NHS
Nottingham and Nottinghamshire

what matters to you?

Personalised care

ask what matters - **listen** to what matters - **do** what matters

Personalised Care Strategy and Key Commitments

Contents

Foreword

Personalised care is at the heart of quality interactions with people, leading to better outcomes. It relies on people who use services being empowered to ask questions and identify things that are important to them as well as those involved in their care actively listening and using this information to tailor and personalise their care, support and treatment.

An essential element of prevention that allows people to enjoy their best possible health and wellbeing is supported self-management to make positive lifestyle changes, this is part of personalised care. Personalised care also supports the reduction of health inequalities by looking at how to make the system more equitable for the individuals trying to access services and adapting to their needs.

These broad principles are challenging to deliver as change relies upon shifts in culture, facilitated by subtle influencing over long periods of time. As described in detail within the document, the use of training and education, good communication through our system and compassionate challenge will support delivery of the personalised care model. We work creatively with personal health care budgets, social prescribing and green space social prescribing to be innovative in our delivery of these principles. As personalised care is about people, the work will be coproduced with individuals with lived experience to ensure it meets the needs of our population.

Dr Rebecca Barker, Consultant Anaesthetist and Personalised Care Clinical Lead

Introduction

This strategy sets out how the Integrated Care Board (ICB) will work to make personalised care an essential driver in health and social care service improvement across all commissioned services in Nottingham and Nottinghamshire. To ensure the strategy is delivered, it sets out the priorities as eight commitments that the ICB and Executives are asked to acknowledge and accept as vital to the successful provision of system-wide high quality personalised care.

The strategy outlines how we will change the way we work to ensure personalised care is embedded across our transformation plans, new services and existing services, and how we will work together as a system to bring a culture of personalised care. This work builds on six years of committed system working, work that has recognised us as national leaders in the field of personalised care. Partnership working with My Life Choices, our coproduction in action group, has remained central to our approach. Listening and learning from people with lived experience, ensuring their voice is heard and working in partnership at a senior and strategic level, is an essential component of our personalised care agenda.

This strategy is not a standalone document. The overarching aim of the personalised care workstream is to ensure that personalised care becomes everybody's business and runs throughout transformation plans, workstreams, partner plans and commissioning.

The ICB ambition is to maintain our status as national leaders in personalised care and deliver the Universal Comprehensive Model of Personalised Care, making it a golden thread through everything we do and an everyday reality for the people of Nottingham and Nottinghamshire.

What is Personalised Care?

Personalised care can mean different things to different people. The definition we are using is from NHS England » What is personalised care? that states services must ensure:

'people have choice and control over the way their care is planned and delivered. It is based on "what matters" to them and their individual strengths and needs'.

Personalised care is one of the five major practical changes to the NHS as detailed in the NHS Long Term Plan. It simply means that people have more control and choice when it comes to the way their care is planned and delivered, considering individual needs, preferences and circumstances. It is important to make these changes because a one-size-fits-all health and care system simply cannot meet the increasing complexity and diversity of people's needs. Choice plays a big factor in everyday life, and that should be no different when it comes to decisions about the care people receive for their physical and/or mental health.

Personalised care is grounded in the increasing need to shift from a reactive, professional-led illness focused, 'medicalised' approach, towards a proactive, asset based, partnership and holistic care 'socialised' approach. Successful progress towards personalised care would see care delivered with these two approaches coexisting in unison. Effective widespread personalised care supports the ICB in meeting its system level outcomes by using Population Health Management data, considering the building blocks of health and wellbeing and how to meet them.

