Leadership for Personalised Care

Impact evaluation

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April 2023
Report 595

Institute for Employment Studies

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Acknowledgements

The authors of this report are indebted to the 84 individuals who took the time to complete the survey and all the individuals who engaged in the case studies. We would like to thank Heather Simpson and Catherine Wilton for their support in the development of this work. Further, we would like to thank Dr Alison Carter for her support and contributions to this work throughout. Many thanks to Ehecatl Hunt Duarte for his project support and proofreading.

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Executive Summary

The Institute for Employment Studies (IES) conducted an independent impact evaluation of the Leadership for Personalised Care (LPC) suite of programmes. The LPC offers a range of programmes that deliver learning and development on the key elements of personalised care, and how this can be introduced into individuals', organisations' and systems' practice. The aim of the programmes is to produce a cadre of people working across health and social care, who can drive forward the personalisation agenda by leading change in their local setting. The programmes originated as a cross-sector partnership initiative across health and social care and are currently hosted by In Control Partnerships and funded by NHS England.

IES conducted a mixed-methods evaluation consisting of a quantitative survey and deep-dive qualitative case studies. The survey aimed to understand any personal attitudinal, cognitive and behavioural change following the programme, while the case studies sought to explore wider changes in the local setting and the subsequent impact. The survey was distributed to 560 programme alumni, of which 84 completed it, demonstrating a 15 per cent response rate. Fifteen interviews were conducted with participants and local stakeholders, to produce seven case studies that documented the personalisation journeys in local settings.

Overall, the **programme appears to have had a positive impact on the participants, their communities and people with health and care needs**. Participants reported feeling, thinking and behaving differently following the programme, this included:

- **Programme participants reported high levels of self-efficacy.** Measured on a scale from 10 to 40, the average score for LPC participants was 32.9, which demonstrates 'high' levels of self-belief in their own ability to lead personalisation.
- **Being more aligned with a personalised mindset** - 97% are more focused on embedding personalisation approaches in their practice and 94% are more likely to believe that people and the community are assets to ensure the population stay as well as possible.
- **More knowledge about personalisation in their local setting** - 81% have a good knowledge of the people and organisations in the local community, and what personalised care could mean to them.
- **Increased confidence in leading change** - 87% are confident to challenge established ways of working and 86% are confident to communicate a consistent and clear vision for personalised care to staff, stakeholders, and the wider community.
- **Working more collaboratively** - 98% encourage other people to work collaboratively to innovate and find solutions and 94% actively connect people and organisations to each other in the system, taking action to embed personalisation in their local setting.

Participants implemented a wide range of approaches to drive the personalisation agenda forward in their own settings. The types of activities can be organised thematically, and to some extent, be considered chronologically, with actions at the top of the list typically being established earlier on in the journey:

- **Creating a local infrastructure for collaboration**, such as establishing cross sector meetings.
- **Developing governance and documentation**, such as creating a framework for collaborative agreed ways of working.
- **Creating job roles and reorganising teams**, such as aligning roles across the local system to ensure a consistent experience for those with health and care needs.
- **Engaging with people with lived experience**, such as co-producing local service development.
- **Improving the experience of those with care and support needs**, considering the entry to, journey through and exit from a service or interaction.
- **Evaluating the impact of personalisation**, such as using simple tools to demonstrate the impact of changes in local practice.

Participants felt that **their change in mindset and actions following the programme has had a positive effect on people their local setting**. With 72 per cent believing they have impacted stakeholders, 67 per cent impacting partners, 64 per cent impacting colleagues, 63 per cent impacting direct reports, and 47 per cent impacting those with care and support needs (47%). Not all of the respondents worked in a direct patient care role, those that did directly work with people with health a care needs reported additional positive outcomes following the programme:

- 100 per cent think that they are enabling people to make decisions based on the evidence and what they think is right for them more often.
- 100 per cent think that *they* and 94 per cent thought *people in their setting* were connecting people to their communities and non-medical support more often.
- 96 per cent think that people with health and care needs are listened to more effectively, find the personalised approach taken for their care more useful, and effective health and care outcomes are achieved more.

The impact of these changes on the NHS and wider system are, on the whole, yet to be realised. Participants believe that it will take a ‘long time’ to observe systemic outcomes. Nevertheless, early evidence suggests that in the settings investigated, cultures may be shifting and people with health and support needs are likely to benefit from the actions participants are taking to embed personalisation. Participants did experience several barriers to leading the change locally, these were predominantly relating to time and resource constraints, as well as meeting challenges when working across organisational boundaries. There are also some differences in outcomes depending on the level of influence of a participant’s job. Those with lower levels of influence reported less positive impact personally and within their setting, suggesting they experience additional barriers.

1 Introduction

1.1 Research context

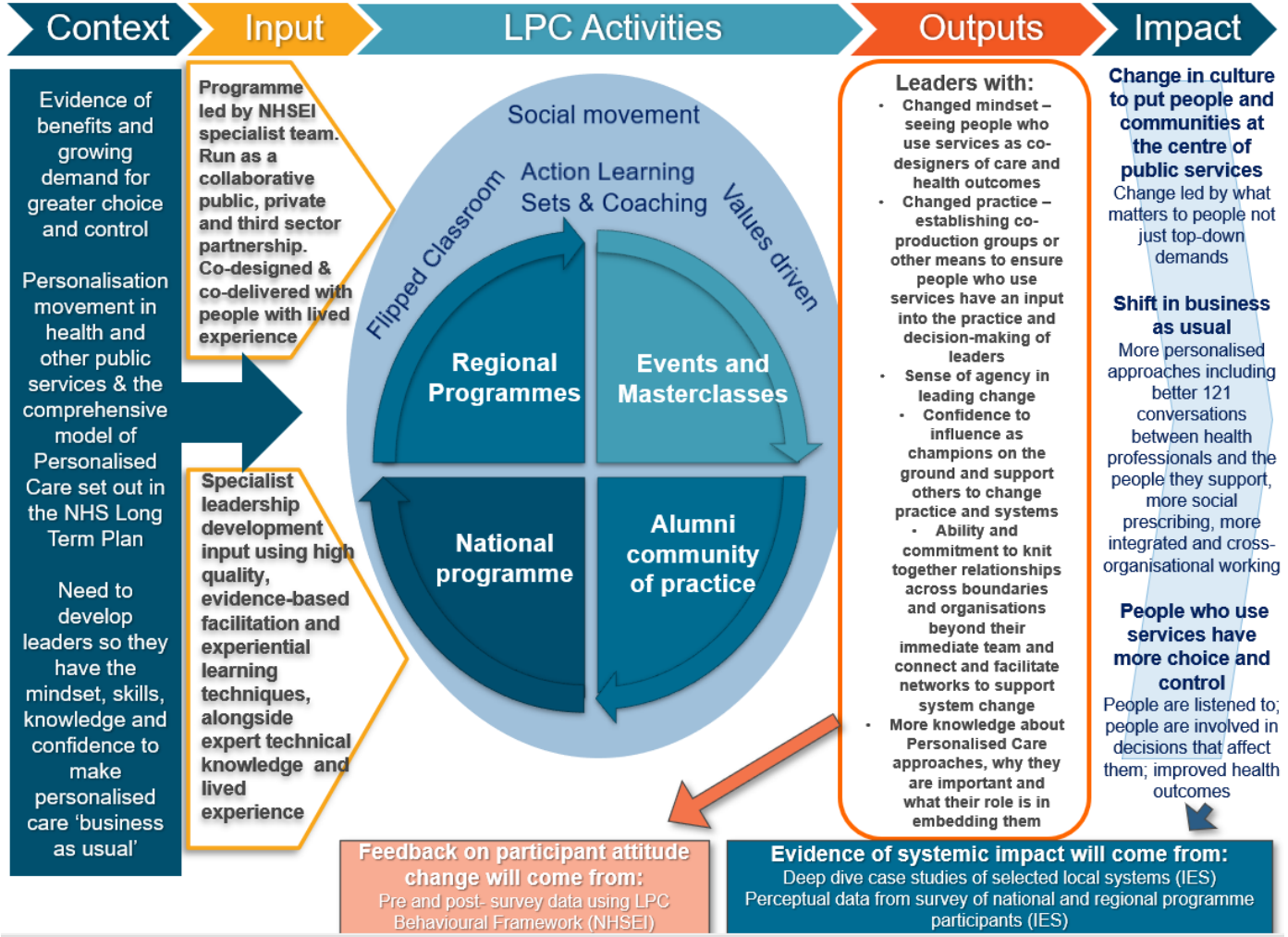
The Institute for Employment Studies (IES) conducted an independent impact evaluation of the Leadership for Personalised Care suite of programmes. The Leadership for Personalised Care (LPC) suite offers a range of programmes that deliver training on the key elements of personalised care, and how this can be introduced into individuals', organisations' and systems' practice. The suite of programmes include the flagship Leadership for Empowered Communities and Personalised Care programme. This is a six-day face to face programme delivered to a national cohort. The Leadership for Personalised Care programme is a three-day virtual programme, delivered to regional cohorts. The regional LPC programme is aimed at cross-sector teams drawn from a place who can lead collectively to achieve positive change in their community. Additionally, the suite offers an online range of offers including online events and masterclasses, one-off workshops and an Alumni Community of Practice. The programmes originated as a cross-sector partnership initiative across health and social care and are currently hosted by In Control Partnerships and funded by NHS England[1].

To undertake an impact evaluation, IES conducted a mixed-methods project exploring the programme from a range of stakeholders' perspectives. First, interviews with key stakeholders were carried out in order to inform a Logic Model (Figure 2) for the LPC suite of programmes. This Logic Model was used to inform both an evaluation survey and qualitative case studies. The evaluation survey was distributed to LPC alumni, with contact information provided by NHSE, and aimed to understand changes in individual and organisational practice. At the end of the survey, respondents were given the opportunity to opt in to the qualitative research element of the impact evaluation. From this, seven deep dive case studies were completed to understand the impact the LPC programme had on the delivery of personalised care within a local system. The case studies document how far personalisation has travelled towards becoming business as usual and the role of the LPC programme in providing the inspiration and/or route map for change.

[1] More can be found about the programmes at www.leadershipforpersonalisedcare.org.uk.

1.2 Leadership for Personalised care logic model

Figure 1: Logic model



1.3 Method

The methodological design consisted of two research components; a survey and case studies, each seeking to explore different elements of the logical model. The survey primarily aimed to understand any personal change following the programme, while the goal of the case studies was to understand wider changes to the local setting and subsequent impact.

1.3.1 Survey design and analysis

The evaluation survey was a cross-sectional survey hosted online and distributed to individuals who had engaged with the programme via email using a list of contacts provided by NHSE. Email invitations to complete the survey were sent to 560 individuals, of which 84 completed or partially completed the survey and are included in the analysis.

The survey included a well-validated measure of self-efficacy, alongside questions designed to explore embedding personalisation, building relationships, influencing people, change in practice, and influence on people with care and support needs. Full details about the survey measures can be found in appendix 5.2. Respondents were also asked for demographic, occupational and programme engagement details, as well as information about the impact on their network.

The primary analysis assessed the average responses across all measures for the total sample. The measures of mindset, individual practice, organisational practice, and impact on people produced ratings reflecting change since individuals took part in the programme. Overall scores were derived for the measures of self-efficacy (GSE), embedding practice, building relationships and confidence; and average agreement ratings across each statement were also analysed for the latter three measures.

Significance testing (t-test) was used to explore differences in responses by level of influence[2], type of organisation[3], and between those who worked directly with people with care and support needs and those who did not. Significance testing was only conducted on differences where there were 30 or more cases per group (a standard cut-off to ensure test validity). The analysis also examined the relationship between self-efficacy and embedding practices, change in individual practice, and change in organisational practices using correlational analysis. Correlational analysis also investigated the relationship between change in individual and organisational practices. Where significant differences exist between groups the effect size (Cohen's *d*) is also reported. Full results are available on request.

[2] Low influence (I have no formal leadership responsibilities, I am responsible for one other individual or a small team (approx.1-10 people), and I am responsible for a larger team) and High influence (I am responsible for making decisions which affect the whole organisation, I am responsible for making decisions which affect my community, I am responsible for making decisions which affect the wider system at a regional or multi-agency level, and I am responsible for making decisions which affect wider national policy).

[3] NHS (Primary, Secondary, and Community) and all Other organisations (Local authority, 3rd or voluntary sector or community group, Private sector, and Government department, agency or public body)

1.3.2 Case study design

Programme participants were recruited for the case study element of the research via an opt-in question on the survey, by word of mouth at LPC programme events and through communication with the programme alumni. The purpose of the case studies was to provide a detailed account of the personalisation journeys in a diverse range of settings from different perspectives, as well as to explore the impact of the programme on the individual, the organisation and the wider community. To ensure that the final case studies met the intended purpose, all case study volunteers firstly participated in a short screening call. The screening call intended to gain some insight into the journey, details of the local setting and information about the case study volunteer. To ensure a diverse range of case studies, the final selection process considered the following variables:

- stage in the personalisation journey;
- geographical location;
- type of organisation; and
- level of seniority.

When the final shortlist was confirmed, topic guides were created guided by the logic model. All case study participants were then invited to take part in an hour-long interview, which discussed:

- the local context;
- the personalisation journey to business as usual;
- the personal impact of the programme; and
- outcomes in the local setting.

Interviewees were provided with a research briefing and were asked for informed consent prior to participating in an interview. Interviews were recorded where consent was provided and detailed notes were typed up from recordings, including quotes. In addition, interviewees were asked during the phone interview if they were able to provide IES access to any data, qualitative and quantitative, that further demonstrated the impact of personalisation. Where provided, the data was incorporated into the final case study.

At the end of the interview, participants were asked to nominate up to two stakeholders who could comment further on personalisation in the local setting. Shorter, 30 minute, interviews were conducted with the stakeholders to provided richer context to the case study story. Using the multiple data sources outlined above, named organisational case studies were produced by the IES research team and approval to publish requested from each participant. If approval was not provided, the case study was written-up anonymously using a pseudonym.

1.4 Sample

1.4.1 Survey sample

In total, 84 programme participants completed the evaluation survey. A third of respondents worked in an NHS organisation (33%), and the remainder worked in other organisations most commonly a local authority (23%) or a third or voluntary sector or community group (23%). Slightly less than half of the sample worked directly with people with care and support needs (46%), of which 40 per cent provided social care and 29 per cent provided clinical care.

As the evaluation was voluntary and participants self-selected to take part, the survey sample is not necessary representative of the demographic profile of the programme as a whole. Of those who completed the survey the majority were female (77%), aged 50-64 (51%), White (85%) and not living with a disability or long-term health condition (82%). Respondents worked across all regions of the UK but the highest proportion worked in the South East (27%), East of England (16%) or the Midlands (16%).

Respondents also indicated the level of influence they had: 60 per cent of respondents reported having a low level of influence (no leadership responsibilities, one individual or a small team, or a large team), while the remainder had influence over their organisation (16%), community (12%), system (11%) or national policy (1%). Full details can be found in Survey sample characteristics 5.1.

The majority of respondents had engaged with the 3-day virtual regional programme (73%), and a quarter of respondents had engaged in the 6-day face-to-face programme (25%; see Table 1.1). The time since individuals engaged in the programme varied: individuals reported taking part in the 6-day programme from 2013 to 2022, whereas participants of 3-day programme and one-off events had engaged in the last 4-5 years.

