



Better Skills  
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Better Health

# **Scoping for Personalisation**

## ***Skills for Health***

Final Report

*24 November 2009*

## **ACKNOWLEDGEMENT**

This report was commissioned by Skills for Health from GHK to undertake a

Scoping Study:

Examining the impact of 'personalisation'

on the health sector

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# 1 INTRODUCTION

## 1.1 About this report

In June 2009, Skills for Health (SfH) asked GHK to undertake this scoping study examining the impact of 'personalisation' on the health sector, with a particular focus on:

- analysing the existing and emergent policy drivers in relation to the 'personalisation agenda' across the four UK countries;
- analysing current activity in relation to the personalisation agenda across the UK;
- examining the anticipated impact on the development of the healthcare workforce;
- formulating a definition of personalisation that will assist SfH and its stakeholders to understand what it is and its importance in future health policy; and
- completing a gap analysis to identify what SfH can offer in relation to the personalisation agenda in the context of workforce and skills development.

Using depth interviews and focus group methodologies, GHK engaged with 46 respondents across the health and social care sectors, including the policy makers leading on the personalisation agenda, as well as employers and managers across the health sector. The respondents included:

- senior managers across SfH;
- stakeholders in the Department of Health (England), the Scottish Government Health and Community Care Department, the Welsh Assembly Government Health and Social Care Department and the Northern Ireland Health, Social Services and Public Safety Department;
- social partners, including employer representative organisations, trades unions and bodies representing the healthcare professions;
- partner organisations in social care, including Skills for Care (SfC) and agencies that were involved in developing 'personalised' social care;
- senior NHS managers with an interest in developing personalised services;
- senior managers in relevant national third sector organisations; and
- academics with an interest in 'personalisation' policies across health and social care.

Alongside this consultation, GHK also administered an e-survey of NHS and wider health sector employers across the UK; and completed a literature review of policy in the field of personalisation.

## 1.2 Structure of this report

This report continues in the following sections:

- section 2, '**Defining Personalisation**' examines how the term 'personalisation' is currently interpreted by policy makers and employers, the policies that the term is associated with, the main policy drivers and the future direction of 'personalised' policies;
- section 3, '**Risks and Barriers**' outlines the policy discussions currently taking place about the risks and barriers that are associated with extending 'personalisation';
- section 4, '**Workforce Implications**' outlines the main implications for the workforce, including skills gaps and the potential for the development of new roles in the future;

- section 5, '**Stakeholder perspectives on how Skills for Health should act**', outlines the implications for SfH based on the external stakeholder interviews carried out;
- section 6, '**Feedback from the Internal Workshop**', outlines the findings from an internal stakeholder workshop facilitated by GHK on the possible implications of personalisation for SfH and the actions it could take.

It should be noted that throughout this report, the term 'service users' is used to describe 'patients' 'users' 'clients' 'consumers' or the general public who use health and social care services.

## 2 DEFINING PERSONALISATION

### 2.1 What is 'Personalisation' in health care?

'Personalisation' and 'personalised services' are terms that are used widely, not just in health and social care policy circles, but increasingly across public services in general. As many respondents pointed out, while the term has its roots in the 'bottom up' movement to empower the users of social care, 'personalisation' is now used in a more indiscriminate way as a catch-all term, as the following remark from the former Care Services Minister shows:

*"I am beginning to worry we have created another fashion: people talking about personalisation who know nothing about it. We need to take a step back to develop and be clear about [its] definition."*

*Ivan Lewis, Parliamentary Under-Secretary (Care Services), Department of Health (2008)*

The responses to the consultation have shown that many experts in the health and social care sectors agree with Ivan Lewis' comments about the need to ensure a common understanding of what is meant when services and policy makers talk about 'personalisation'. The diverse interpretations of the term have led, as one respondent said, to personalisation losing its meaning. Therefore it is important for SfH to have a clear understanding of what personalisation is, and how it is understood by its stakeholders. The following sections examine some of the different ways in which personalisation is interpreted and how it can be defined.