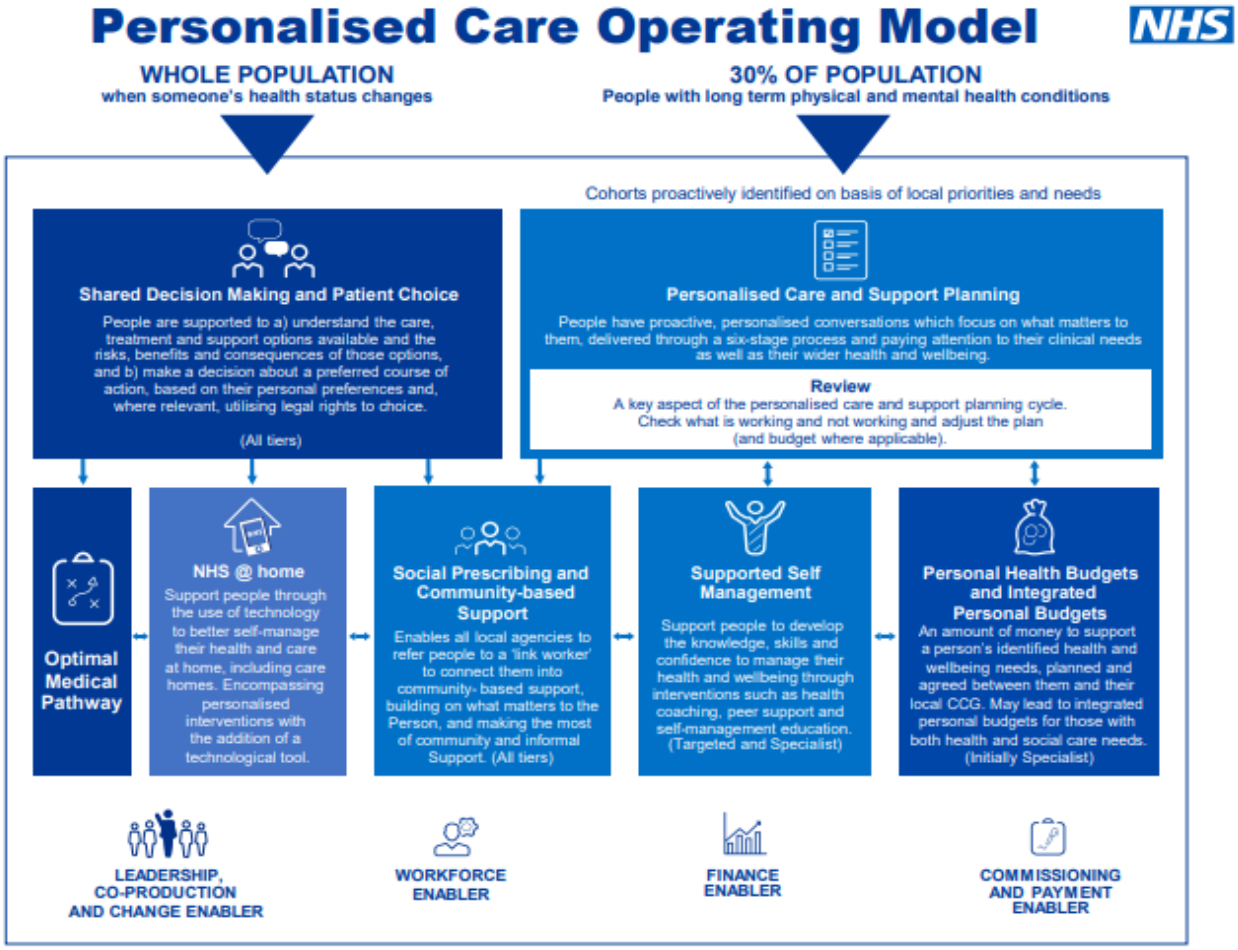
Through personalised care, people can be actively involved in the decision-making process of their treatment options and care by being given the opportunity to self-advocate the things that matter and are most important to them. This shift towards personalised care provides an opportune moment for people to feel seen, heard, informed and empowered to take back control of their lives. True personalised care provides opportunity of strengthened relationships between people, health and care professionals and local communities.

The Comprehensive model of Personalised Care outlines how we will deliver this cultural shift by bringing together six evidence-based components, each of which is defined by a standard set of practices. These are:

1. Shared decision making
2. Personalised care and support planning
3. Enabling choice, including legal rights to choice
4. Social prescribing and community-based support

5. Supported self-management
6. Personal health budgets and Integrated Personal Budgets (health and social care funded)

The Personalised Care operating model illustrates how all the various components work together to deliver a joined-up approach, fully acknowledging the needs of each individual and the key enablers required to make it happen.



Our Ambition and Vision

Our ambition is to embed personalised approach in all that we do.

The Integrated Care System Personalised Care Strategic Oversight Group agreed the vision:

To maximise independence, choice, control, good health, and wellbeing throughout people's lives, focussing on 'what matters to you'.

This is with the aim of:

- Understanding people in the context of their own life and the things that are most important to them.
- Maximising people's independence, good health, and wellbeing throughout their lives, to live well and age well.
- Involving people in decisions about their own health and care based on what is best for them.
- Supporting people and give them choice and control in how they manage their own health and care and well-being.