Table 1.1 Engagement with programme

Programme element	N	Per cent	Year of engagement
Regional programme (3-day virtual programme)	61	72.6%	2019-2022
National Leadership for Empowered and Healthy Communities programme or Leadership for Empowered Communities and Personalised Care programme (6-day face to face programme)	21	25.0%	2013-2022
One-off event, workshop or masterclass	11	13.1%	2018-2022
Other	2	2.4%	2022

Source: IES 2022

1.4.2 Case study sample

Overall, nine screening interviews were conducted. This resulted in a shortlist of seven case studies. Fifteen case study interviews were conducted, including the stakeholders. A summary of the final case study sample is below.

Table 1.2: Case study sample

Case study	Name	Programme	Location	Organisation type	Seniority
3.1	Melanie	One-off event	South-east	Charity	Junior
3.2	Karen	Regional	South East	NHS	Senior
3.3	Prince	Regional	South East	NHS	Senior
3.4	Helen	National	East	Residential care	Senior
3.5	Lee	Regional	North East and Yorkshire	NHS	Senior
3.6	Sam*	Regional	London	Charity	Senior
3.7	Gillian	National	Midlands	Primary care	Senior

**Pseudonym*

2 Survey evaluation findings

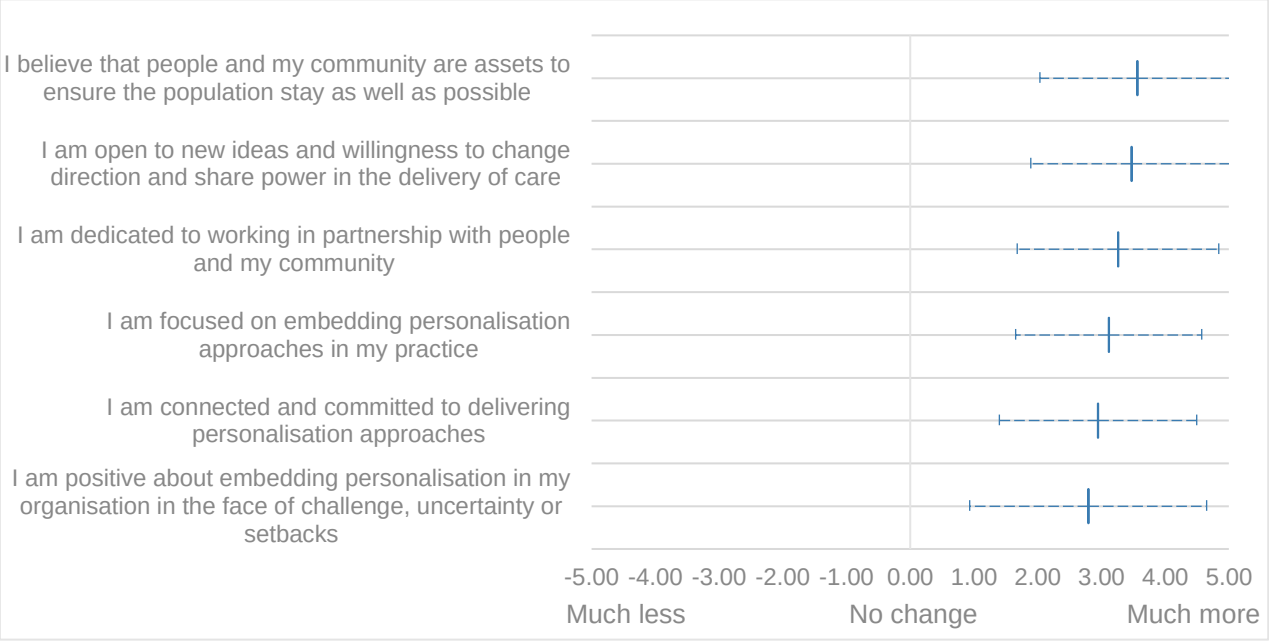
The following chapter describes the findings from the survey, which was distributed in July 2022.

2.1 Embedding Personalisation

2.1.1 Mindset

Overall, the ratings indicate that **respondents experienced a positive change in mindset** across all elements of personalisation since taking part in the programme (see Figure 2). The greatest changes were observed in openness to new ideas and to share power in the delivery of care (M=3.5), and belief that people and one's community are assets to ensure the population stay as well as possible (M=3.6). The smallest mindset change was in positivity about embedding personalisation in one's organisation in the face of challenge, uncertainty or setbacks (M=2.8).

Figure 2: Mindset scores



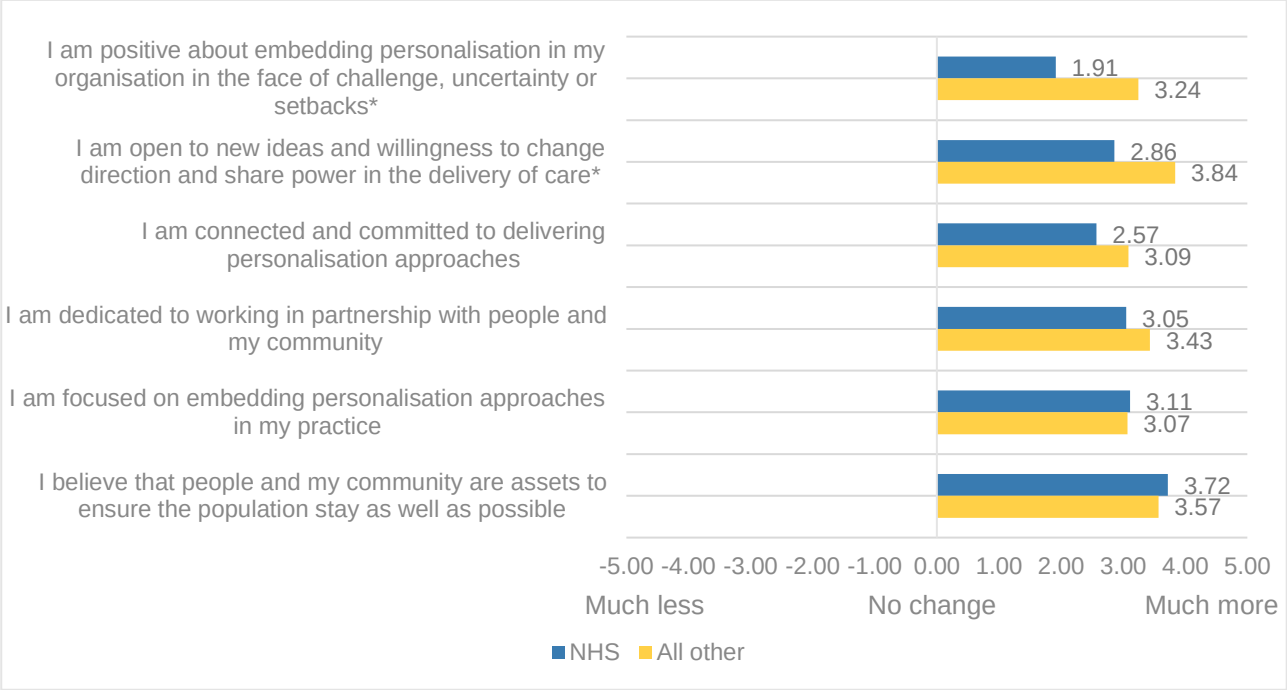
– *Standard deviation*
Source: IES 2022

Mindset change and type of organisation

Individuals who worked in non-NHS organisations in were more positive about embedding personalisation in the face of challenge (M=3.2) and openness to new ideas and to share

power in the delivery of care (M=3.8) compared to those who worked in NHS organisations (M=1.9 and M=2.9, *d=0.7 and d=0.6* respectively; see Figure 3).

Figure 3: Mindset scores by organisation



*Note: * denotes statistically significant difference (p<0.05)*
Source: IES 2022

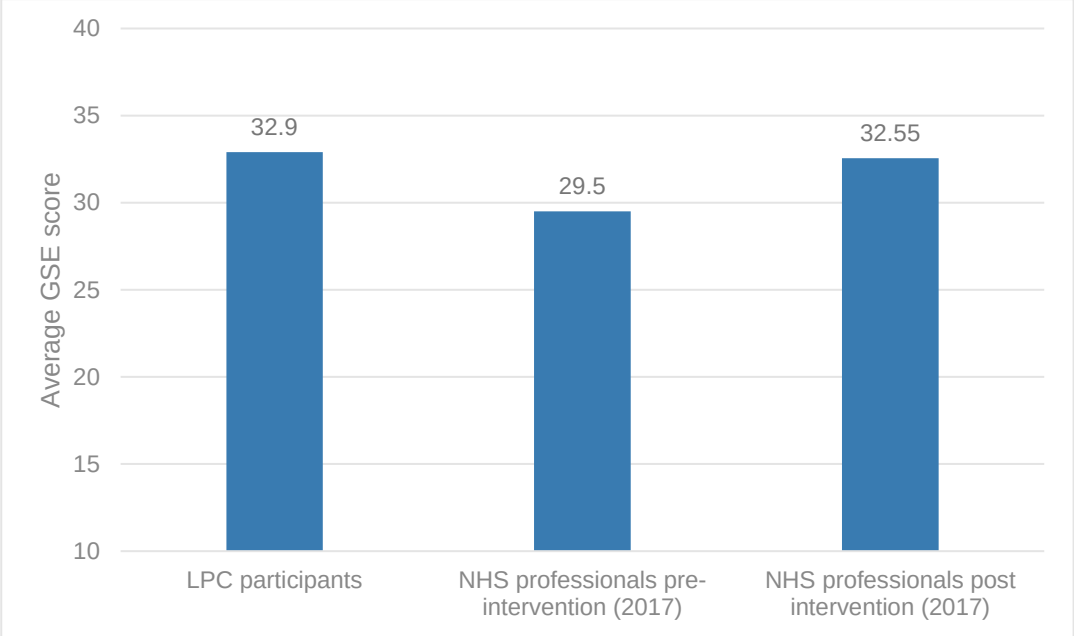
2.1.2 Self-efficacy

Self-efficacy is measured on a scale of 10 – 40, with higher scores representing higher levels. Overall, respondents reported high levels of self-efficacy, with an average self efficacy (GSE) score of 32.9 across all responses. Individual responses ranged from scores of 22 to 39. However, this is only a post programme measure and it is not known if this score differed from levels of self-efficacy prior to the programme.

To put the score in context, a 2017 study[4] conducted in the NHS measured the GSE of healthcare professionals before and after a skills development intervention. These scores could be used as a benchmark to show the 'typical' self-efficacy levels of NHS professionals. The graph below shows that programme participants had higher levels of self-efficacy before and after a skills intervention .

[4] Tweed, A., & Gilbert, L. (2018). The impact of a quality improvement skills-building programme on self-efficacy. *British Journal of Healthcare Management*, *24*(10), 481-485.

Figure 4: GSE score and comparison

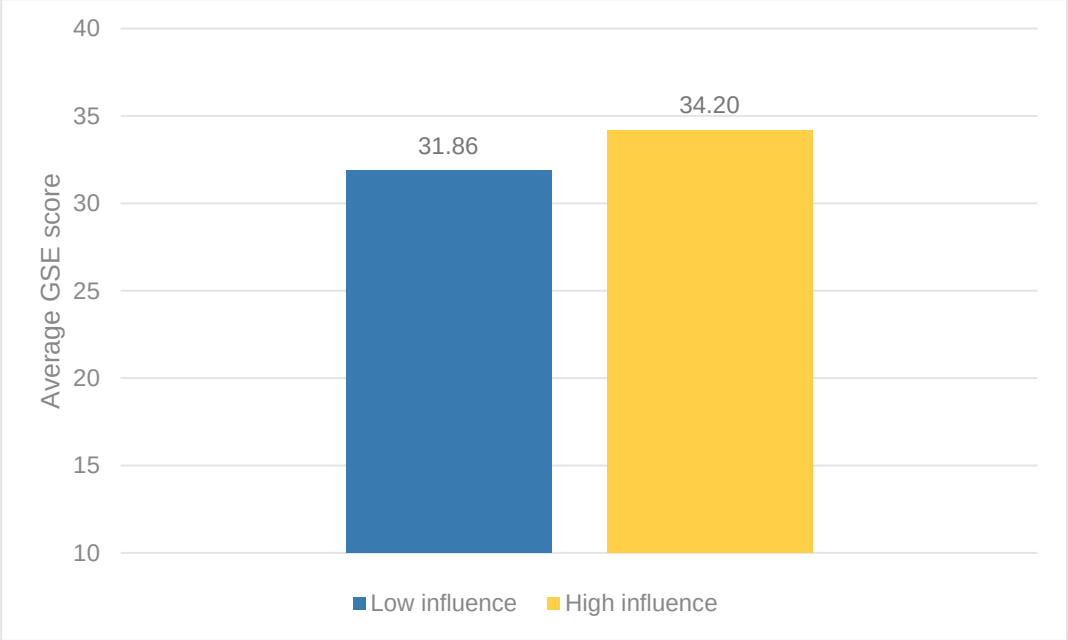


Source: IES, 2022

Self-efficacy and level of influence

Individuals with lower levels of influence reported significantly lower self-efficacy (M=31.9), compared to people with higher levels of influence (M=34.2; see Figure 5). The effect size suggests that level of influence had a medium to large effect on self-efficacy (*d*=.7).

Figure 5: Average GSE scores by level of influence

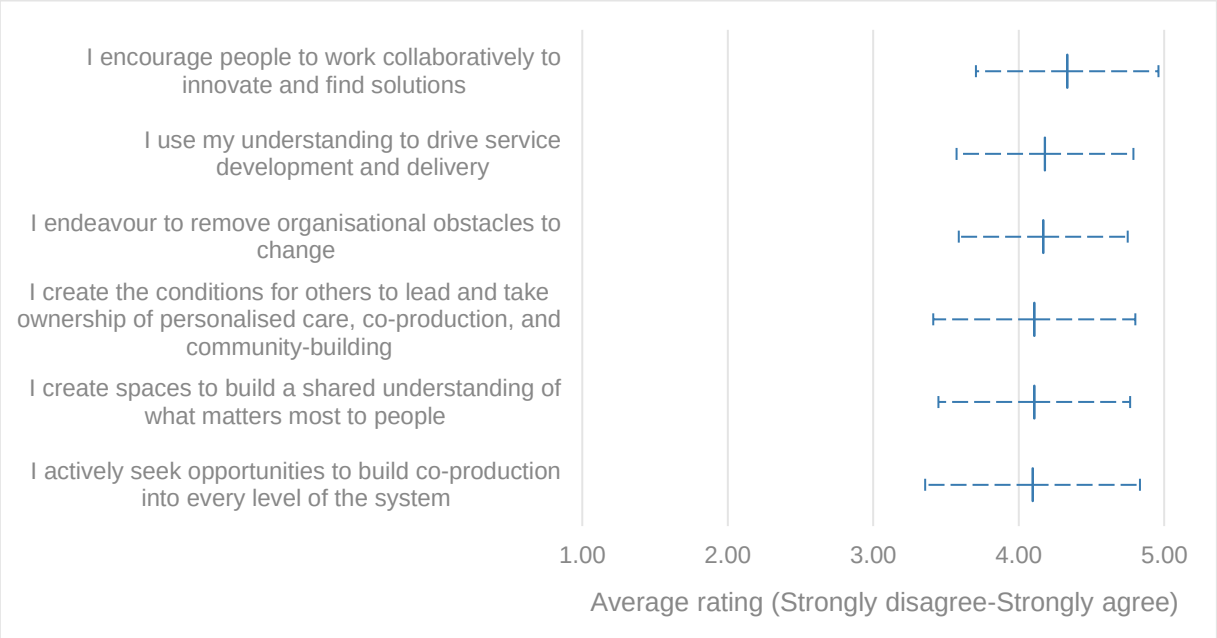


Source: IES, 2022

2.1.3 Embedding practice

Overall, **respondents are taking action to embed personalisation in their setting** (M=4.2 out of 5). Average scores across the six statements were similar (see Figure 6), with respondents **most likely to report collaborative working in their organisations** (M=4.3), and least likely to report embedding co-production into all levels of the system (M=4.1).