### 2.2 Personalisation as a broad philosophy

One way to look at personalisation is as a broad philosophy, which encapsulates policies not only in health, but across public services. This understanding of personalisation is explored in the work of Charles Leadbeater<sup>1</sup>, an academic working on personalisation and reform of public services, who believes personalised services can be achieved through a number of steps:

- **Intimate consultation:** professionals work with service users to unlock their needs, preferences and aspirations;
- **Expanded choice:** service users are given greater choice over the way their needs might be met;
- **Enhanced voice:** articulating preferences is easier for service users if they are able to make comparisons between alternatives;
- **Partnership provision:** public services need to work in partnership if they are to assemble an appropriate package of solutions for the service user.
- **Advocacy:** professionals should act as advocates for service users, helping them to navigate through the system;
- **Co-production:** service users who are more involved in shaping the service they receive should be expected to become more active in their own service delivery;
- **Funding:** should follow the choices that service users make, and in some cases, payments should be made directly to the user to commission their own services.

A model was developed with three linked themes to conceptualise personalisation as a philosophy, which draws on this work. Taking account of the different aspects of 'personalisation' emphasised in each of the UK nations, the themes are sufficiently broad to be inclusive of a range of specific principles and policies associated with 'personalisation'

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<sup>1</sup> Leadbeater, C (2004), *Personalisation through participation: A new script for public services*, p. 57 - 60

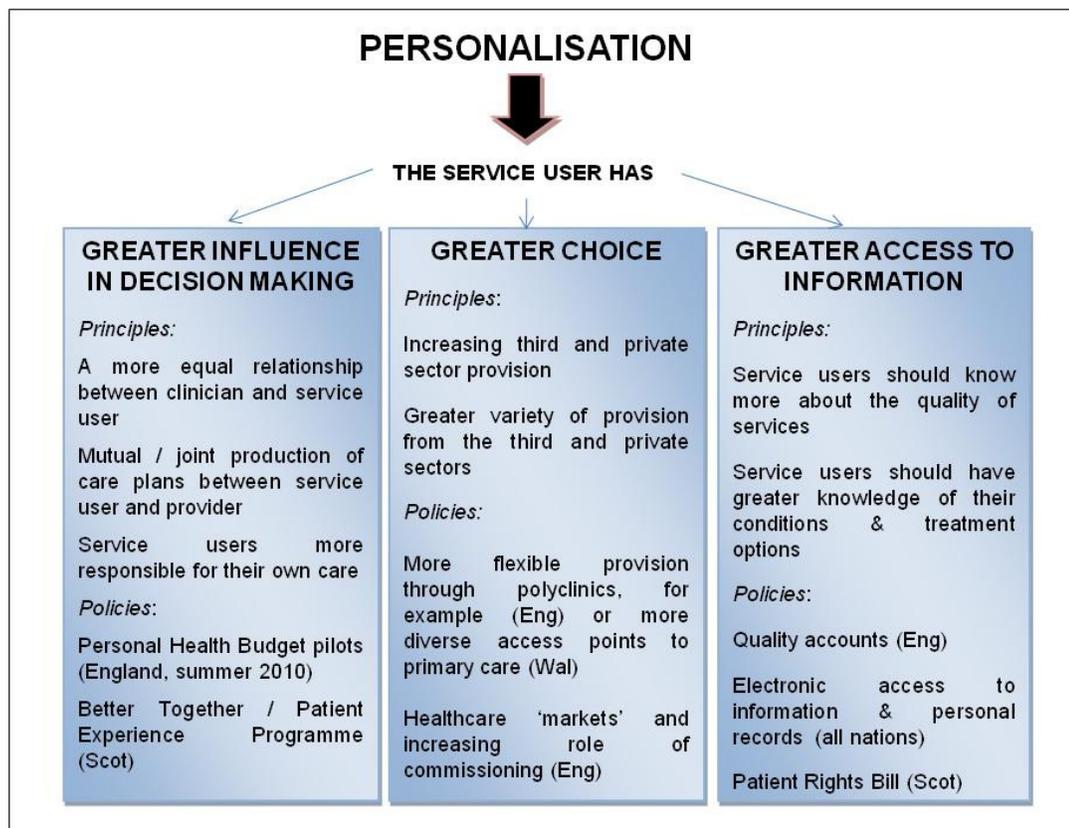
(see below), whilst being consistent with most respondents' feedback as well as the findings of the e-survey. The three themes are:

