in England working for a strong patient and citizen voice and services built around people. National Voices has published systematic reviews of existing research which looks at the impact of a range of person-centred approaches.

NHS RightCare Decision Aids

Twenty-eight short form Patient Decision Aids (PDAs) have been developed to support patients to have informed conversations about their condition with clinicians.

NHS England, Personalised care and support planning

Information on personalised care and support planning, with a recommended set of principles to help ensure that the process is truly person-centred.

NHS England, Transforming participation in health and care

Guidance to help clinical commissioning groups (CCGs) and other commissioners of health and care services to involve patients and carers in decisions relating to care and treatment.

NHS Leadership Academy

NHS Leadership Academy joined with other like-minded partners in public service to found the Systems Leadership steering group. Together, they commissioned research to deepen their collective understanding of the behaviour that enables people to lead successfully across and between organisations.

NICE Guidance PH49 (2014), Behaviour change: individual approaches

This guideline covers changing health-damaging behaviours among people aged 16 and over using interventions such as goals and planning, feedback and monitoring, and social support. It aims to help tackle a range of behaviours including alcohol misuse, poor eating patterns, lack of physical activity, unsafe sexual behaviour and smoking.

NICE guideline NG44 (2016), Community engagement: improving health and wellbeing and reducing health inequalities

This guideline covers community engagement approaches to reduce health inequalities, ensure health and wellbeing initiatives are effective and help local authorities and health bodies meet their statutory obligations.

NICE Guidance NG56 (2016), Multimorbidity: clinical assessment and management

This guideline covers optimising care for adults with multimorbidity (multiple long-term conditions) by reducing treatment burden (polypharmacy and multiple appointments) and unplanned care. It aims to improve quality of life by promoting shared decisions based on what is important to each person in terms of treatments, health priorities, lifestyle and goals. The guideline sets out which people are most likely to benefit from an approach to care that takes account of multimorbidity, how they can be identified and what the care involves.

NICE Guidance CG138 (2012), Patient experience in adult NHS services: improving the experience of care for people using adult NHS services

This guideline covers the components of a good patient experience. It aims to make sure that all adults using NHS services have the best possible experience of care.

NICE Guidance CG136 (2011), Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services

This guideline covers the components of a good experience of service use. It aims to make sure that all adults using NHS mental health services have the best possible experience of care.

NICE web page, Shared decision making

Information about shared decision-making – which starts with the conversation between the person receiving care and the person delivering care. Shared decision making puts people at the centre of decisions about their own treatment and care.

ORCHA, Promoting better apps for better outcomes

This web site offers access to a range of apps and aims makes it easier to find, compare and benefit from using the best apps for health and care needs.

People and Communities Board (2016), Six principles for engaging people and communities

These six principles were developed by the People and Communities Board, in conjunction with the new models of care ‘vanguards’ sites, to give practical support to services as they deliver the ‘new relationship with people and communities’ set out in the Five Year Forward View. These ‘six principles’ set out the basis of good person-centred, community focused health and care.

Public Health England, A guide to community-centred approaches for health and wellbeing

This guide outlines a ‘family of approaches’ for evidence-based community-centred approaches to health and wellbeing.

Realising the Value: Tools and Resources

This set of tools and resources has been produced by the Realising the Value programme, which aims to enable people to take an active role in their own health and care, in support of the NHS Five Year Forward View vision to develop a new relationship with people and communities. The resources, which include publications and practical tools, are grounded in both evidence and practice and are directly relevant to commissioners, providers and practitioners putting person- and community-centred approaches into practice, as well as to policymakers and regulators.

Royal College of General Practitioners, Collaborative care and support planning

The Collaborative Care and Support Planning toolkit offers a framework, which recommends a proactive holistic, flexible, and tailored approach to care, and recognises the individual as an expert in their own care. This toolkit provides a collection of relevant tools and information to assist members of the primary care team to implement the six-step model of collaborative care and support planning.

Royal College of Physicians, Shared decision making: information and resources

Information, resources and downloads to support Shared decision making (SDM) and support for self-management (SSM).

Royal College of Speech and Language Therapists: Inclusive communication

By adopting inclusive communication, a society shows how it values, respects and includes people with communication support needs. This approach recognises that people communicate in many different ways and the environment must support this.

Skills for Care (2014), Skills Around the Person

Guidance to support the implementation of asset-based approaches in adult social care and end of life care.

Skills for Care: Self care

Tools and resources to help in supporting people to self-care.

Skills for Care (2015), Workforce shaping and commissioning for better outcomes

This sets out standards for continuous improvement in person-centred and outcomes-focused care and support. This support should be inclusive, well-led and promote a sustainable and diverse market. High quality commissioning and high quality workforce commissioning focuses on citizenship, health and wellbeing, achieving good outcomes with people, and using evidence, local knowledge, skills and resources to best effect. It creates the conditions in which individuals with personal budgets can make informed choices.

Social Care Institute for Excellence (SCIE)

Resources and services for the social care and health sectors.

Skills for Health: Stand by Me

Online e-learning developed by Skills for Health, the Association for Dementia Studies and key partners to improve the communication and person-centred care for people with dementia.

Teach-back

Teach-back is an easy-to-use technique to check that the health professional has clearly explained information to the patient and that the patient has understood what they have been told.

Think Local Act Personal (TLAP)

TLAP is a national partnership of more than 50 organisations committed to transforming health and care through personalisation and community-based support. Its resource library provides access to a wide range of documents and resources.
For example, it provides a Personalised care and support planning tool.

What Matters to You

Resources, activities and stories with the aim of encouraging and supporting more meaningful conversations between people who provide health and social care and the people, families and carers who receive health and social care.