Figure 6: Embedded in practice statement scores

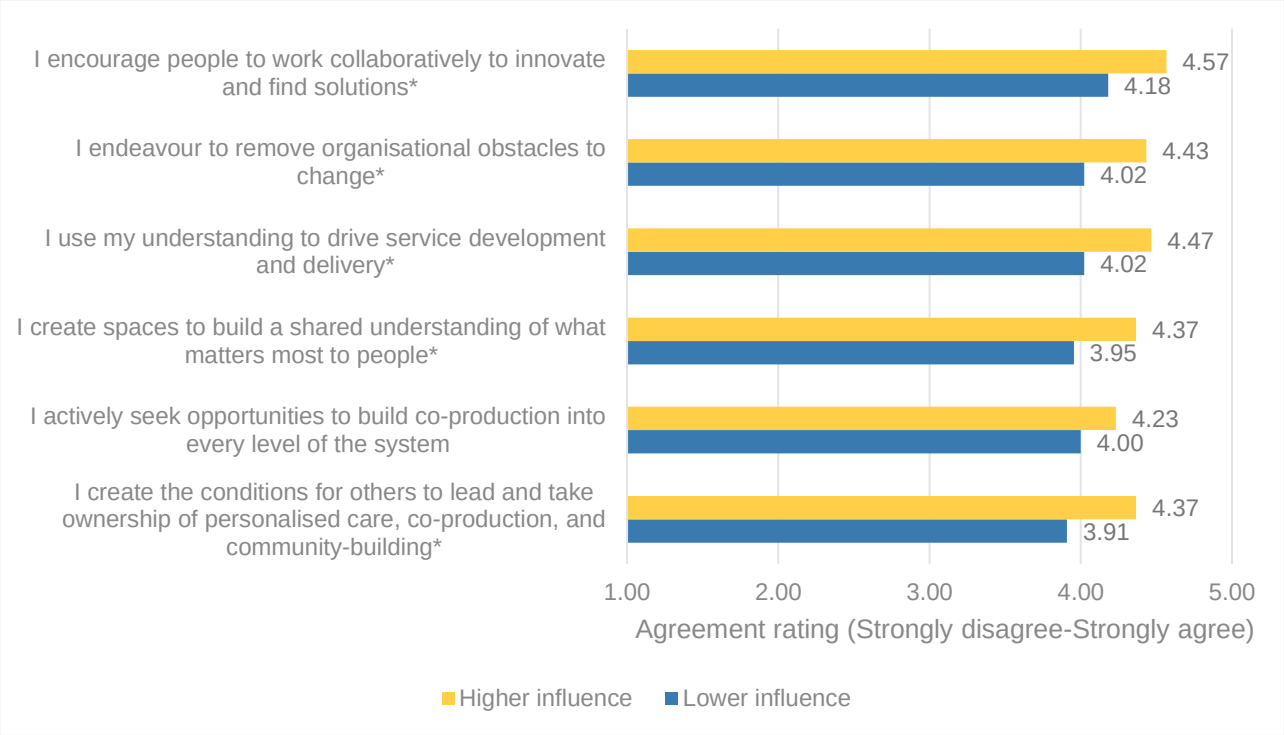


Standard deviation
Source: IES, 2022

Embedded practice and level of influence

Individuals with higher levels of influence were, overall, significantly more likely to report embed personalisation into their setting (M=4.4) compared to those with low influence (M=4.0). The effect size suggests the impact was medium to large (*d*=0.7; see Figure 7). The only statement to not produce a statistically significant response was related to actively seeking opportunities to build co-production into every level of the system.

Figure 7: Embedded in practice scores by level of influence, by statement

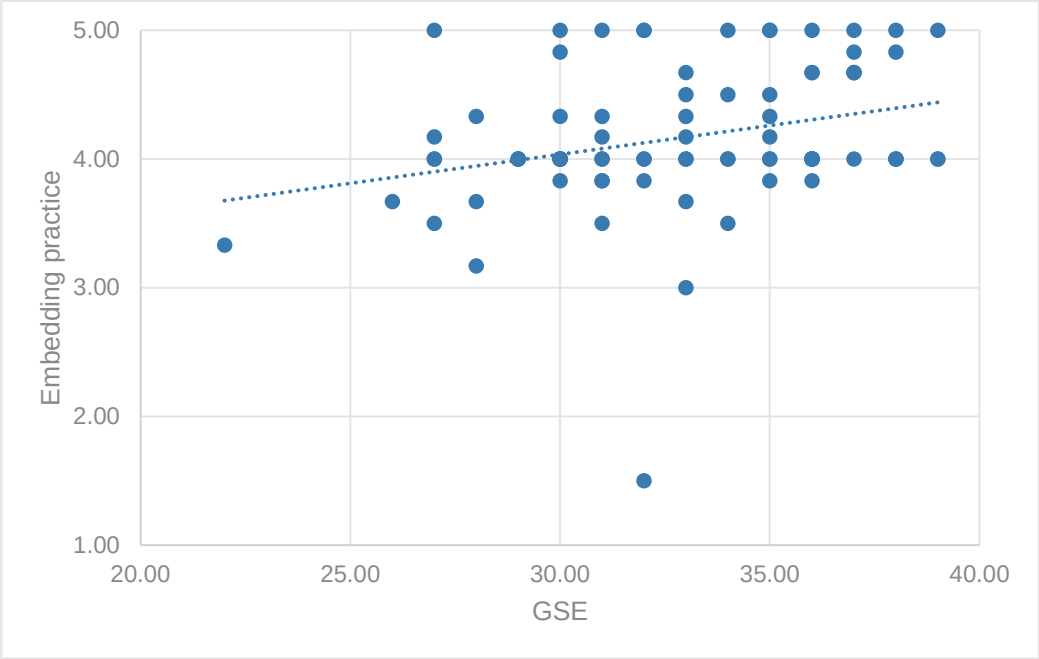


*Note: * denotes statistically significant difference (p<0.05)*
Source: IES, 2022

Embedded practice and self-efficacy

The analysis identified a weak significant positive correlation between respondents' self-efficacy and their ability to embed personalisation in their organisation (r=.29). As self-efficacy scores increase, self-reported ability to embed personalisation in organisational practice also increases. The direction of the effect however, cannot be confirmed and therefore this could suggest that as an individual begins embedding personalisation in their practice, their self-efficacy increases. The graph below shows the correlation between embedding practice and self-efficacy.

Figure 8: Correlation between embedding practice and self-efficacy.



Source: IES, 2022

2.2 Building relationships and influencing

2.2.1 Building relationships

The overall score across all building relationships statements suggests **respondents, on average, agreed or strongly agreed that were able to build relationships and influence people within and outside their organisation** (M=4.4 out of 5). Analysis of responses to individual statements showed that agreement was highest in terms of listening and acting on what others have to say, engaging with a wide range of people, and creating a culture of reflective practice (M=4.5 for all; see Figure 9).

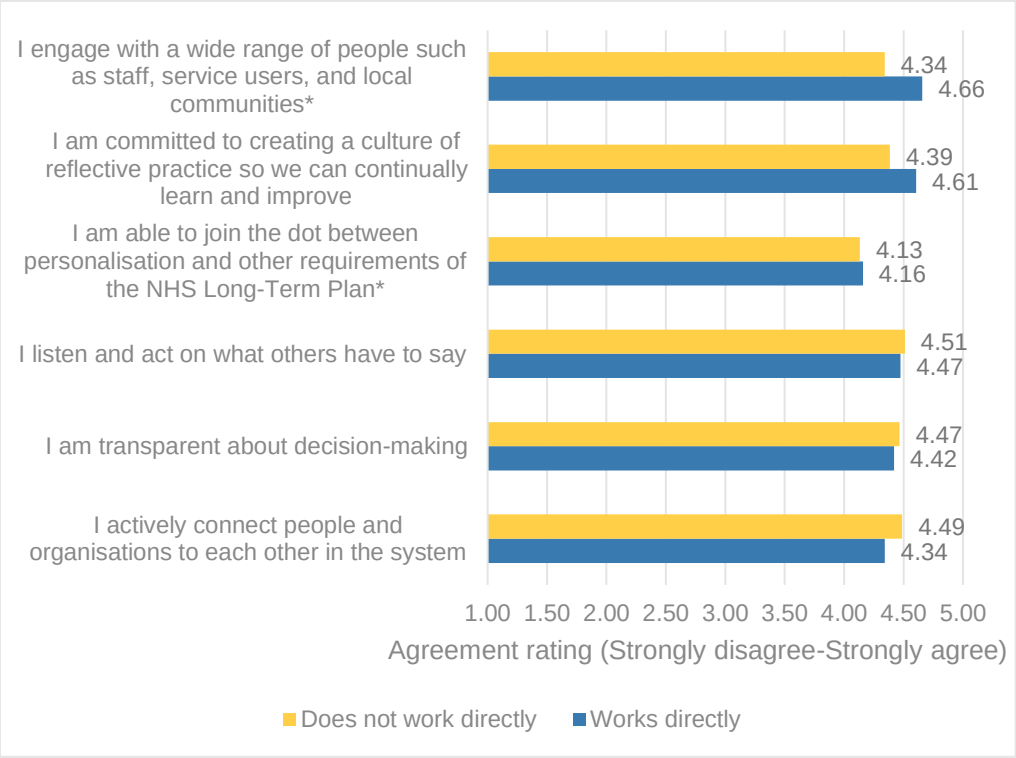
Figure 9: Average building relationships statements ratings

– *Standard deviation*
Source: IES, 2022

Building relationships and direct care

Further analysis explored differences in responses to the building relationships statements between those who provided care directly to people with care and support needs and those who do not. The results showed although there was no significant difference when examining the overall scores, analysis of differences across two individual statements showed those who worked directly with people agreed more strongly that they engage with a wide range of people (M=4.7) compared to those who do not work directly with people showing a medium sized effect (M=4.3, *d*=.6). Additionally, those working directly with people were more able to join the dot between personalisation and other requirements of the NHS Long-Term Plan (M=4.16) compared to those not working directly with people (M=4.13, *d=0.04*). Although, this represents a very small effect size.

Figure 10: Building relationships ratings by direct care

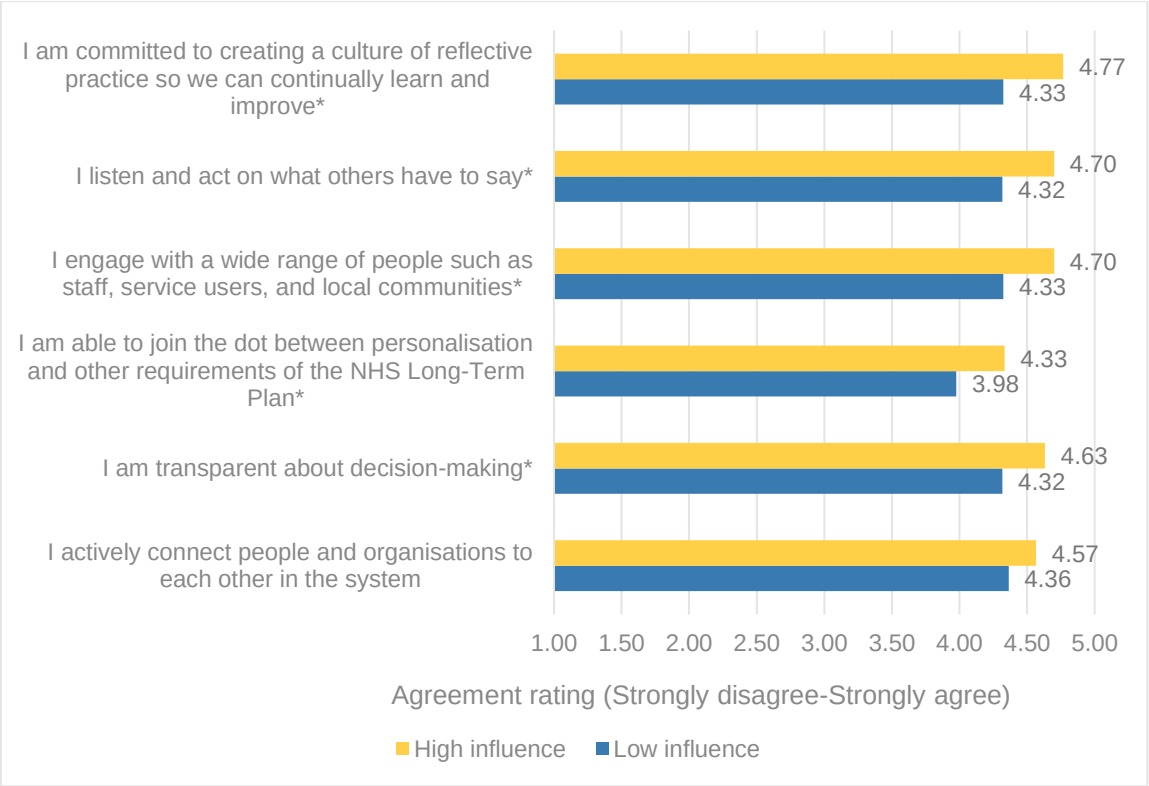


*Note: * denotes statistically significant difference (p<0.05)*
Source: IES, 2022

Building relationships and level of influence

The analysis revealed a significant difference in overall building relationships scores between respondents with different levels of influence. **Those with higher influence reporting greater agreement that they were able to build relationships and influence people** demonstrating a large effect size (*d*=.9). See Figure 11 for differences across individual statements.