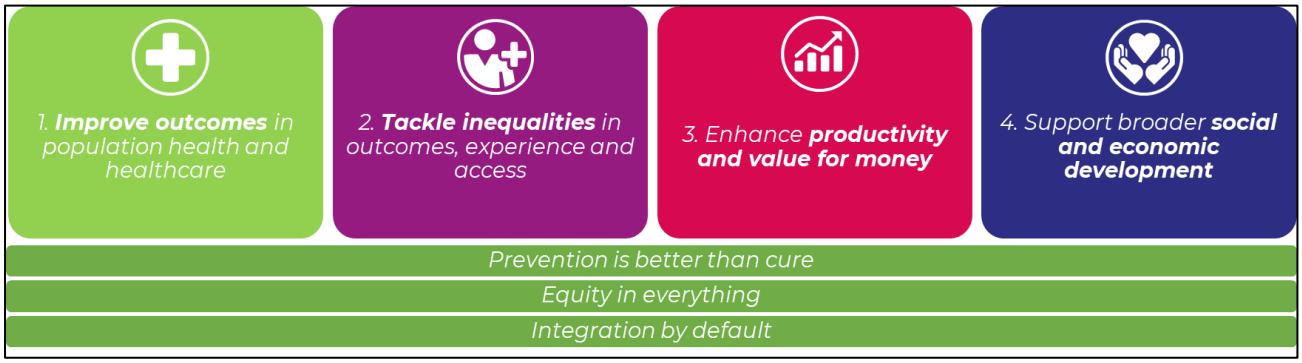
By systematically embedding personalised care approaches in all that we do, we will support the people of Nottingham and Nottinghamshire to have the best quality health and wellbeing. This will support us to achieve the 4 aims and 3 principles of the Integrated Care System.

How Personalised supports our four core aims

We know that many people in Nottingham and Nottinghamshire could be living longer, healthier, happier lives than they currently do. To address this, all partners in the Integrated Care Partnership have agreed that we will work together to ensure that:

'Every person will enjoy their best possible health and wellbeing'.

The four aims and three principles of the Integrated Care Partnership



Upscaling and delivering personalised care is essential if we are to deliver the four national aims of our Integrated Care Partnership, underpinned by our local principles to improve integration, prevention and equity across the system.

1.Improve outcomes in population health and healthcare

Personalised care is all about working with people to support them to achieve their outcomes. It provides the evidence, as every interaction with people is outcome focused, based on what matters to them. The workstream includes My Life Choices – our co-production in action group, the voice of people with lived experience of long-term conditions and unpaid carers and what matters to them.

Personalised care will prevent ill health, promote positive health and support individuals with existing conditions to live as independently as possible. This requires a rebalance of

the relationship between people and public services towards community resilience and taking shared responsibility for keeping as healthy and well as possible. By doing so, people will live happier and healthier lives, whilst also reducing demand on services.

We know that supporting people to manage their own health conditions can reduce the need for hospital admission. Offering people rehabilitation and reablement after illness enables the return to independent living and avoids the need for long-term care. Supportive social networks and resilient communities are good for people's health and wellbeing. Frequently, the health and care system is better at reacting to crises and relies heavily upon hospitals and long-term care. This results in strained A&E departments, delayed discharges and admission to long-term care in place of going home. We require a different, sustainable model. We will only see this improvement in health and wellbeing if we change our approach. This means that we need to focus on people and place rather than organisations. The evidence behind personalised care (personalisedcareinstitute.org.uk) demonstrates improvements in health outcomes, better adherence to medical and care advice and increased satisfaction for both people and clinicians.

The ICB and ICP provides an opportunity to develop genuinely joined-up, personalised care:

There is an opportunity for both health and social care partners to focus on what works for the person accessing services, not around who works for which team and whose budget incurs the cost. Social care has an important part to play in delivering better health and wellbeing for the population alongside the NHS.

Fluidity around the person is crucial to delivering integrated care. Rigid structures can act as a barrier to delivering integrated care: care needs to move around and change as people's needs change.

People using services and their carers, frontline staff, smaller flexible providers, and private providers offer unique 'on-the-ground' insights, expertise, and solutions. There needs to be space to channel this local and frontline insight and intelligence into broader ICS discussions.

"The starting point is around person-centred care and trying to make sure that this is the strongest narrative, both through the ICP and the ICB. Because when you come back to people, you come back to the principle of everyone being focused on the same thing, whereas otherwise it becomes and organisational focus."

Rosie Seymour, Programme Director, Better Care Fund.

Source: Integrated care systems and social care: \| The King's Fund (kingsfund.org.uk)

Peoples Stories

All components of personalised care support people to achieve their outcomes. The About Me is a one-page summary to find out what matters to people. Read Michelle and Karl's story on the impact of the About Me.