- **increasing the influence of the service user in decision making** (sometimes called a person-centred approach or a 'co-production' approach);
- **greater choice for the service user** – this can include concepts such as a choice of provider, or a choice over what action (treatment) is taken; and
- **more information for the service user.**

The narrative linking these three themes describes how service users should have **more control in their relationship with public services**. It can be seen that there are many workforce implications – not only for the skills and competences of professionals, but also the skills of the service user, as they will be taking more responsibilities for their care. These implications are explained more fully in section 4.

Under each theme is listed some of the policies or broad policy areas which show how personalisation could manifest itself in service users' everyday lives in the coming years.

**Figure 2.1: The 'broad philosophy' approach to personalisation**



### 2.2.1 Greater influence in decision making

Many respondents saw this as a key element of personalisation that was central to the empowerment of service users. This may mean that the viewpoints of service users are given greater weight in consultation with clinicians, so that they are more actively involved in decisions concerning their own healthcare. Another interpretation is that service users may have greater influence over the formation and oversight of health policy. An example of this is the existence of Public Partnership Forums in Scotland which allow individuals or community groups interested in health and social care services to be involved in how they are designed and delivered in their area. Relevant policies include:

- **Increasing the co-production of care plans**, where service users work alongside a health professional to produce a health plan which takes into account their personal needs and wishes. This places collaborative working on a formal basis. This is relevant across the UK; and is sometimes called 'mutuality' in Scotland.
- In England, **personal health budgets** are viewed as a potential driver to increase service users' influence over their care and link with Leadbeater's argument that, in some cases, funding should follow the choices that service users make. It may be that service users will have their own budget over which they have control, and which they will use to formulate and purchase their own care. Other models include a nominal budget being held on behalf of the service user by a third party, who could be an individual or an organisation.
- In Scotland, the implementation of a **Patient Experience Programme** is seen as central to improving the way in which services take account of patient / service user experiences and give them a greater say in the design and delivery of the care that they receive: "*NHS Scotland is committed to delivering patient-centred care which is respectful, compassionate, and responsive to individual patient needs, values and preferences...the Scottish Government committed to delivering an NHS based on a mutual ethos where staff and patients are co-owners of the NHS and have a greater say in the way services are delivered.*"<sup>2</sup>

### 2.2.2 Greater Choice

Most respondents agreed that a personalised health service will be one where patients will have greater choice. However, greater detail is required. Vidhya Alakeson, an influential thinker in this area, writes that: "*A lot of emphasis has been placed on choice of provider but who provides a service is only one dimension of choice and a fairly limited one*". Respondents laid out three types of choice which are important to a personalised health service:

- **Greater choice of providers** – in England, where there is a commissioner-provider split, the focus in recent years has been on giving service users a greater choice of providers (for instance, through 'Choose and Book'). Commissioners undertake the role of managing a local market of providers and assuring their quality by setting the conditions under which providers can operate. The intention is that if providers compete, they will be incentivised to improve their services and tailor them to service users' individual needs;
- **Greater choice over how treatment is delivered** includes choice over the setting where healthcare is delivered (for instance, the policy of opening more polyclinics in England; or the drive to increase rural access points to health in Wales). It also includes the timing of care – where care takes place at a time that is convenient to the user, rather than the service. This dimension of choice is closely related to the drive to increase 'care closer to home' and make healthcare more flexible to users' circumstances;
- **Greater choice of treatment** means giving service users a choice over which treatment or care pathway they take up. This is likely to be especially relevant for people with complex health needs, where every person may respond differently to the same care package. So far, this has been emphasised least under the 'choice' policies pursued in the English health service. However, it is the principle behind '**self-direction**' in social care (mainly in England), where choice of treatment coupled with control of a budget is intended to allow individuals to choose the care most appropriate to them.