Figure 11: Building relationships ratings by level of influence

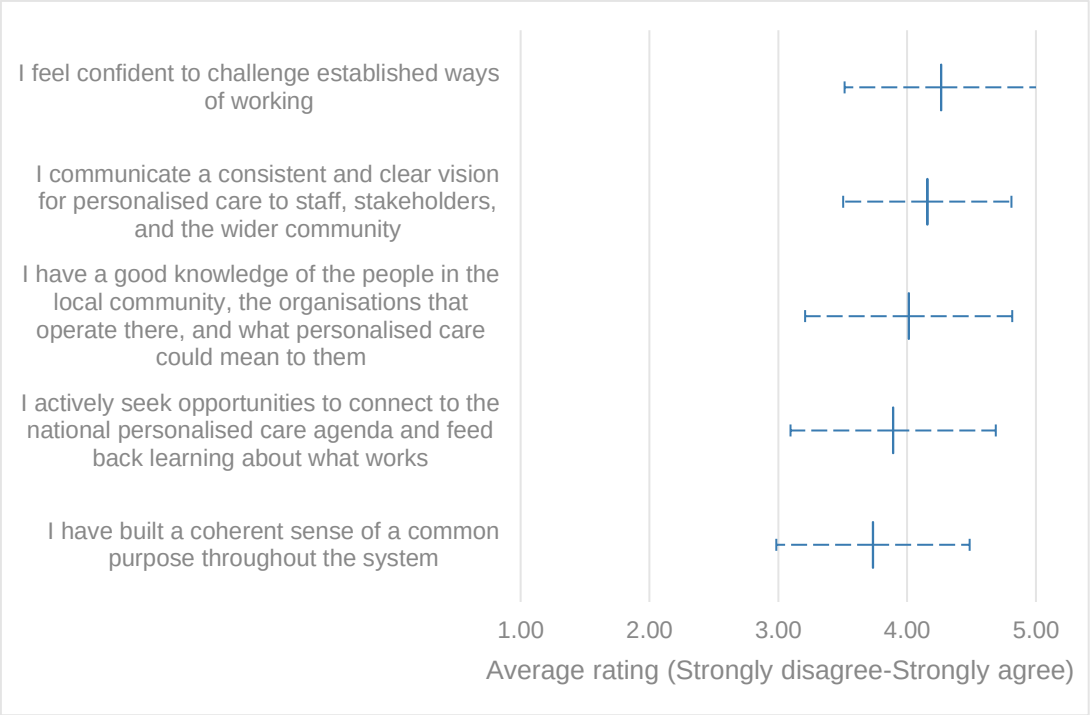


*Note: * denotes statistically significant difference (p<0.05)*
Source: IES, 2022

2.2.2 Confidence

Average scores across all confidence statements suggest that **respondents agreed they influence others as a leader of personalisation within their setting** (M=4.0 out of 5). Assessment of responses to the individual statements reveals that respondents tended to agree most highly that they feel confident to establish ways of working (M=4.3), and to communicate a consistent and clear vision (M=4.2; see Figure 12). Respondents were less confident about building a common purpose in their system (M=3.7).

Figure 12: Average confidence statements ratings

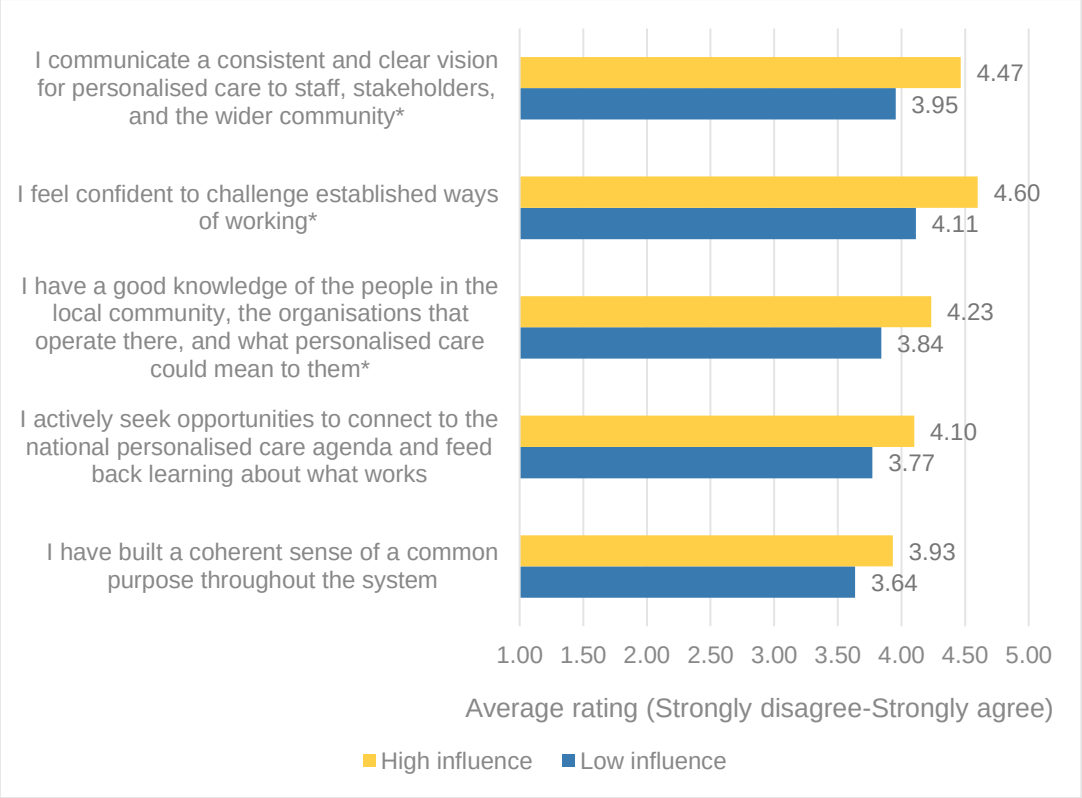


Standard deviation
Source: IES, 2022

Confidence and level of influence

Confidence scores were significantly different between respondents with different levels of influence, with **those working in positions with high levels of influence reported higher confidence scores**. The effect size for these scores also displayed a large effect (*d*=.8). Exploring the differences across statements shows that individuals with high influence felt more confident to challenge established ways of working (M=4.6, *d*=.7), to communicate a consistent and clear vision (M=4.5, *d*=.9) and that they have good knowledge of the people in their community (M=4.2, *d*=.5), compared to those with low influence (see Figure 13). The effect sizes can be interpreted as medium to large.

Figure 13: Confidence ratings by level of influence



*Note: * denotes statistically significant difference (p<0.05)*
Source: IES, 2022

2.2.3 Impact of personal change on others

Survey respondents were asked to identify who they thought had been impacted as a result of their changed behaviour since engaging with the programme. **Stakeholders (72%) and partners (67%) were the most commonly identified groups who had been impacted by respondent behaviour change** (see Table 2.1). The number of people impacted in each group tended to be low, however, almost half of respondents who said they had impacted people with care and support needs reported impacting more than 100 individuals (46%).

The ways in which respondents had impacted their network varied. Respondents who had influenced people they manage or other co-workers reported sharing learning (79%) and influencing their mindset (76%). Working in partnership was most common among those who had impacted stakeholders (79%) or partners (91%), as was sharing learning (65% and 68%, respectively). Whereas making a positive difference to people's experiences of services was most commonly identified by 85%those who had impacted people with care and support needs.

Table 2.1: Influence on network

	People I manage	Other co-workers	Stakeholders	Partners	People with care and support needs

Impacted		53%	64%	72%	67%	47%
Number impacted	1-10	83%	71%	61%	58%	9%
	11-50	8%	25%	24%	36%	27%
	51-100	8%	0%	6%	2%	18%
	More than 100	3%	4%	10%	4%	46%
Type of impact	Influenced mindset	76%	69%	58%	47%	58%
	Influenced behaviour or practice	68%	62%	48%	43%	55%
	Shared learning	79%	80%	65%	68%	42%
	Worked in partnership	68%	58%	79%	91%	52%
	Made a positive difference to their experience of services	-	-	-	-	85%

Source: IES 2022

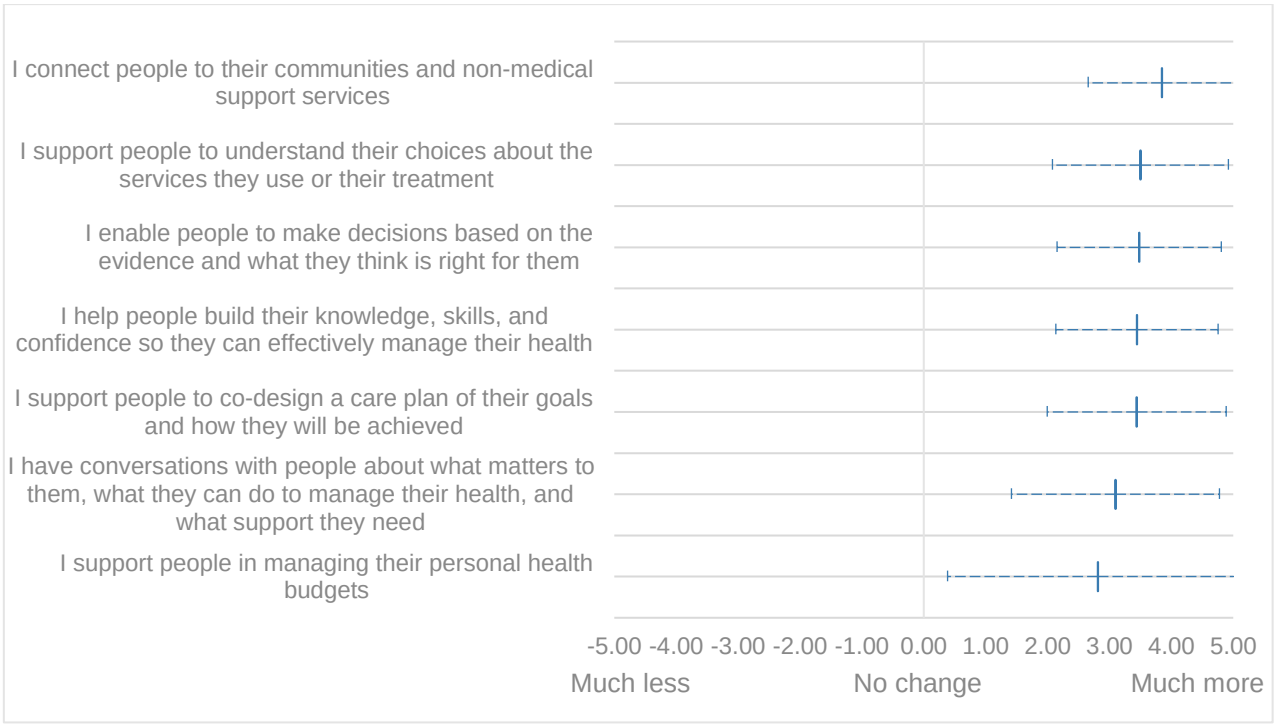
2.3 Changed practice

2.3.1 Individual practice

Within the survey, respondents working in direct patient care roles were asked a series of questions related to their individual practice. The results showed that **people working in direct patient care roles had made positive changes to their own practice** since engaging with the personalisation programme (see Figure 14). The activity that respondents were undertaking most commonly was connecting people to their communities and non-medical services (M=3.9). Respondents were also supporting people to understand their choices about services and treatment, and enabling people to make decisions based on the evidence and what they think is right for them more often than prior to the programme (M=3.5 for both).

The average change in supporting people in managing their personal health budgets was the activity undertaken least and varied greatly, as indicated by the standard deviation around the mean score (± 2.4), which shows that while some people had embedded this activity in their practice to a great extent, others had done so much less. This could be as not all respondents have an active role in supporting people to manage their personal health budgets.

Figure 14: Individual practice scores



Standard deviation

Source: IES 2022

Individual practice and organisational business as usual

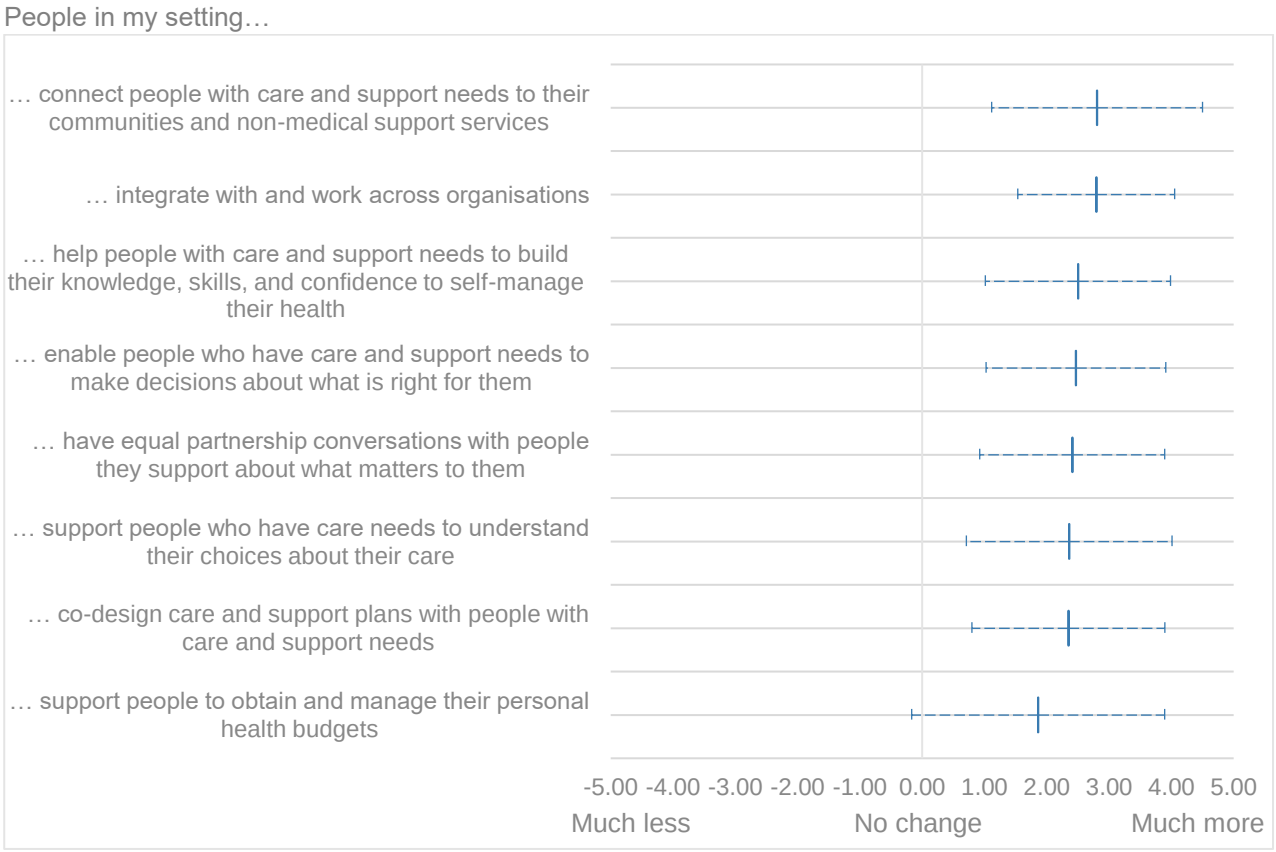
Further analysis highlighted a strong significant positive correlation between an individual's practice of personalisation, and how they perceived the personalisation as business as usual in their organisation (r=.91). This finding highlights the relationship between individual and organisational practice, however, the direction of the impact cannot be determined from this data. Working in an organisation where personalisation is considered business as usual may increase likelihood of embedding personalisation in individual practice, however, establishing personalisation as an individual may also lead to greater personalisation in the organisation which effects perceptions of business as usual.

2.3.2 Organisational practice

Compared to before, respondents engaged with the programme, **all elements of personalised practice were considered business as usual to a greater extent in the place where they lived and worked** (see Figure 15). Connecting people to their communities and non-medical support services (M=2.8) and integrating with and working across organisations (M=2.8) were the practices that were identified most commonly.

Supporting people to obtain and manage personal health budgets was the practice least commonly recognised by respondents as business as usual (M=1.9) and the results also showed large variation in scores (as indicated by the standard deviation around the mean ± 2.0).