Michelle's story - NHS Nottingham and Nottinghamshire ICB

Karl's story - NHS Nottingham and Nottinghamshire ICB

2. Tackle inequalities in outcomes, experience and access

Reducing health inequalities means giving everyone the opportunity to lead a healthy life, no matter where they live or who they are. Data shows that people from marginalised backgrounds have worse experiences of care and treatment.

The World Health Organisation states that factors such as stress, unemployment, debt, loneliness, lack of education and support in early childhood, insecure housing and discrimination can impact 30-55% of the health outcomes that people experience.

We know that one in five GP appointments are about issues wider than health, especially for people living in areas of high deprivation. Individuals living with multiple long-term conditions, disability, frailty or who live in ethnic minority communities are bearing the brunt of the widening gap in health inequalities.

- "People with learning disabilities die 15-20 years earlier than the general population, as do people with severe and prolonged mental illness
- One million people over the age of 65 report being lonely. Social isolation affects people of all ages, leads to poorer health, higher use of medication, increased falls, and increased use of GP services
- Clinicians and people routinely overestimate treatment benefits by 20% and underestimate harms by 30%.
- Only 40% of adults report that they have had a conversation with a healthcare professional in their GP practice to discuss what is important to them.
- Only 7% of adults have been given (or offered) a written copy of their care plan.
- Only 55% of adults living with long-term conditions feel they have the knowledge, skills and confidence to manage their health and wellbeing on a daily basis"

Source: Universal Personalised Care, NHS England, 2019

To tackle inequality, we need to pay more attention to those at the greatest risk of poor health. Making healthcare more personalised is one way to do this. It means that people can access health and care services that are more tailored to their needs, make sense to them and focus on what really matters in their lives.

We want to empower local people to make healthier choices that support their own health and wellbeing.

This ‘healthy’ state of being should be experienced fairly by all our communities. We want to ensure that people living with an existing disability or long-term condition can live as well as possible through access to the right advice, treatment, care and support.

By enabling communities to support people to have a healthy lifestyle, with support from local services to do this, we aim to help people to manage their own health and wellbeing, alongside health and social care services if required.

Peoples Stories

All the approaches of personalised care provide an opportunity to address health inequalities. A good demonstration of how this is happening is the work of:

Social prescribing, that can demonstrate its value in linking people to community-based services that provide coordinated, integrated, and proactive care.

Watch Jason's story to find out how social prescribing created a wider opportunity after suffering from mental health problems and being unemployed for 30 years.

Green social prescribing in Nottingham - YouTube is connecting people to nature-based activities and supporting people with mental health problems.

3. Enhance productivity and value for money

Established working relationships between the Local Authorities and the ICB have increased opportunities for collaborative planning and securing integrated provision. In turn examples can be given of how this has made better use of limited resources and make sense to providers and families.

“I think we’ve got really skilled at how to make the best use of assets and budgets, integrated around a person, and that certainly is something I think health systems can learn from local government.”

Melanie Brooks, Corporate Director, Adult Social Care and Health, Nottinghamshire County Council.

Source: Integrated care systems and social care: | The King's Fund (kingsfund.org.uk)

Health and social care work in partnership to provide an Integrated Care and Support Plan and Budget. By working together to meet a person needs, in a way that works for them, we enhance productivity and achieve value for money. This is also the case for people we support with a personal health budget. When we give people control and choice to organise care in a way that works for them, it provides better quality and is more cost-effective

An example of how personalised care offers value for money, is a developing a Green Social Prescribing offer for children and young people. Currently some pilots and research are underway on the work, co-produced with young people that will inform what the offer

will look like. This will include activities, providers and opportunities around learning and skill development in the green/nature-based environment to provide a non-clinical option for children and young people with mental health issues, but potentially other conditions as well, for example weight management.

A specific example is work in South Place-Based-Partnership to develop a Green Social Prescribing intervention for young people between 15 to 19 years old. They have over 1000 young people presenting at the Emergency Department with mild to moderate mental health issues and are exploring different ways to support them. The young people have specifically requested a non-clinical intervention.

This approach is backed up by evidence, National Association Social Prescribing and Natural England released an evidence note about nature connection for children and young people.

Peoples Stories

Read Emma's story of an Integrated Personal Budget and the impact on her and her family

4. Support broader social and economic development

Working as a system to improve the health and wellbeing of people supports their ability to access learning, reduces future reliance on services and supports movement into employment. A good example of how this is being delivered through the bid for Active Travel Social prescribing.