Year of Care Partnerships

Year of Care Partnerships is an NHS based organisation that is dedicated to driving improvement in long term condition care using care and support planning to shape services which involve people in their own care, provide a more personalised approach and which supports self management.

Frameworks and standards

Accessible Information Standard (NHS England)

From 31 July 2016, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support so they can communicate effectively with health and social care services.

Care Navigation: A Competency Framework (HEE)

This is a three tiered care navigation competency framework, which describes the core competencies for people providing care navigation across a wide range of health, social and voluntary care sectors.

Care Quality Commission, The fundamental standards: Person-centred care

The CQC fundamental standards are the standards below which care must never fall. This includes the standard: *You must have care or treatment that is tailored to you and meets your needs and preferences.*

Community Development National Occupational Standards

The Community Development National Occupational Standards (NOS) aim to define the skills, knowledge and understanding required to undertake the functions carried out by the community development practitioner.

GMC generic professional capabilities

Generic professional capabilities (GPCs) are broad human skills, such as communication and team working, needed by doctors to help provide safe and effective patient care. They are common to doctors across all medical specialties.

Health Coaching: Promoting better conversations through health coaching (HEE)

In 2015, Health Education England commissioned a strategic review to explore how the local workforce could best be supported in developing conversational skills to support person-centred care and self-management for patients. Three products emerged from this strategic review that address this need:

- A Quality Framework to help in the commissioning of high quality health coaching staff development programmes, giving examples of projects from across the country
- A Quality Framework Summary with the main strategies and approaches from the full framework, but without the examples); and
- The Area Delivery Template which provides ideas on ways in which a health coaching approach can be developed and sustained across a geographical area.

Health & Care Professions Council (HCPC) standards

The HCPC standards of conduct, performance and ethics are the standards set for all professionals on the HCPC Register, stating in broad terms the expectations of their behaviour and conduct.

NHS England and Local Government Association, Personalised Health and Care Framework

This framework provides advice and practical guides for the NHS and local government to support progress with Integrated Personal Commissioning and personal health budgets. It updates the personal health budgets toolkit, building on learning from implementation since 2012 and from the Integrated Personal Commissioning programme.

NHS Leadership Academy: Health Care Leadership Model

The Healthcare Leadership Model describes the things you can see leaders doing at work and demonstrates how you can develop as a leader – even if you're not in a formal leadership role. The model is made up of nine leadership dimensions, each of which includes a brief description of what the dimension is about and why it is important, and a section that says 'what it is not' to provide further clarity. For each dimension, leadership behaviours are shown on a four-part scale which ranges from 'essential' through 'proficient' and 'strong' to 'exemplary'. Although the complexity and sophistication of the behaviours increase as we move up the scale, the scale is not tied to particular job roles or levels.

NHS Improvement (2016), Developing People – Improving Care

Evidence-based national framework to guide action on improvement skill-building, leadership development and talent management for people in NHS-funded roles.

NHS Yorkshire and The Humber (2010), Prevention and Lifestyle Behaviour Change: A Competence Framework

The Prevention and Lifestyle Behaviour Change Competence Framework is essentially a commissioning led framework for workforce change. It describes the competences required by the workforce to enable them to develop their skills in addressing the health and wellbeing needs of the local population.

NMC standards

The Code for nurses and midwives presents the professional standards that nurses and midwives must uphold in order to be registered to practise in the UK. It is structured around four themes – prioritise people, practise effectively, preserve safety and promote professionalism and trust.

Public Health England

Public Health Skills and Knowledge Framework (2016).

Royal College of Speech and Language Therapists: The five good communication standards

Reasonable adjustments to communication that individuals with learning disability and/or autism should expect in specialist hospital and residential settings.

Skills for Health: Core Skills Education and Training Frameworks (CSTF)

Core Skills Education and Training Frameworks provide guidance and recommended minimum standards for the delivery of education and training in health and care. The following frameworks are available:

- Statutory/Mandatory
- Clinical/Care
- Dementia
- Learning Disabilities
- Mental Health
- End of Life Care

Policy and legislation

Care Act (2014)

The Care Act brings together care and support legislation in England with the principle of well-being at its heart. The Care Act changes the way councils, care providers and user organisations work. It changes peoples' roles in the delivery of care, and the expectations and duties placed on people.

Equality Act 2010

The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. It replaced previous anti-discrimination laws with a single Act, making the law easier to understand and strengthening protection in some situations. It sets out the different ways in which it's unlawful to treat someone.

Mental Capacity Act (2005)

The MCA has been in force since 2007 and applies to England and Wales. The primary purpose of the MCA is to promote and safeguard decision-making within a legal framework. It does this in two ways:

- by empowering people to make decisions for themselves wherever possible, and by protecting people who lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process
- by allowing people to plan ahead for a time in the future when they might lack the capacity, for any number of reasons

NHS England (2014), Five Year Forward View

The NHS Five Year Forward View was published on 23 October 2014 and sets out a new shared vision for the future of the NHS based around the new models of care. It has been developed by the partner organisations that deliver and oversee health and care services including Care Quality Commission, Public Health England and NHS Improvement (previously Monitor and National Trust Development Authority).

NHS (2015), The NHS Constitution

In March 2011, the Department of Health published the NHS Constitution. It sets out the guiding principles of the NHS and your rights as an NHS patient. The seven key principles guide the NHS in all it does. They are underpinned by core values which have been derived from extensive discussions with staff, patients and the public.

Public Services Social Value Act (2012)

The Public Services (Social Value) Act came into force on 31 January 2013. It requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits.

Sustainability and Transformation Plans (STPs)

Sustainability and transformation plans (STPs) are five year plans for the future of health and care services in local areas. NHS organisations have come together with local authorities and other partners to develop the plans in 44 areas of the country.

Appendix 7.
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