Figure 15: Organisational practice scores



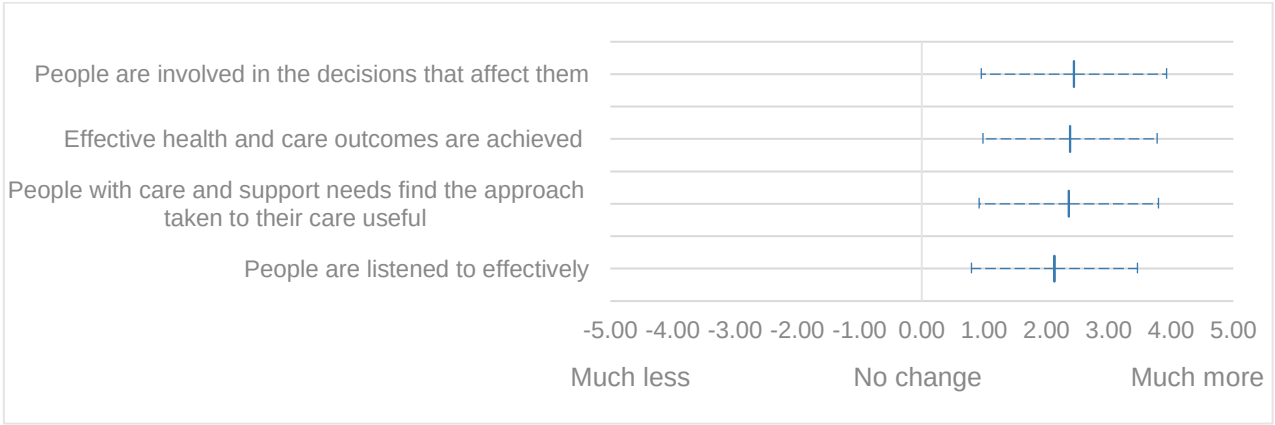
– –*Standard deviation*

Source: IES 2022

2.3.3 Impact on people with care and support needs

The impact on people with care and support needs as a result of respondents engaging with the programme was positive (see Figure 16). Respondents reported that people were more involved in decisions that affect them (M=2.4) and effective health and care outcomes are achieved more (M=2.4).

Figure 16: Impact on people scores



Standard deviation
Source: IES 2022

2.3.4 Successes and Barriers

Changes made since the programme

Respondents were asked to highlight a single change they have enacted since taking part in the programme which has influenced the biggest positive impact in the place they live and work. Most commonly, **individuals reported that increasing their levels of partnership working, both within their organisation and across their community had fostered the most positive impact**. Individuals commonly described that increased levels of partnership working was facilitating integrated, local ways of thinking and supporting the development of the local personalisation offer.

Additionally, some individuals reported **increasing their engagement with people in the community with lived experience and improving co-production**. Respondents had varying approaches to engaging with the community, with some increasing their levels of social activism and advocacy, others amplifying the community voice when decisions are being made and others taking time to ensure the community's wants and needs are being addressed.

'Collaborative working with partners to create a community inclusive for all [has increased]. If I am leading an event, I now ask partners if they would like me to take their information or links along with mine.'

Third or voluntary sector, North East and Yorkshire, responsible for an individual or small team

'Working in partnership with VCSE, Healthwatch and the Local Authority to establish a community partnership. This has developed PCN community action networks to ensure we are listening to the voices of out community and working together to identify changes required and strategically review these to respond to or include in planning.'

NHS, Midlands, responsible for making decisions that affect national policy

'[The programme] has made me think very much about co-producing work a lot more and getting [the community's] engagement, and looking more at what they want and feel they need.'

Third or voluntary sector, North East and Yorkshire, responsible for a large team

Further, some individuals felt that taking part in the programme **provided them with the confidence to challenge the current practice** within their organisation and begin discussing potential changes to practice more openly with their colleagues.

'[The biggest change has been] thinking the impossible and challenging the norm. I was inspired by the courage people had to challenge individuals in a constructive manner. I have found myself considering strategies to achieve better outcomes with colleagues, rather than working around them to achieve goals.'

Private sector, London, responsible for an organisation

Conversely, some individuals reported not making any changes to the direction of personalisation in their local setting since taking part in the programme. Rather, they felt **the programme validated their way of working** prior to engagement and provided an increased level of confidence to continue working toward personalisation in the way they already were.

> *'The course didn't change anything, it confirmed I had the right mindset and had been travelling [in] the right path. I'm not sure the programme did more than improve my confidence.'*
>
> NHS, East of England, responsible for an organisation

A small number of participants have not made any changes since participating in the programme as they felt the content did not motivate them to do anything differently in their day job.

Collaboration with colleagues

Respondents were asked to highlight how they have collaborated with colleagues in their place of work that also took part in the programme since their engagement. Response rate to this question was low, with only 20 responses. Many of these **respondents reported that they had not had the opportunity to work with their colleagues who had taken part in the LPC programme, largely due to time and capacity constraints.**

Of those that reported being able to work with their fellow LPC colleagues, some discussed being able to **work collaboratively to address local challenges** through the personalisation agenda, with a key aim to improve opportunities to all. Further, some **regrouped to assess the current personalisation approach within their local area**, ensuring this is central to the aims and missions of the local service.

> *'[Together we] have reinforced the personalised care approach and ensured it is central to the aims and mission of the service we provide locally. This has improved the working relationship across the PCN, improving client/patient care and support.'*
>
> Third or voluntary sector, South East, no formal leadership responsibility
>
> *'We attended the course as a cross-organisational team across the ICS. Attending has established a personalised care champions group across our ICS who support and lead change across the system.'*
>
> NHS, Midlands, responsible at a wider system level

Hindering progress toward personalisation

The last open text question in the survey asked respondents to discuss anything that has hindered them from making progress in leading personalisation in the place that they live and work. Overwhelmingly the **most common responses to this were time, staff and organisational capacity**, particularly due to the impact of Covid-19 on services.

Time was mentioned frequently as the biggest hinderance to making progress toward personalisation locally. Individuals reported feeling that there is not enough time in their

role to meet all the demands of the personalisation agenda, and ultimately competing priorities often came first.

'Time! I could do with admin support to help me manage all the comms (incoming and outgoing) that are required to develop network relationships at strategic and operational levels.'

Third or voluntary sector, London, responsible at organisational level

The stretched capacity of individuals, organisations and systems were further reported to commonly hinder progress toward personalisation in respondent's local areas. The impact of increasing pressure of services providing care and support, particularly since the onset of the pandemic, has driven a more clinical approach within services. This is preventing individuals in these settings from taking a step back to view the wider picture of a personalised approach. Additionally, service fatigue that developed before, and intensified throughout the pandemic is reducing capacity for thinking space and slowing the speed of change across the system.

'There is a much more clinical focus coming out of the pandemic, no-one has headspace to look at the bigger picture.'

NHS, East of England, responsible for an individual or small team

'Staff and service fatigue… and competing priorities due to the mounting pressure created from the deterioration of the National Health Service… Staff are not bouncing back and the people who use our services continue to mostly see the worst in what staff provide…'

NHS, East of England, responsible at organisational level

The final commonly reported challenge was the **difficulty of working across organisational boundaries**, particularly those across and within the NHS. Respondents reported that engaging with partners and working with different working cultures presents a challenge to the efficiency of embedding personalised practice. Participants also discussed inoperability barriers when working with other organisations, particularly where there are differences between social and medical models of practice.

'Working across boundaries, different working cultures and the general high-level situations [hinders progress], particularly within acute trusts, as it is not seen as a priority.'

Local Authority, East of England, responsible for a large team

Additionally, some participants felt that the **continuous changes to structure and leadership within the NHS present challenges in maintaining change**, and thus change is short lived.

'There was initially significant impact but the NHS is constantly changing its structure and senior figures so too often change and improvements are short lived.'

Private sector, Midlands, responsible at organisational level

'We are currently going through a restructure and our exec team are still not in place. This makes it much harder for us to progress on pieces of work due to the lack of governance being established.'

NHS, South East, responsible for an individual or small team

3 Case Studies

3.1 Melanie, Social Prescriber Link Worker

Background and context

Melanie is a Social Prescriber Link Worker working for Arun & Chichester Citizens Advice in the South-East of England. She helps people take control of their health and wellbeing by supporting them to decide which organisations, services, charities, or groups they wish to engage with to move forward. She encourages her clients to make authentic changes at their own pace. Many of her clients have felt 'let down' by their local community as they often have 'doors shut' on them when trying to access services.

Melanie participated in the Leadership for Personalised Care programme in 2021. While she was already working with a 'personalised approach', she sought something 'structured' to enable her to delve further into personalisation. She was the only one from her organisation to attend, but she saw it as an opportunity to learn how to improve the services they offer clients.

The impact of the programme

Melanie thought the programme was 'inspirational' and provided her with a 'safe space' to learn from her peers. She has gained more confidence as a practitioner and, while she always had a personalised philosophy, the programme allowed it to develop and deepen. Since the programme, Melanie has felt 'empowered' to 'disrupt' in a way that she believes will bring meaningful change to practice from the ground up.

> *'The personalisation programme gave me confidence in to be radical in my approach…it gave me permission to be radical.'*

She sees herself as an agent for change in her local system, influencing mindsets and wider practices in a non-directive and gentle way.

> *'If services aren't at the place of fully embracing personalisation is my role to support, challenge disrupt, but gently so, and to support the change.'*

Her colleagues see Melanie as a vocal advocate of personalisation, both within and outside their organisation.

The personalisation journey

Melanie's approach to influencing change centres around her practice; she relies on her 'steadfast' approach to personalisation as a lever to provoke curiosity and conversation.

She seeks out ways in which she can improve processes to make them person-centred, such as changing her approach to writing client case notes to ensure they focus on the person and their journey. She has also reframed what is thought of as a client 'outcome' by documenting actions that may be considered 'small' but are significant personal achievements.

> *'The outcomes weren't personalised [in case notes]…They [the client] can choose not to do anything, but if a client made a decision and it might seem small, this decision, but it was a big decision and the client made that decision and the client hadn't made any decision before.'*

These changes have been noticed by managers and peers within the organisation. It has sparked conversation and interest about how she practices in a personalised way, which Melanie hopes will result in changes to how her colleagues work with their clients. Although she is aware that this is a 'slower' approach to change, her organisation does not put any barriers in her way. As well as internally, she has also driven change in the wider community. She has worked with local charity partners to personalise the routes to engage with services.

> *'One of the big issues that we were finding was supporting individuals to engage. Now they wanted to engage. So, it's not that we're forcing anybody to engage, but there's a big space between an individual wishing to engage and that point of engagement.'*

Melanie worked with a charity to design a gentle, personalised way of transitioning into the service. They removed the need for a client to self-refer, and instead, the service reaches out to the individual to support them in the transition. However, Melanie believes it is more difficult to influence the local community as stakeholders are less likely to have a 'personalised mindset'. Despite these challenges, Melanie remains clear that the best way to influence change is to focus on herself and role model personalised practice.

The future impact of personalisation

For Melanie, embedding personalisation can have an immediate impact on the individual but a slower impact on wider health and social care outcomes. She acknowledges that by changing practice on the ground, the system is unlikely to see an immediate 'big impact', but gradually she believes the system will become 'more human'. However, she is clear that personalisation must be 'authentic' to each individual and not become 'controlled' and 'dictated by the system'.

> *'You can't dictate what personalisation is. As long as it stays authentically personalised. Not developed into some entity.'*

To take the personalisation agenda forward, Melanie will continue to take 'responsibility for her practice' and fully personalise the experience for her clients. She believes that changing practice will slowly influence change from the ground up. So, she calls upon other practitioners to be an advocate by embedding personalisation in their approach and challenging any barriers that prevent personalised practice.

'Resist and challenge pressure or demand from external influences which may interfere or hinder with the provision of a personalised approach.'

3.2 Karen, ICS Programme Lead

Background and context

Karen is the ICS Programme Lead for the Community Deal within the Frimley ICS. The Community Deal is one of Frimley's six key ambitions and aims to build relationships with communities to co-produce solutions to local issues. Karen oversees Frimley's approach to the Personalised Care model set out in the NHS long-term plan. She hopes that embedding personalisation in the system will empower residents to vocalise what matters to them and what they want from local services.

'It's that shift of power, of how we make our patients understand and think about what matters to them, for us to be able to deliver what they need to achieve their outcomes.'

Karen joined the regional Leadership for Personalised Care programme in 2021 with colleagues from across the ICS. Although personalisation was underway within Frimley through the Community Deal, the programme came at a time when place-based teams were accelerating their local personalisation journeys. Place-based teams are tailoring their approach to personalisation to meet the needs of their residents while collaborating with other teams across the ICS to share best practices and innovation.

'[Different place teams] are all doing different things so part of that has also been about us... having that coordinating role to try and align us to get us into a situation where we then… have a system wide view of how we deliver…'

The impact of the programme

The programme provided Karen with the time and space to reflect and take stock of Frimley's progress towards personalisation. This protected time to reflect motivated Karen to continue to change mindsets and practices in a range of health, social care, and voluntary organisations.

Karen also learned the importance of holistic thinking and not viewing elements of personalisation in silos. She feels that by taking part she can identify opportunities for different aspects of personalisation more frequently, setting the groundwork for personalisation to efficiently be embedded into the ICS' practice.

Frimley's personalisation journey

Following the programme, Karen led on the establishment of the ICS personalisation steering group, which is responsible for overseeing both the place-based and system wide personalisation journeys. Involved in the steering group there are representatives from the Local Authority, Primary and Secondary Care, and the community sector. The

group collaborated to deliver a set of principles outlining Frimley's personalisation goals, and the steps to be taken to embed personalisation.

'We've developed a set of core principles for the system as a focus on how we deliver personalised care and for our population'

Co-production is high on the agenda for Karen. With the personalisation steering group, she convened a group of people with lived experience to review the principles and share their experiences of the health and social care system. Working with this group of people, Karen and the steering group have tested these core principles, ensuring that they are understood by the local population and that personalisation is properly embedded into practice. Their insight was also used to inform similar changes in different elements of the system.

'We kind of wanted to get us some footing as a system of work, that means we've always wanted to go and talk to people with lived experience.'

Karen also identified that generally, personal health budgets were an underutilised resource. She challenged the system to expand their use. By doing so, she hopes to increase the level of freedom residents have in improving their health and wellbeing. The ICS has begun to source personal health budgets for individuals at the point of entry to services and Between April 2021 and March 2022, the number of personal health budgets increased from 74 to almost 1200.

'[With] new cases coming on, we automatically think what we can do as part of a personal budget with a personalised care support plan… When we started counting in April [2021], we were starting at a point of 74… at the end of [March 2022] we were 63 off our 1200 target.'

Karen feels that before tackling systemic practice change, mindsets toward personalisation must change. To help others understand the importance of personalisation, Karen has delivered presentations and workshops to organisations providing support to Frimley residents. Through these, she hopes to influence individual mindsets and organisational cultures and support the development of personalised practices.

'So hopefully [spreading awareness and keeping up the conversation] will then get people to change their mindset and their thinking.'

Frimley's journey benefits from having strategic system-wide oversight, alongside operational place-based teams that can respond to community needs, and pilot initiatives in the local setting. Karen and other ICS representatives can use insights and data from these pilots to show the impact of personalisation initiatives in different places, highlighting any practices that can be rolled out across the ICS.

The future

As the personalisation journey across Frimley continues, Karen's priority is to continue work to change the mindsets of organisations involved in the delivery of services across Frimley. She hopes doing this will instil belief in the principles of personalisation, encouraging as many people engage in the journey as possible. This, Karen feels, will support the adoption of a shared, personalised vision across the ICS and further support the delivery of the Community Deal and the ICS' personalisation strategy.