A multi-layered engagement approach was applied to the co-design process to ensure that strategic and local stakeholders, existing and future delivery partners; and community representatives shape the proposed programme. Specific engagement activity included: 1 to 1 discussion with organisations that will form part of the steering group to secure strategic support, including: Nottingham City Placed-Based Partnership, Active Travel Social Prescribing Stakeholder & Community Engagement Report, Nottingham City Council, Nottingham Community & Voluntary Service (NCVS), My Life Choices Co-Production Group and British Cycling.

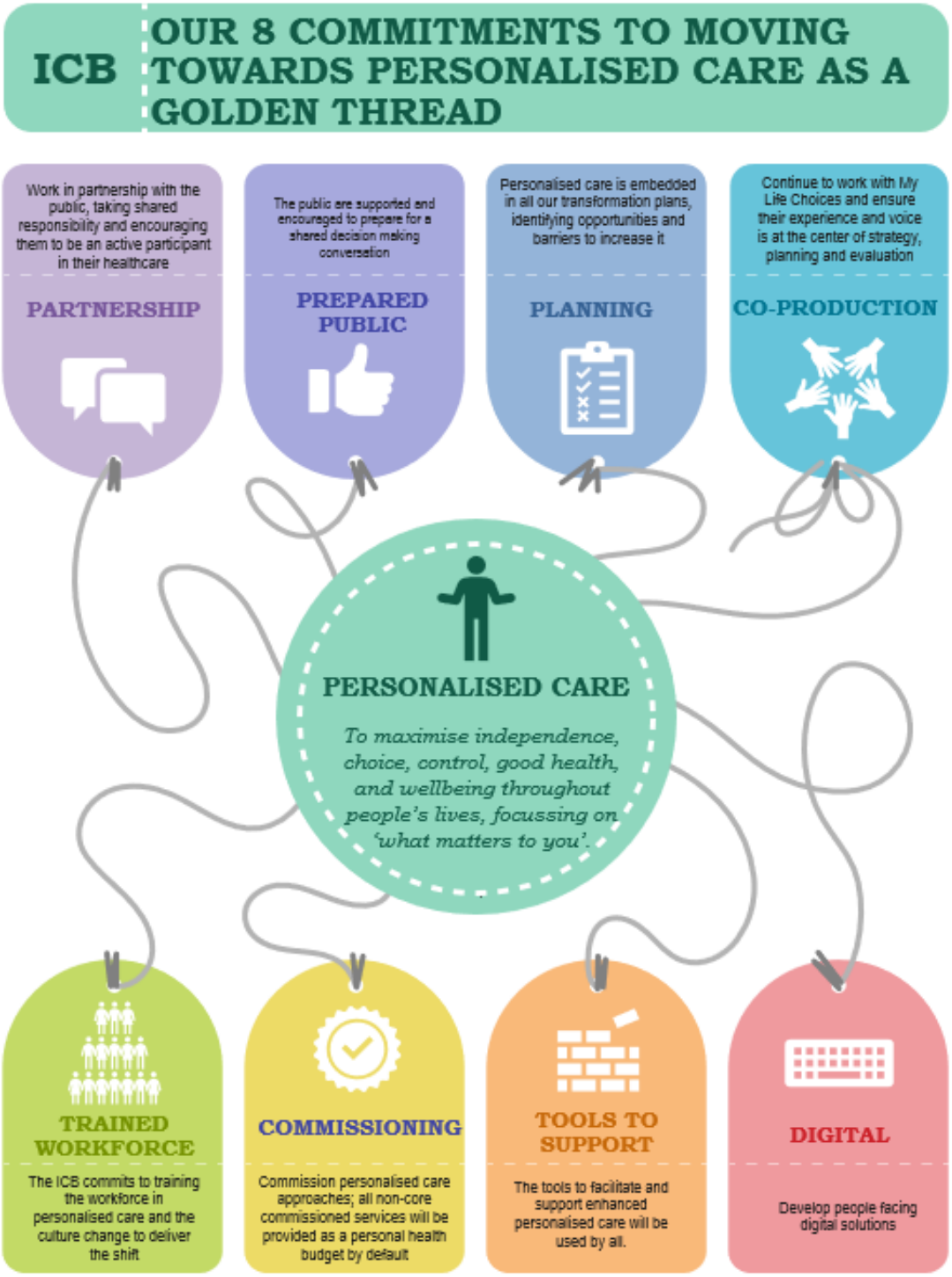
The work will focus on three beneficiary groups:

- Those on clinical treatment pathways where lifestyles changes such as walking more will improve their physical health and related health conditions.
- Those experiencing poor mental health as this is the reason for most social prescribing from primary healthcare in the city.