She also intends for people with lived experience to play an even bigger role in the design and delivery of the journey as it progresses. This will continue to be through their involvement in the personalisation steering group meetings, work with the voluntary and community sector which Karen hopes will grow in size and influence as the community begins to see change in the system and support they receive.#

3.3 Prince, Integrated Care Transformation Senior Manager

Background and context

Prince is the Integrated Care Transformation Senior Manager within the Royal Borough of Windsor and Maidenhead (RBWM), based in the Frimley ICS. His role focuses on integrating the services available to people in the community by encouraging collaboration and developing streamlined support. The key aim of personalisation in the RBWM is to empower residents to make decisions about their health that fit best with their lifestyle and priorities. The RBWM hopes to achieve this by encouraging organisations to provide a minimum standard of service that allows residents to know what they can expect when accessing health, social care and voluntary services.

Prince, along with colleagues working locally and throughout the ICS, attended the regional Leadership for Personalised Care programme in 2021. This came at a time when place-based teams within the ICS, such as the RBWM, were accelerating their local personalisation journey. RBWM collaborates closely with the wider Frimley ICS through sharing key learnings, best practice and innovation.

The impact of the programme

By taking part in the programme, Prince developed his understanding of the importance of collaborative working to ensure local services are supporting one another to deliver a personalised approach. Therefore, he has encouraged organisations to increase their levels of collaborative working. By improving collaboration, people working across the system can achieve a seamless level of service, capable of delivering personalised support.

The personalisation journey

The RBWM are at the developing stage of their personalisation journey. Since attending the programme, Prince has focused on developing relationships and preparing the local community for personalisation. He has established a local personalisation group, which engages in regular personalisation meetings. Attending these meetings are individuals working for the NHS, voluntary and community sector organisations, Local Authority, and on some occasions individuals from the local community. The first task for the personalisation group was to develop Terms of Reference, outlining the goals of the personalisation agenda and their roles and responsibilities. The first draft of the Terms of Reference was signed by 17 stakeholders from a range of sectors involved in the personalisation group.

'[The terms of reference] is very much saying "how do we bring ourselves together", "how do we make sure that we empower, train, educate ourselves so that we are able to deliver personalised care?"'

The group also developed a local 'Maturity Matrix', a framework that is used to track the system's progress towards fully embedding personalisation. The framework was developed from the principles of personalisation shared through the Leadership for Personalised Care programme, the NHS long-term plan, the NHS England Memorandum of Understanding self-assessment tool, and the vision shared locally. Members of the group evaluate their organisations against the matrix to identify areas of strength and weakness, which is then shared and discussed at steering group meetings. Importantly, the matrix is also used to understand how the system is working as a whole to deliver personalisation and to identify any systemic issues that require addressing.

'Doing the personalisation matrix in the group, it's been really interesting to reflect on actually what other organisations have been doing and how they've been working… if there's anything we can do better and take from that.'

Prince has encouraged staff to access the free bitesize programmes and masterclasses available on the Leadership for Personalised Care website. So far, there has been a high uptake of the training among staff working in social prescribing, care coordinator, and health and wellbeing coach roles. Prince hopes that these frontline roles will kickstart a gradual change in practice across the RBWM as their personalised skills increase.

'I think personalisation training's always really good to do every now and then. It's one of those things we should do every few years like safeguarding… because things change constantly within the world of social work, it's good to just remind yourself.'

He has also participated in the Alumni Action Learning Sets organised by the Personalised Care Team. These have allowed him to share their goals and the challenges they have faced, while being inspired by the journeys happening in other systems.

'[The Personalised Care Team] had action learning sets which I got involved in. That's been really immensely helpful… it was in a small group, and we were able to kind of talk through some of the challenges and hopes that we have for our personalisation journey.'

The future of personalisation

Prince, in collaboration with the personalisation group, has laid much of the groundwork to achieve the goals set out in the Terms of Reference. Prince feels that to begin delivering personalisation, a significant practice change is needed amongst staff working across the system. To help support this, an increasing number of people working across the RBWM are accessing the Personalised Care Institute training hub and 'Frimley Academy', a bespoke training programme designed to increase the leadership qualities of everyone in the workforce, giving them agency to understand and deliver personalised support.

There is now a less formal approach to personalisation taking shape across within local organisations. This is including working with people experiencing homelessness and Lived Experience Practitioners in mental health, as well as introducing a default reablement offer for both preventative and discharge pathways.

Moving forward, Prince plans to continue encouraging organisations to work together to increase personalisation across the system. This will include co-producing with residents, through the local personalisation group meetings, to ensure the personalisation journey is responsive to, and in the best interests of the local communities. The future for the RBWM will develop by identifying these emerging examples of personalised care and providing advice, information, support, training and practical help to staff who wish to take the next step to further embed personalisation into their professional practice.

3.4 Helen, Senior Project Manager and Clinical Lead

Background and context

Helen is a Senior Project Manager and Clinical Lead for a small company that specialises in improving residential nursing care in the East of England. The organisation assists local authorities and the Integrated Care Board (ICB) to implement a care framework that moves towards proactive, personalised support that is centred on the needs of individual residents, their families and care home staff. They also run the Trusted Assessor scheme, a nationwide initiative that supports safe and timely discharge from hospitals for care home residents.

Helen was motivated to participate in the National Leadership for Personalised Care programme to advocate for her talented colleagues in social care and drive forward the personalised care agenda, particularly in acute trusts. While personalisation is an intrinsic part of social care, forming part of the Care Quality Commission's (CQC's) inspection protocol, it is not the case for acute care.

'We work within acute hospitals. And we felt as a team that actually personalised care… still wasn't seen as important. The care wasn't personalised, so it was an opportunity again to really

push forward the personalised care agenda within the acute trusts… but also just as a sort of refresher for social care.'

Impact of the programme

Helen thought that the programme was fantastic, motivating and empowering. She gained more knowledge about personalisation and developed some tools and techniques that supported her to get her voice heard in a large and noisy system. It provided her with a 'safe space' to network with like-minded people working toward delivering personalised support in their system. These new connections gave her the encouragement to 'go out and do it and give it a try'. Overall, her confidence and knowledge have increased, which has enabled her to take more risks and push boundaries.

'There was lots of opportunity to discuss and go "I've got this issue" and "Yeah, right. Let's just go and do it". And it was very confidence building for me as a person.'

Personalisation journey

Since her time on the programme, Helen has made significant changes to the Trusted Assessor operating procedures. During Covid, the approach to patient assessments inadvertently became more medicalised and depersonalised due to system pressures. Her time on the programme reinforced for Helen that she was not comfortable with the direction of change, so she gathered her team together to overhaul their approach.

'I had the opportunity and was lucky enough to get a place on the leadership programme and from that, it reinforced in my mind that I'm not happy with this. So as a team we got together and again sort of really looked at what personalised care meant to us as a team and completely overhauled the assessment, so it was very much written from the patient's perspective. So it was as simple as starting with "My name" instead of just "name".'

Despite being a comprehensive assessment document, they completely redesigned the paperwork to ensure that it was personalised at its core. All questions were rewritten to start with 'I' and the assessments now include detailed conversations with the next of kin. These changes were made in collaboration with care providers, who were 'over the moon', despite the fact assessments would take a little bit longer. There was a lot of enthusiasm from care staff, and the CQC were 'really positive' about the new approach. The new assessment procedure was piloted, and anecdotal data suggest that the changes have had a real impact on the mindsets of nursing staff. Patients are no longer seen as just 'beds', but as people with names, families, needs and wants.

Helen was also invited to manage the ICB personalised care agenda, which has introduced her to contacts involved in the delivery of personalised support. With support from these new contacts, she established a project working group that meets fortnightly, which brings together colleagues from the ICS, local authorities, care homes and voluntary organisations. Helen and the project group organised and delivered a personalised care conference aimed at anyone delivering health and social care in the local community. The goal of the conference was for stakeholders to collectively develop

a shared personalised care plan that will inform their practice across the community. Helen shared that the conference was well received by attendees, and provided her with more confidence to follow the personalised care agenda.

'So what a personalised care plan looks for from a GP perspective or district nurse compared to care providers again is a vast difference. So it's all about trying to bring them together.'

The project group is also looking at opportunities for training and development for colleagues within the Primary Care Network to develop knowledge about personalisation and integrate it into business as usual. Helen has been instrumental in pushing the personalisation agenda through networking.

'I do a lot of visits around my care homes and with domiciliary care and it's, you know, how you're getting on with sort of looking at the personalised care agenda…It's just getting out there and getting yourself known. And yeah, listening, networking, finding out what everyone else is doing.'

The future

It has been difficult, as someone outside of healthcare, for Helen to influence mindsets in acute care. However, she continues to advocate for a different approach by role modelling and having ongoing authentic conversations.

'I'm not in a position within an acute trust to be able to say this is what should be happening. All I can do is kind of lead from role modelling, "this is what we're doing, we're not changing it because of time frames". It doesn't take that much longer, I'd say perhaps 15-20 minutes, but obviously, that does add up during the day.'

Helen believes that it is critical to engage acute trusts in personalised care, as it has the opportunity to prevent negative events such as unsafe failed discharges, complaints and safeguarding concerns. Therefore, Helen has organised an additional conference, targeted to acute settings, to build momentum in this area. This will be a one-off event, aimed at engaging acute trusts in the conversation surrounding personalisation by sharing the benefits of a personalised way of working.

Despite the challenges, Helen is proud of her and her team's work so far, which has put personalisation firmly on the ICS's agenda.

3.5 Lee, Place Based Partnership Programme Director

Background and context

Lee is the Bassetlaw Place-Based Partnership Programme Director within the Nottingham and Nottinghamshire ICB. She is responsible for overseeing the integration and service improvement programmes across Bassetlaw Place Partnership. Due to its rural location, rapid house building and poor transport links, a high proportion of residents have limited access to public services and experience high levels of health inequality.

Along with colleagues from the Local Authority, Primary Care and the voluntary and community sector, Lee took part in the regional Leadership for Personalised Care programme in 2021. While personalisation was already on the agenda for Bassetlaw's place partnership prior to the programme, taking part provided a timely opportunity to collaborate as an integrated team to promote personalised care as a core shared ethos and develop the agenda locally.

The impact of the programme

Taking part in the programme enabled Lee and her colleagues to dedicate time to meet regularly, enabling the team to develop closer working relationships and develop shared vision for personalisation outcomes. She feels that the programme's content helped improve their understanding of the theoretical principles of personalisation and the methods of application as part of system change across organisations. The content input and protected time to be together enabled the team to discuss the future roll out of personalisation within Bassetlaw and how to work towards delivering a truly person centred, personalised, approach to service redesign and co-production of services.

The personalisation journey

The team in Bassetlaw wanted to deliver an integrated service that provides accessible, wrap-around support to young adults within a small town. They envisaged this to be a physical 'one stop shop' that provides physical and mental health support, employment support and general advice for people living locally. They hoped to deliver this by drawing upon a variety of skills and service offers from local community groups as well as statutory bodies.

After the programme, Lee and colleagues established a personalisation partnership group including representatives from primary care, statutory bodies and stakeholders from a range of organisations providing support across Bassetlaw. This group meets regularly to discuss the progress of each organisation, and Bassetlaw's ongoing journey of embedding personalisation. All members agreed in principle to a partnership charter, agreeing to only engage in new initiatives collectively to ensure that all local services deliver the same level of personalisation.

'…The council was signing up to a mental health prevention concordat… we knew nothing about it. They got in touch and all of a sudden that signature and sign up expanded… the council said 'not only will we sign up to this, the partnership will sign up to this.'

'The wider Bassetlaw partners have also come together to sign up to a tobacco control concordat rather than any one organisation signing up to it'

The personalisation partnership identified an ex-mining town in the north of Bassetlaw as the target location to pilot their wrap-around service based on feedback received by a local councillor from local community members. The town has pockets of severe deprivation, with 42 per cent of residents having a diagnosed mental health condition. The personalisation partnership engaged with a newly opening Youth Hub, initially established

by the Department for Work and Pensions to increase young people's access to employment support. The partnership agreed the Hub was the perfect place to base the 'one stop shop'. The partner approach expanded the service offered to include individualised support services. Here, young people from the local community can now access a wide variety of personalised support provided by 8 different organisations.

The Youth Hub is open every Tuesday for young people living locally and can be used anonymously on a drop-in basis to access a wide range of mental and physical health and wellbeing services, employment support and general advice. A short exit interview was undertaken with the community on the day of its opening, this suggested highly positive responses from community members.

'We went on this journey of bringing together a whole host of agencies that could be there on the same day that DWP was in. So people had access to mental health support, they've got the physical health support, they've got housing in there, health prevention services. There was just a host of partners within a town hall space.'

To further build trust with the communities, some of the partners piloted a smaller Pride event in the area where the Youth Hub had been established, engaging with local young people and communities to co-produce this. The event was successful with partners planning a larger event for 2023. Twelve partners contributed to a community event 'healthy Sunday' that included information on support services available within Bassetlaw Place, mental health and wellbeing information, provided defibrillator demonstrations and rapid health checks. Over 300 people interacted with the partnership group and engaged with the demonstrations. More of these community events will be planned across the Bassetlaw area.

'We got almost all our [community and voluntary sector] partners out at Pride offering bags with support information and sharing what services they offer locally…Partners also attended Healthy Sunday this community event included showing people how to use the defib… we had a footfall of 300 and of that 50 had rapid health checks…'

The future and impact of personalisation

The steps taken by the partnership have improved local access to services for young people, helping reduce the time and money spent on using often unreliable transport to engage in employment, health and other services in the wider Bassetlaw area. They hope that this will support a decline in health inequality in the local area.

The personalisation partnership group have noticed an improvement in community cohesion, achieved through the increasing collaboration between organisations. The community is now building on this successful collaborative approach and co-developing new solutions to address local concerns in relation to the cost of living crisis. This has included personalised support to tackle live issues impacting local people, such as creating winter warm spaces, additional food banks and school uniform swap sites.

As the personalisation journey continues, the personalisation partnership group hope to roll out a similar version of the Youth Hub aimed at those aged 50+ to ensure this

population also has regular, local access to services and further reduce health inequalities.

3.6 Sam, Voluntary Sector Organisation Manager

Background and Context

Sam* is a manager in a not-for-profit organisation. Their local community has high levels of deprivation and experiences stark inequalities in terms of health and social care outcomes. Voluntary sector organisations play a core role in engaging with the community to tackle these challenges, with around 80 per cent of voluntary sector organisations directly involved in health and social care activities. Sam feels that organisations delivering health and social care in the local community can be 'siloed' and have a 'scattergun approach' to delivering services. They were motivated to participate in the Leadership for Personalised Care regional programme in 2021 to gain support in leading a 'strategic' approach to personalisation, bringing together voluntary and public sector organisations in the Integrated Care System to deliver personalised health and social care. [5]

> *'Evidence indicates that if this integrated care system is going to work, then the players have to understand each other's operating systems, jargon, drivers, restrictions and so on.'*

In the past, there has been tension between the voluntary and public sectors, with some voluntary sector organisations seeing themselves as 'filling the gap' of insufficient public sector services. Sam knew that this negative narrative had to shift to enable effective collaboration across the system. They believed that the programme would support them to address these challenges and inspire partnership working.

> *'It's very much about "we're doing what you don't do, we're filling the gaps because you don't do it." So it's quite a negative. And so, one of the other things that I saw that needed to happen was that we needed to change that narrative, that the voluntary sector had got to see itself as an essential part of the system of providing health and wellbeing support services to the community.'*

Programme impact

Sam was the only person from their community to attend the programme. It helped them to understand the 'direction of travel' for leading personalised care, particularly by developing their understanding of what is expected of leaders at all levels of the Integrated Care System. This knowledge was crucial for Sam to formulate a strategy to bring together the voluntary and public sectors to collaborate and coproduce.

**Sam is a pseudonym*

'It helped me to formulate in my mind what we're going to need to do with the voluntary sector to bring them in line with this, so that collaboration can take place. Because if you've got people in the room who need each other in this system but still don't understand each other's language, or respect each other's differences, then then we never going to have coproduction.'

The principles of personalised care and other knowledge gained from the programme feed into 'everything' Sam does, using their increased knowledge to ready the system for personalisation.

'So what I'm doing is I'm drip feeding information into everything I do that is based upon the principles of the leadership programme.'

Personalisation journey

The journey towards personalisation began before Sam participated in the programme. Back in 2019, some 'transformational' projects were developed in the voluntary sector, including an initiative where community-based members of the public are trained to use their life experience, understanding and position of influence to help people in their community lead healthier lives. Sam facilitates quarterly meetings for these volunteers, where they provide the voice of the communities they serve about the health inequalities that they experience. Sam sees these strategic meetings as an opportunity to build the foundations for personalisation by starting a dialogue and educating the wider system about the activities happening in the community. Sam hopes that by coproducing, they will build trust in the voluntary sector, shift mindsets in the wider system and highlight the need for cross-system working to deliver personalised services.

'We start to gain confidence in each other. We start to trust each other. We start to open the doorway to a dialogue that's not just dependent upon "what's in it for me".'

While at an early stage of the personalisation journey, Sam sees themself as a driver for change and is vocal about the need to get 'different parts of the system on board'. As well as continuing to 'bang on' about personalisation at a strategic level, Sam is developing ways to support collaboration in the system. One idea is a strategic buddying programme, where people are assigned a 'professional friend' from other sectors to reduce barriers to collaboration. The buddies would support each other, for example, to navigate technical jargon or understand statutory requirements, to break down boundaries between sectors.

'So, if somebody got asked to read a document, if somebody is a Professional friend, we can support each other because we need to. I need to be able to ask stupid questions and I'm not going ask them in an open forum'.

The future

Having been the only person to participate in the programme, trying to influence change and prepare the system has been challenging. Sam hopes the agenda will gain better traction as more people from their local community attend future programmes. In the

meantime, Sam will continue to prepare the groundwork in the local community to drive forward the personalisation agenda.

3.7 Gillian, Head of Primary Care Network Development and Partnerships

Background and Context

Gillian is the Head of Primary Care Network (PCN) Development and Partnerships at Taurus Healthcare, a GP federation based in Herefordshire. The federation represents all 19 practices across the county, supporting them to work together to provide more resilient services for the local community. As a federation, they work with practices as 'one General Practice' across the county and enjoy economies of scale, while having the flexibility for local GPs to adapt to their community needs. Gillian's role focuses on personalised care, community development, health inequalities, and relationship building across networks. Gillian hoped that the Leadership for Personalised Care programme would help to develop a 'single narrative' across the county and inspire organisations to start working together to deliver on county priorities, rather than as independent organisations. Herefordshire is a rural county with a very high elderly population, which contributes to low levels of health and digital literacy.

The personal impact of the programme

Gillian attended the national programme in 2022 with a team of people from organisations across the, then, CCG. She saw the programme as an opportunity to upskill and widen her knowledge, which was especially valuable for her organisation as personalised care was a core service specification in which they must perform well. Attending with local colleagues was instrumental in developing strong relationships and building an effective team across the county.

> *'It gave us time to actually reflect on each of our pressures, learn from one another and build a sense of team.'*

For Gillian, the programme was particularly eye-opening as it highlighted that personalised care was central to 'absolutely everything' they deliver as an organisation. This 'lightbulb' moment sparked a passion for Gillian to ensure that the person is 'absolutely central' to how they operate across the federation.

> *'So I think for me it's that lightbulb moment of actually, so if we're developing a new pathway, how do we bring in the personalised care element? How are we asking patients what matters to them? How are we delivering it in a way that matters to them? How are we listening to our patient voices to co design things?'*

Personalisation journey

Regular collaboration

Since participating in the programme, Gillian and her colleagues across the PCNs recognised that they would make more progress on their personalisation journey by working together. Collectively, they became personalised care 'champions' for the ICS and established regular monthly meetings for colleagues across the ICB, which she believes 'changed the conversation' around personalised care in the system. These meetings were very powerful, as it was the only workstream where providers would come together to collaborate and talk about funding and future planning.

'It really changed the conversation from the ICB, or CCG at the time, from saying actually "we've got this money and we've decided we're going to spend it that way", to them coming to us as a group and saying "we've got an opportunity for some funding here, how do we all think we can best use that?"'

Measuring service user confidence

The monthly meetings identified the challenges faced by different parts of the system. The group then worked together to find solutions to move forward. Low levels of health literacy in the community was presenting difficulties when trying to measure 'Patient Activation', the group wanted to find a quicker and simpler way of measuring activation that would be more adaptable to meet service user needs. So working with the National Association of Primary Care (NAPC) and the ICB they piloted 'Simple Activation Questions' designed to measure patient confidence in self-health management. Patients are asked 'how would you rate your confidence to manage your own health and wellbeing', and 'what one thing do you need to help you improve your health & wellbeing'. These questions were piloted in Social Prescribing, where they were asked at the start of a service user/practitioner conversation.

The pilot analysis showed that the questions were as effective as the most widely used activation measure, 'PAM,' and were asked at 83 per cent of interactions during the pilot. On average there was a 1.4 increase in activation score from the first appointment to discharge. They were found to help service-users lead decision making, increase the awareness of their wider needs and support them to have a more active role in the conversation. The questions are now being rolled out across all wellbeing roles and other roles across the ICB.

'I'd like to think that it becomes common language that every clinician to think of, Right. How confident is that person? Because actually then that enables us to identify what type of role can best support the patient. So if they're quite confident actually they might need just some signposting and we can give them links and leaflets and letters, but if they're less confident, they'll need some more social prescribing time'

Conducting an evaluation of the pilot was invaluable for Gillian, as it provided evidence that she could share across the system to demonstrate the impact of personalised ways of working.

'You can't beat evaluating and then sharing that as widely as possible'

Creating new job roles

The ICB has funded two Personalised Care Programme Manager roles, based in Worcester and Herefordshire respectively. The roles will work across primary and secondary care to facilitate a single vision across all provider organisations in both counties. Aligning the roles across the county boundaries is a big step forward in collaborative working.

'I think it's quite a big step change for us, actually. I think before we've been in competition…. But actually, because we recognise that using the same language and we all understand personalised care at the same level, we know it's the same thing, and that's really exciting.'

The roles will have three main responsibilities:

- ensure personalised care education is in place across secondary and primary care and that clinicians are delivering against these expectations;
- look at service specifications for personalised care across the PCN; and
- bring all wellbeing roles together as a 'wellbeing team' that will, hopefully, have a single point of access for service users and in-team referral pathways.

Gillian hopes this will remove duplication, maximise capacity, and empower teams to support patients and whole households with a range of preventative support enabling their independence, providing the right wellbeing service with easy access within communities.

Co-production

Covid-19 presented a challenge when trying to co-produce services, however, it is something the team are keen to develop further. Most recently, people with lived experience of fibromyalgia and obesity were invited to participate in the development of a new programme of work providing group consultations for wellbeing to patients.

'Now we've got some patients that are on board with us to help us redesign how we do that going forward. It's a very new way of working for us. Everyone knows that the right thing... And that's a big change for us.'

The future

Gillian and her colleagues across the PCN have made great progress in delivering personalised care to their community, however, there is plenty more work in the pipeline. They are introducing a new case management system for all wellbeing roles across

Herefordshire. It will be consistent across PCNs, so data can be better input, managed and shared across the system. This should allow them, not only to better support the service user, but identify any gaps in the support offered by community groups. Collecting this data will allow Gillian and her colleagues to support the community groups by helping them with bid writing to grow and gain funding.

'So, this is all very new. We're only just starting this, but that's a big change for us. Again, to have that direct conversation then with community groups.'

Gillian is also working to fully strengthen their integration with the wider system. By, for example, creating a shared governance system, bringing people more formally into meetings and sharing plans at the Herefordshire health inequalities group.

'We're really looking out now to other people to work collectively and from doing that as well, other people come up with opportunities you might not have thought of to link in differently and work in a much more integrated way. …You're not talking about general practice working at scale, you're talking about an integrated primary care network with all the organisations working together.'

For Gillian, she has observed a huge shift in mindset and practice in some areas of the county, with more referrals to wellbeing teams and service-users being better connected with the right support for them. However, in the future, they plan more cultural change work to help the wider system to fully understand and embrace personalisation.

'More work is needed to really get teams to understand what personalised care means. So really believing it and understanding'

Attending the Leadership for Personalised Care Programme has brought together strengths across organisations in the system to embed personalised care together. The power of shared learning from our system and region has developed networks which remain today. Having the opportunity to hear approaches which have worked well for others from health, social care and voluntary sector, and the expertise of the personalised care team has been invaluable. They brought personalised care to life and shared skills to drive health improvements which enables us to lead change across the system.

Key learning for programme participants

The case study participants provided insight into the key learnings have taken from their journey so far.

- Use the space the programme provides to develop strengthen and develop local relationship, use the momentum from the programme to create a formal meeting structure in the local setting.
- Plan the evaluation before changes are made to practice – data and evidence is a valuable tool to create a business case and foster support for the initiative.
- Engage with the community – bringing the community voice to the table is likely to support cultural change in the system, as is the power of lived experience.

4 Discussion

This mixed-methods impact evaluation sought to explore the impact of the LPC suite of offers and understand the difference that programme participation can make to participants and local communities. Overall, the programme seems to have produced a cadre of alumni who are:

- more knowledgeable about personalisation;
- more aligned with a personalised mindset;
- working more collaboratively;
- have increased confidence in leading change; and
- taking action to embed personalisation in their local setting.

The impact of these changes on the NHS and wider system are, on the whole, yet to be realised. This finding is consistent with the participants' belief that it would take a 'long time' to observe systemic outcomes. Despite this, early evidence suggests that in the local settings, cultures may have started shifting and people with health and support needs are likely to benefit from the actions participants are taking to embed personalisation.

4.1 Mindset shift

Programme participants appeared to be more aligned with **personalised ways of thinking** after completing the programme, such as seeing people and the community as assets in population health. Although the programme did not fundamentally change personal philosophies, it **reinforced and strengthened participants' existing beliefs** and refocused attention on the importance of personalisation and its role in health and social care. For some, it **sparked a renewed passion** for personalised care. The programme also appeared to be successful in **improving participants' knowledge about personalised approaches** to delivering care, and increasing confidence to take this back to their setting and accelerate their plans.

There were **some differences** in the extent of the mindset shift **depending on the type of organisation** in which someone was employed. Those working in NHS organisations were less likely to be positive about embedding personalisation in the face of challenges and less open to new ideas. The findings suggest that the predominant 'medical model' of care in the NHS can make it more challenging to introduce ways of working that deviate from the traditional approach. Many of the case study subjects were **developing strategies to specifically support NHS colleagues to consider and embed different ways of working** as there were cultural challenges associated with affecting change in

NHS organisations. These difficulties were exacerbated by Covid-19, where some existing elements of personalised working were lost as the NHS focused on responding medically to the pandemic.

4.2 Perceived ability to influence change

Overall, survey participants demonstrated high levels of self-efficacy, that is, their belief in their ability to enact behaviours that produce a desired outcome. However, those with **less influence in their roles reported lower levels of self-efficacy**, suggesting that participants with less senior jobs face additional personal barriers when trying drive the personalisation agenda forward. The majority of case study participants were positions with a higher level of influence, and their stories are reflective of trying to affect change at a systemic level. While they did experience barriers, their belief in their ability to influence the system did not appear to be one. The case study participants in a less senior role focused their efforts to influence change at a more local level, concentrating on influencing those they interact with as part of their day-to-day role. While they seemed confident they could behave in a way to drive the agenda forward within their network, there was less consideration given to influencing the system more widely. That is not to say that a bottom-up approach to change is not important, but if the programme hopes that all participants feel able to create wider scale change, then there may need to be special consideration given to the role of the participants and how they are supported after the programme.

4.3 Building the confidence to work differently

The **programme built confidence in people's perceived ability to work in a person-centric way.** Overall, participants felt that they **can influence people as a leader of personalisation** within their setting, particularly by challenging established ways of working and communicating a clear vision. Although, they were **less confident when considering building a common sense of purpose across the system**. This finding could be explained by the barriers presented by organisational and sectorial differences, as highlighted in the case studies. Differences in terminology and jargon, working practices, funding, systems and governance can make it very difficult to bring partners across the system to work collaborative with a shared vision. Case study participants recognised this challenge, and some directed their initial efforts to break down these barriers to prepare the system for change. Similar to previous findings, those with **higher levels of influence were more confident overall,** reiterating the need to consider level of seniority as a factor that influences perceived ability to influence change.

4.4 Taking action to embed personalisation locally

As well as the cognitive impact on the participants, this evaluation aimed to explore how people changed their behaviours and practice following the programme. Evidence shows that participants are **taking action to embed personalisation in their setting**, such as encouraging collaborative working, removing obstacles and seeking opportunities for co production. However, those with **higher levels of influence were more likely to report**

that they had made practice changes following the programme. Similarly, higher levels of self-efficacy were associated with more practice change. This shows that an increased sense of agency is likely to support people to make changes to practice in a personalised way. The case studies provide rich detail of individual personalisation journeys.

4.4.1 Developing relationships

Following the programme, participants felt able to behave in a way that **successfully built relationships with people in and outside of their organisation**. Once more, those with higher influence felt more able to build relationships and influence people. The case studies emphasised the significant **role the programme played in creating the space for relationship building**. Attending the regional programme in particular provided the added benefit of creating the space for relationships to develop. Attending as a local group gave participants protected time to reflect on the system and strengthen their relationship and create a stable foundation to take back to their local setting.

4.4.2 Increased collaboration

Almost all case study participants began their journey by **organising local meetings** to build on the momentum gained from the programme. The specific purpose and attendees of the meetings varied, but the ultimate aim remained consistent; to increase collaboration to drive forward the personalisation agenda. The meeting infrastructure varied depending on how established personalisation already was in the local context. With those further along the journey having **multiple formal opportunities for collaboration across diffident parts of the system**. These networks and relationships are considered fundamental to better understand the local community, help solve community challenges, remove barriers to collaborative working, develop new ideas and relationships and to establish a consistent local approach. There were some examples of coproduction and community participation, mostly in the form of community group engagement, but this was not a robustly established practice.

4.4.3 Changing practice

Following the programme, **participants had made changes to their individual practice** in a variety of ways. These ranged from connecting people to their community. developing people's skills and capability, and co-designing services to have personalised conversations with service users. Furthermore, participants felt that **people in their setting were also working in a more personalised way** compared to before they participated in the programme, suggesting that the programme encouraged action that contributed to personalisation becoming 'business as usual'. The areas that showed most organisational progress were **connecting people to non-medical support and working across organisational boundaries.**

Looking across the case study journeys, participants engaged in a range of actions that moved personalisation forward. These can be grouped thematically, and to some extent,

be considered chronologically, with actions at the top of the list typically being established earlier on in the journey.