- Inactive families - by targeting the adults of busy households with young children through family-friendly activities, it will not only have the benefit of improving the adult's physical health but also support a generational change in travel behaviour.
- The possible barriers to participation for beneficiaries are the financial cost of buying clothing / equipment to start cycling, a lack of confidence or motivation to start a new activity (particularly for some of the priority beneficiary groups), a lack Active Travel Social Prescribing Stakeholder & Community Engagement Report 23 cultural awareness when delivering active travel projects in more diverse communities; and the topography of some neighbourhoods which have hilly terrain which is not favourable for new cyclists.

Our 8 Commitments – a call to action

To achieve personalised care, we have a call to action for the ICB to deliver on 8 commitments. Embedding personalised care is a challenge, as we need to change practice, processes and the behaviours of people, the community, the workforce and the whole system.



Commitment 1 – We will work in partnership with people

An essential step to delivering personalised care is achieving a genuine shirt towards working in partnerships with people, not telling them what to do or doing it to them. We require a culture shift towards empowering people and being less risk averse. All services health, social care, communities need to encourage people to be confident in sharing 'what matters to them'.

Where people have capacity, they are responsible for themselves and managing risks. Different people will have different thresholds of risk. Clinicians' responsibility is to provide clear and evidenced information to enable people in making informed choices about their health options, presented in a simple way that people can understand and is health literate. This is fundamental to good, shared decision making.

This requires a rebalance in the relationship between people and public services towards prevention, community resilience and taking shared responsibility for keeping as healthy and well as possible.

It involves changing behaviours at the level of the individual, to be active participants in their health and wellbeing. We need to support people to achieve lifestyle and health improvement goals developed with them, based on what matters to them and their strengths.

To embed a strength-based approach we will learn and build on the work in Adult Social Care, Nottinghamshire County Council and the integrated work with Community Services and Primary Care in Place-Based-Partnerships. The aim is to achieve a system that embeds a strength-based approach, both as leaders and with the people we support. This work has achieved better outcomes for people, working with Partners 4 Change, they have developed good practice, improved people's experience of Adult Social Care and producing better outcomes for them. It is built on the assumption that if you collaborate with and allow people to be co-designers of their support then their positive outcomes go up, and their use of health and social care resources goes down. This has been evidenced where this approach has been used in other local authorities.

Strength-based approach

Strength based approaches hold hope and ambition for people that they can achieve their goals and wishes

Asks the question ‘what does a good life look like for you rather than focus on someone's needs

Walking alongside people power sharing and working with them

Focusses on what's strong not what's wrong

What's possible and who cares reflecting and improving

Reconnects people with their community building resilience

Encourage a positive attitude to risk

Changing	Change the narrative on risk
Ensuring	Ensure staff feel that they have ‘permission’ to take risks and that managers support them
Promoting	Promote a ‘learning’ culture rather than a ‘blame’ culture
Providing	Provide constructive challenge in a supportive space to help staff feel brave and safe

Commitment 2 – A Prepared public – It's ok to ask

It is essential that people are supported to decide how they wish to participate in the decision-making process about their care, being active, informed participants. We can achieve this by ensuring people are prepared to share decisions by establishing an equal relationship and creating an environment that is safe, where the person feels confident to actively participate in a shared decision about their health and the potential outcomes by providing:

- Timely, clear communication that people can understand
- An environment where people are confident to ask questions
- The public with the confidence, knowledge and skills to be active participants in their health and care, and share decision making with health and care

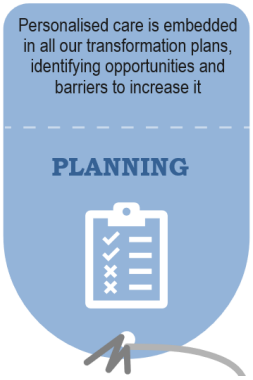
This will be achieved through a rolling innovative communications campaign to encourage people that It's ok to ask - NHS Nottingham and Nottinghamshire ICB and by adopting the tools in commitment 7.

This approach encourages people to ask the questions that matter to them and understand:

- What is my main problem?
- What do I need to do?
- Why is it important to do this?

We will encourage people to prepare for an appointment and have the confidence to say if they do not understand the information they are being given.