- **Creating a local infrastructure for collaboration** - eg developing relationships and networks, establishing meetings and action groups, hosting conferences and events, and community engagement via community leaders and groups.
- **Developing governance and documentation for ways of working** – eg established charters, terms of references and frameworks, reviewed existing documentation with a personalisation lens and implemented shared systems across the local setting.
- **Creating job roles and reorganising teams** – eg introduction of new wellbeing roles, restructuring team to enhance the service user experiences, working collaboratively across country boundaries and using common systems for wellbeing referrals across organisations.
- **Engaging with people with lived experience** – eg co-production of local service development, involving people with lived experience in meetings, developing social activism programmes based on community needs and reviewing language on documentation.
- **Improving the experience of those with care and support needs**:
  - Entry into a service – eg smoother referral pathways, utilising personalised health budgets, creation of personalised care plans, establishing service user confidence at the start of their journey.
  - Journey through the service – eg removing the maximum number of appointments, introducing joined up referral pathways allowing for referrals between wellbeing roles, creation of 'one shop' hubs to bring all services to one place.
  - Exit from a service – eg, a personalised hospital discharge process, measurement of service user confidence.
- **Evaluating changes in practice** – eg measurement of patient activation/confidence levels to establish the impact of interventions, piloting and evaluating of schemes before wider roll-out, collecting informal feedback from colleagues across the setting.

4.5 Impact of changes in practice

In the survey, participants were asked to identify who had been impacted a result of the personal changes they had made. Interestingly, participants more commonly felt they **influenced stakeholders and partners external to the organisation** than co-workers and direct reports. On the whole, the number of people participants' thought they had influenced was low, and people with care and support needs were least likely to have been impacted as a result of the programme. However, for participants who thought they had influenced people with care and support needs, the numbers that were likely to have felt the impact tended to be much higher. This suggests that although **participants' actions were less likely to influence service users, when they did, it tended to reach far more people**. Respondents felt that they impacted different groups of people in different ways; they had shared their learning with people in their organisation, worked in

partnership with people outside their organisation and made a positive difference to the experience of the service for those with care and support. Overall, **participants felt that people with care and support needs benefitted from their participation in the programme to a moderate extent**, while acknowledging there was still progress to be made across all elements (such as shared decision making, achieving outcomes, listening).

The case studies provided a wider understand of the impact in a variety of contexts. On the whole, i**mpact was commonly thought to be difficult to measure**. Despite this, all participants **understood the value in measuring impact**, particularly in terms of gathering evidence to create the 'business case' for personalisation. There was little evidence of systematic evaluation taking place, apart from in one case study, and those earlier in their journey had not fully considered their approach to evaluation and demonstrating impact. Anecdotally, participants thought they had observed a 'mindset shift' and cultural change in some elements of the system, with some areas being more difficult to change (such as acute NHS organisations). While steps had been made to change practice, the findings suggests that **personalisation is not embedded as 'business as usual'. Case study participants felt that personalisation as business as usual would take a long time to be realised, and therefore outcomes for the NHS are not immediate**. However, there were some examples of, mostly anecdotal and isolated, impacts observed in the system. These included, timelier discharges from hospitals to residential care home, increased trust in services, increased service user confidence and improved participation in managing personal health and decision making.

4.6 Barriers to change

The barriers identified in this evaluation tended to be to be related to the wider system, rather than the programme or individual themselves. Most commonly, **time and resource constraints were the primary barrier to progressing personalisation**. This was common across all organisations involved in personalisation. Particularly within the NHS and social care, respondents felt that service fatigue was the largest contributor to time and resource constraints whereas in the third sector, funding constraints restricted the amount of resource that could be dedicated to driving personalisation forward.

Further, **working across organisational and sectoral boundaries was difficult** for respondents. Different ways of working often presented as large barriers to those trying to harmonise the approach to personalisation across organisations. This was most commonly reported by individuals working outside of the NHS. These respondents indicated that frequent structural change within the NHS and it's rigidity made it most difficult to work with. The case studies did highlight areas that the participants would have welcomed more content during the programme related to more practical aspects of personalisation, such as; ways to break down boundaries across organisations, how to communicate across sectors and how to measure and demonstrate the impact of personalisation.

A final barrier was the **demonstrating the business case for personalisation**. As resourcing and funding becomes increasingly challenging, stakeholders leading

personalisation are more frequently asked to present the business case for a personalised approach to improving health and wellbeing.

4.7 Limitations

There were a number of limitations associated with this evaluation. Firstly, the survey was cross sectional in design and therefore did not measure change before and after the programme. While participants were asked to compare and contrast their actions before and after they were on the programme, there is likely to be an element of bias in this data. The survey only yielded a 15 per cent response rate, which resulted in a small sample size. A small sample could lead to statistical errors in the analysis, potentially masking significant findings and creating 'false negative' results. Further evaluation work should be conducted with a larger sample. Secondly, the majority of participants in this research had attended the programme in recent years, this meant that they were not very far along their journey and impact had not be realised yet. Many case study participants felt that they would need a much longer timeline to identify sustained outcomes for the local community. Thirdly, despite the best efforts of the research design, the case study participants typically held senior roles and were in the south of the country. Finally, while case study stakeholders were happy to engage with the research, if the stakeholder themselves had not been on the programme they could not offer much further insight into the impact of the programme on the local system.

4.8 Recommendations

Based on this evaluation, recommendations have been developed for commissioners, programme developers and organisations delivering health and social care.

4.8.1 Programme commissioners

Commissioners should consider the following points when investing in future Leadership for Personalised Care programmes:

- To help translate programme content into action, participants would welcome practical examples and sharing of best practice that they can apply and adapt to their settings, particularly around:
  - Working across organisational boundaries – content related to demystifying the differences between sectors/industries, such as a glossary of key terms or outlining funding structures, could narrow the knowledge gaps that some participants experience.
  - Demonstrating the business case of personalisation – guidance about how participants can demonstrate the value of investing in personalised care in their setting. Such as, a shared repository that collates a body of evidence or stories of impact.

- Measuring and evaluating impact– guidance around evaluating the impact of any initiatives / practice changes. This could include models or methods of evaluation that participants could adapt to their setting.

- Invest in longitudinal impact evaluations to build a body of evidence that demonstrates the health, social and economic outcomes of personalisation. Provide the system with evaluation models that organisations can use without incurring a licence fee.
- The Covid-19 pandemic derailed personalisation journeys in some settings, with time and resources being deployed elsewhere as personalisation became less of a priority. For personalised care to become 'business as usual', consideration should be given to supporting organisations to sustain the personalisation agenda when they face turbulent times and/or support organisations to get back on track after significant disruption or change

4.8.2 Leadership for Empowered Communities and Personalised Care Programme developers

The evidence suggests several areas for the programme syllabus that could be further developed:

- Programme developers should consider if all participants, regardless of level of influence, should strive to lead change at an organisational or systemic level following participation. The evaluation found that people with less influence were more likely to lead change on a smaller scale.
- Participants with lower levels of influence could benefit from additional content and support to help lead significant change in their setting. Content could be tailored to account for participants sphere of influence and the different barriers that they experience.
- Conduct a review of the content related to co-production in relation to the specific barriers people face when leading the personalised care agenda. Eg, time and resource constraints, working across organisational boundaries.
- The proportion of participants who work directly with people with care and support needs was relatively low, however these participants reported reaching and impacting the largest number of people with care and support needs. To maximise the impact of the programme, consideration could be given to increasing the number of participants who have a wide and direct reach to those with care and support needs.
- Participants with high levels of influence reported being more able to build relationships and influence people external to their organisation. The programme could consider how to attract participants with a high level of external influence who are more likely to engage in partnership working and influence change at a strategic level.

4.8.3 Organisations delivering health and social care

The research identified several barriers related to the wider health and social care context that prevented them from moving the personalisation agenda forward. Organisations

delivering health and social care could consider the following factors to develop personalised care in their setting:

- Address workload pressures that act as a barrier to personalised conversations and enable staff to 'make time' for personalisation.
- Tackle culture change from the top-down, particularly in more medicalised settings, to empower individuals and create the environment for change. Where appropriate, draw a link to the NHS Long Term Plan to reinforce the strategic priority of personalisation.
- Considering the perception that a personalised approach can take more time in short term, conduct research in the organisation to understand the relative time investment of end-to-end personalised ways of working to support an 'invest to save' business case.
- Considering that personalisation is not embedded as 'business as usual', organisation leaders should create/develop the infrastructure to embed personalisation and facilitate staff to work in a different way. This could include formal opportunities to collaborate across the system, new job role, restructuring teams, aligning processes with partner organisations or collaborating for funding opportunities.

4.8.4 Further research

This research identified several areas that would benefit from further research.

- Fully investigate the barriers that participants are experiencing, the extent of their impact and possible solutions. Understanding how to mitigate potential barriers will support participants to implement change.
- Further explore the differences in outcomes based on job role seniority, considering how the programme could better support participants with low levels of influence.
- Further understand the barriers that people face when trying to facilitate coproduction and engagement with community groups in their local setting.
- To provide further evidence to support the business case for personalisation, conduct evaluations of local initiatives using an experimental design. If possible, focus on the time and financial investment of personalised approaches in additional to user outcomes.

4.9 Concluding comments

The NHS long term plan sets out a goal for people to get more control over their own health and receive more personalised care when they need it[6]. The Leadership for Personalised Care suite of programmes contributes to this aim by delivering learning and development that helps leaders to champion personalisation and lead transformation from the ground up. This evaluation has identified areas of good practice that are taking place around the country, which vary in their levels of maturity. While practice in some of local

[6] https://www.longtermplan.nhs.uk/online-version/chapter-1-a-new-service-model-for-the-21st-century/3-people-will-get-more-control-over-their-own-health-and-more-personalised-care-when-they-need-it/

settings outlined in this report are more advanced, the personalisation agenda is still some distance from being considered ‘business as usual’.

Based on the evidence collected for this evaluation, there is still significant work to be done to fully embed personalisation into the strategy and operations of organisations delivering health and social care. The evidence does highlight, however, that there is a powerful opportunity to motivate and accelerate change by continuing to utilise both the top-down and bottom-up approaches that are already evident in the system. People directly working with those with health and support needs have a vast reach and opportunity to impact people on the ground, while those with high levels of influence can facilitate strategic changes across a whole system. Accelerating action at both ends of the spectrum should support the health and care system in its goal to embed personalisation.

5 Appendix

5.1 Survey sample characteristics

Characteristic		N	Per cent
Gender	Female	57	77.0
	Male	17	23.0
Age	25-34	5	6.8
	35-49	27	36.5
	50-64	38	51.4
	65+	2	2.7
Ethnicity	White - British, Irish, Any other White background	63	85.1
	Asian or Asian British (Any other Asian background), Black or Black British (African, Any other Black background) and Mixed (White and Black African, White and Asian)	9	12.2
Disability or LTC	Yes	12	16.7
	No	59	81.9
Region	South East	20	27.0
	East of England	12	16.2
	Midlands	12	16.2
	London	9	12.2
	South West	9	12.2
	North East and Yorkshire	6	8.1
	North West	6	8.1
Working directly with people	Yes	38	45.8
	No	45	54.2
If yes: Support type	Clinical care	11	28.9
	Social care	15	39.5
	Other types of support	12	31.6
Organisation	NHS - Primary care	7	9.5
	NHS - Community	13	17.6
	NHS - Secondary care	4	5.4
	Local authority	17	23.0
	3rd or voluntary sector or community group	17	23.0
	Private sector	2	2.7
	Government department, agency or public body	9	12.2
Level of influence	I have no formal leadership responsibilities	13	17.6
	I am responsible for one other individual or a small team (approx.1-10 people)	21	28.4
	I am responsible for a larger team	10	13.5
	I am responsible for making decisions which affect the whole organisation	12	16.2

	I am responsible for making decisions which affect my community (e.g. my neighbourhood, place, town or city)	9	12.2
	I am responsible for making decisions which affect the wider system at a regional or multi-agency level	8	10.8
	I am responsible for making decisions which affect wider national policy	1	1.4

Source: IES 2022

5.2 Survey measures

Embedding personalisation measures

Mindset was measured using six statements asking respondents to indicate to what extent statements were representative of them now, compared to before they engaged with the programme on an 11-point scale from 'Much less', 'No change', to 'Much more'. Statements included: 'I am connected and committed to delivering personalisation approaches', 'I am dedicated to working in partnership with people and my community', and 'I am open to new ideas and willingness to change direction and share power in the delivery of care'. Responses were coded on a scale of -5 to 5 with 0 representing 'No change'.

Self-efficacy was measured using the well-validated General Self-Efficacy scale (GSE) which demonstrated good reliability (α=.8). It is a 10-item scale measuring an individual's belief in their competence to cope with a range of stressful and challenging demands. GSE has been widely used in a number of contexts to measure the self-efficacy of individuals in a number of contexts, including healthcare. A 4-point scale of 'Not at all true' to Exactly true' is used, and a total score is derived by finding the sum of all items. Statements include: 'I can always manage to solve difficult problems if I try hard enough', 'It is easy for me to stick to my aims and accomplish my goals', and 'I am confident that I could deal efficiently with unexpected events'. Scores range from 10 to 40 with higher scores reflecting more self-efficacy.

Embedding practice was measured by asking respondents to indicate to what extent they agreed with six statements on a 5-point scale from 'Strongly disagree' to 'Strongly agree'. Statements included: 'I actively seek opportunities to build co-production into every level of the system' and 'I use my understanding to drive service development and delivery'. Overall scores were derived using the mean of responses and the scale demonstrated strong reliability (α=.9).

Building relationships and influencing measures

Building relationships was measured by asking respondents to indicate to what extent they agreed with six statements on a 5-point scale from 'Strongly disagree' to 'Strongly agree'. Statements included: 'I listen and act on what others have to say', 'I am able to join the dot between personalisation and other requirements of the NHS Long-Term Plan', and 'I engage with a wide range of people such as staff, service users, and local

communities'. Overall scores were derived using the mean of responses and the scale demonstrated strong reliability (α=.8).

Confidence was measured by asking respondents to indicate to what extent they agreed with six statements on a 5-point scale from 'Strongly disagree' to 'Strongly agree'. Statements included: 'I communicate a consistent and clear vision for personalised care to staff, stakeholders, and the wider community', 'I feel confident to challenge established ways of working', and 'I actively seek opportunities to connect to the national personalised care agenda and feed back learning about what works'. Overall scores were derived using the mean of responses and the scale demonstrated strong reliability (α=.8).

Change in practice measures

Individual practice was measured using seven statements asking respondents to indicate to how frequently they engaged in the specified practices compared to before they engaged with the programme on an 11-point scale from 'Much less', 'No change', to 'Much more'. Statements included: 'I have conversations with people about what matters to them, what they can do to manage their health, and what support they need', 'I connect people to their communities and non-medical support services', and 'I support people to co-design a care plan of their goals and how they will be achieved'. Responses were coded on a scale of -5 to 5 with 0 representing 'No change'.

Organisational practice was measured using eight statements asking respondents to what extent specified practices were considered business as usual in the place that they live and work compared to before they engaged with the programme on an 11-point scale from 'Much less', 'No change', to 'Much more'. Statements included: 'People in my setting support people who have care needs to understand their choices about their care', 'People in my setting integrate with and work across organisations', and 'People in my setting support people to obtain and manage their personal health budgets'. Responses were coded on a scale of -5 to 5 with 0 representing 'No change'.

Impact on people with care and support needs

Impact on people was measured using four statements asking respondents to indicate to what extent people with care and support needs have been impacted compared to before they engaged with the programme on an 11-point scale from 'Much less', 'No change', to 'Much more'. Statements included: 'People are listened to effectively', and 'Effective health and care outcomes are achieved'. Responses were coded on a scale of -5 to 5 with 0 representing 'No change'.