Commitment 3 – Embed it in all our Planning

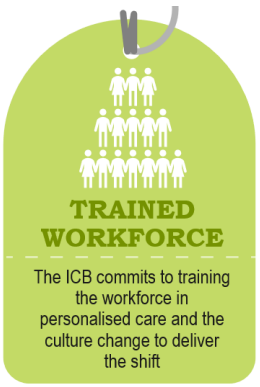


If personalised care is going to be embedded as business as usual, it needs to be an enabler across all transformation programmes, with the approaches and the 8 commitments being adopted in all our work.

Commitment 4 - Co-production - My Life Choices

True coproduction in designing services in partnership with those with lived experience of using the services is truly powerful and enhances the output adding value both in terms of quality as well as productivity. My Life Choices are a group of people with lived experience who have worked in partnership with us on the Strategic direction and shaping of personalised care for six years. We will continue to strengthen and build [My Life Choices - NHS Nottingham and Nottinghamshire ICB.]

Commitment 5 – A trained and skilled workforce



Personalised care approaches are counter-cultural to a healthcare system which is still focused on condition-specific diagnosis, treatment and cure. The challenge is for personalised care approaches to be embraced systematically as complementary to, not in competition with, more medical models of care.

We know that there is a leadership challenge in engaging system leaders at every level to support and endorse this approach. This engagement needs to go beyond giving permission to adopt the approach and instead create an expectation of a new way of working.

To genuinely shift our system culture to personalised care we will educate and train all partners and levels of our workforce. To achieve this, we have a

Personalised Care Charter

We are committed to ensuring:

- Everyone has equitable access to Personalised Care training across the Nottingham & Nottinghamshire ICS.
- Personalised Care training is embedded into all work programmes and new starter inductions over the next 5 years.
- As a minimum the workforce at all levels of organisations will complete the Personalised Care Institute eLearning modules Core Skills and Shared Decision-Making.
- Health & Care organisations across our ICS work together to deliver and undertake Personalised Care training.
- Training is open to all regardless of the employing organisation.
- All training opportunities are advertised on https://notts.icb.nhs.uk/your-health/personalised-care-2/.

The Personalised Care Institute sets the national standards for evidence-based personalised care training. Personalised care training allows health care professionals to

equip themselves with the knowledge and skills to deliver personalised care that considers an individual's strengths, needs and expectations, to deliver the right care for them. The purpose of the curriculum is to embody the values, behaviours and capabilities needed to deliver a streamlined approach to personalised care. As well as develop a shared understanding of the relationships between the social determinants of health, lifestyles and health behaviours and the role of communities in health behaviours and as partners.

Personalised care will be included in all job descriptions and person specifications, inductions, supervision, appraisals and team meetings.

Commitment 6 - Commissioning for Personalised Care

Personalised care approaches need to be considered in all commissioning and contracts to ensure funds are invested to supprort people in a way that works for them, rather than the traditionally commissioned 'one size fits all' approach.

To achieve this shift, the six components of personalised care will be considered for all services, and co-produced with people with lived experience of using them:

- Shared decision making
- Personalised care and support planning
- Enabling choice, including legal rights to choice
- Social prescribing and community-based support
- Supported self-management
- Personal health budgets and integrated personal budgets commissioning.

All non-core commissioned activity will be organised as a personal health budget or integrated personal budget, where health and social care fund the support. This means people who require a support that is not part of our core commissioned activity will all have a different conversation, based on what matters to them and what they want to achieve. This conversation output will be a personalised care and support plan and if support is going to be funded, it will be provided as a personal health budget, providing people with choice and control over how the care and support is planned and delivered.

To ensure we have an onward referral pathway – the 'social prescription' will need to support and invest in community groups.

We will build on our collaborative commissioning, pooling resources where it represents value for money, reduces duplication and siloed working, and to provide a Place-Based approach to meeting needs.

Completing data reporting and using the SNOMED codes will be a key requirement to measure the increase and impact.

Commitment 7 - Adopt the Personalised Care Tools

We will adopt the tools and resources that support good quality personalised care:

- About Me
- It's ok to ask
- Shared decision-making framework

About Me

We will commit to increasing the number of people in our system who have an 'About Me' which is a personalised care and support plan. It is a quick and easy plan, to tell health and care what matters to people and what is important to them. It helps people have a better conversation with their healthcare professional. People will feel listened too and the 'About Me' can be shared across our system partners, which means people only must share their story once.

It's ok to ask materials

All appointment letters will include the It's OK to Ask messaging. This consistent messaging will be adopted across our system and through our communications with the public.

Shared Decision-Making Framework Tool

This is a more personalised, evidence-based approach that is recommended by Academy of Royal Colleges and the NICE Standards framework for shared-decision-making support tools, including patient decision aids.

To find out if people are involved in their treatment decisions, we will measure the impact of the shared decision-making conversation using the SDMQ-9.

Commitment 8 – People Facing-Digital

Personalised care represents a new relationship between people, professionals and the health and care system. It shifts power and decision making to give people a voice, to be heard, to be connected to each other and their communities.

Personalised care and digital are two of the five major, practical changes that will create the new NHS service model fit for the 21st century, as set out in Chapter 1 of the Long Term Plan. To ensure personalised care becomes 'business as usual' we need digital approaches that meet users' needs and enable and accelerate its spread, whilst maintaining and adding value to the fundamental relational approach that personalised care represents. This includes ensuring that we have the digital services, platforms, infrastructure and standards in place that will enable interoperability across care settings and meet the significant increase in people who will receive personalised care over the next 10 years.

At the same time, personalised care supports people to be empowered to participate in their health and care using digital services that meet their needs, target prevention and offer a personalised experience.

Statement of commitment from our ICB Board

(To be obtained)

What does this mean for the public?

It means that they:

- are the most important person in their health and care and are not just seen as a condition or on a pathway but as a person with different experiences and strengths.
- only must tell their story once and the focus of the conversation is what matters to you and what's important to you, ***not*** what's wrong with you.
- will be supported to build their knowledge, confidence, and skills to look after your health and wellbeing, tailored to you.

- can make a shared and informed decisions about their health and care options with doctors, nurses and healthcare professionals (HCPs) who see them as an equal and active partner in their life and care.
- are valued as an active partner in conversations and decisions about their health and wellbeing. This means they are recognised as the expert in their own life, and conversations draw on the knowledge, skills and confidence people bring.
- are supported to find solutions, make plans and break down health and care goals into manageable steps, not what professionals think those goals should be.
- are encouraged to access information and to develop skills and confidence to manage long term conditions and, most importantly, right for you.
- can access peer support from other people with a similar condition or health experiences and support each other to better understand the condition and aid recovery or self-management.
- can access support to self-manage in a variety of ways, including on a one-to-one basis, in pairs or in small groups. Support can be delivered in person, by telephone or online.

What does this mean for the ICB?

- A change to the way we all work in the ICB, reviewing our current work processes around commissioning, service improvement and transformation so we can work using a personalised care approach.
- Having a strategic approach to personalised care, a project level approach and supporting the workforce to deliver personalised care.
- Staff in the ICB learning new ways of doing things and gain new skills in personalised care.
- Personalised care leads to improved health and social care services.

Positive Contributions

We support people to enjoy meaningful lives where they can make positive contributions to their families, networks and communities.

Independence

We support people to live as independently as possible, enabling them to be in control of their lives and support.

Quality of Life

We contribute towards people having a better quality of life.

Use of Resources

We are managing resources and work with partners across the department and the wider system effective, efficient and consistent in supporting good outcomes for people.

How will we make the change to personalised care?

- **By signing up and delivering on the 8 commitments!**
- A Personalised Care Strategic Oversight Group is established, along with a wider Personalised care network, linking to Place-Based-Partnerships and Primary Care Networks and with direct links to the ICB Board.
- A strategic approach to personalised care in the ICB, working with the wider system and embedding personalised care as a golden thread in all transformation programmes.
- A dedicated Personalised Care Team is well established to provide guidance, the art of the possible and support staff on how to embed personalised care in their work areas.
- Encourage staff to learn new ways of working through different learning methods, including collaborative learning and peer to peer support.
- All ICB teams and Place-Based-Partnerships will have a personalised care champion who will implement personalised care in their work.
- The system and Place-based-Partnerships set and meet realistic goals to support the achievement of the operational planning targets for personalised care.
- Not to be afraid to try new things, review how they went and learn from them.

How will we know we have been successful?

- Measure staff knowledge and personalised care activity levels. We will carry out a baseline assessment measuring what staff think personalised care is and how many staff have personalised care as part of their work and then we will measure this again

in July 2023 and July 2024. The number of staff having personalised care as part of their work should increase significantly.

- Have an established a ICB Personalised care team and Strategic Personalised care Group and Personalised care collaborative.
- The operational planning targets continue to increase, with wider rich data collated that demonstrates the impact of personalised care to support people's outcomes.
- Have access to a range of data about personalised care projects and outcomes including qualitative and quantitative data, which can be shared across the system.
- People report improved outcomes.