<sup>2</sup> Scottish Government (2008) Better Together: Scotland's Patient Experience Programme (patient leaflet). See <http://www.bettertogetherscotland.com/bettertogetherscotland/26.html>

### 2.2.3 **More information**

Most respondents emphasised that choice needed to be underpinned by knowledge and understanding. With increased choices (e.g. over both provider and treatment), informed decisions can only be made if a service user has sufficient knowledge about their conditions, the quality of providers available and the type of care which may benefit them. Three key policy areas were identified:

- **Increasing access to healthcare records:** policies aimed at ensuring that the service user has greater access to knowledge about their condition. This has many implications, not least for confidentiality and the way that records are kept. In England, the healthspace website<sup>3</sup>, launched in 2005, is an example of the NHS increasing access to information in this way. The site provides a portal for service users to access their Summary Care Records (SCRs). It is available to all service users, although there is an option to opt out. In time, service users will be able to add to their own SCR, for example, informing clinicians of the way in which they prefer to be contacted;
- **Increasing information about quality of services,** where service users will have access to information on quality, so they can better understand the options in their local area. One potential challenge is that all service users will have a different definition of 'quality'. This was illustrated in the Institute of Medicine's (IOM) 2001 study, 'Crossing the Chasm' which stated that a health care system achieving improvements in six areas would be far better at meeting service user needs. The six areas are:
  - Patient-centred: care provision is responsive to individual patient preferences, needs and values;
  - Safety: avoiding injuries to patients from care that is supposed to help;
  - Effectiveness: services provided that are based on scientific knowledge;
  - Efficiency: avoiding waste, including wasted equipment, ideas, supplies and energy;
  - Equity: providing equal quality of care regardless of personal characteristics such as gender, socio-economic status, geographic location or ethnicity;
  - Timeliness: reducing waits and sometimes harmful delays for both those who receive and those who give care.

According to one union respondent, access to information on quality will be a "*blunt instrument for removing really poor providers*". However, it is thought that the policy needs to "*give a fuller picture which is not necessarily provided through numerical results*". The "*fuller picture*" to which the respondent referred could include contextual information about the provider and qualitative detail which cannot be analysed statistically.

Websites may be used for providing information of this sort, such as the NHS Choices (England) website which invites service users to rate their experience with the health service. A similar service called SHOW exists in Scotland<sup>4</sup>. These sites provide access to data on all the different services and providers. However, these initiatives are at an early stage of development, when compared to the vision set out by the IOM.

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<sup>3</sup> [www.healthspace.nhs.uk](http://www.healthspace.nhs.uk)

<sup>4</sup> [www.nhs.uk](http://www.nhs.uk); and [www.show.scot.nhs.uk](http://www.show.scot.nhs.uk)

- **Access to information on what services are available** – for personalisation to work in practice, it will be vital for service users to have access to, and be informed about, the full array of options. This will be challenging because at the current time, few health professionals know about the full range of health-related services that all agencies provide, even in their local area. In England, the personal budgets pilot team are encouraging pilot sites to focus on how they plan to describe what services are available locally to service users. One respondent from the Department of Health said that In Control's Shop4Support<sup>5</sup> (developed for social care) would be used as an exemplar for the pilot sites. This is an online 'supermarket' of services designed to show detailed information about the local services that are available to a budget holder.

Respondents that were familiar with Shop4Support commented on its accessibility and ease of use. A number of respondents viewed the **accessibility of information as equally important as its availability**. If a wide range of service users are unable to gain access and successfully use such systems then the availability of more information is futile.

Respondents believed it to be vital that both digital and non-digital media are used: *"...remember that the NHS is there for the most vulnerable in our society. They may not have access to or the ability to effectively use IT"*. Information in paper and other forms was seen as essential for some groups to have fair access. Finally, clinicians will have to provide more information in consultations with service users. Some service users will simply not engage with electronic or paper-based information and will continue to want direction and guidance from the clinician, who remains an authority figure and the first point of contact for many people.

### 2.3 Personalisation as a 'spectrum' of policies

Another way of viewing personalisation is as a spectrum of ideas, along which different policies can be placed. When discussing personalisation, respondents distinguished between the following types of changes:

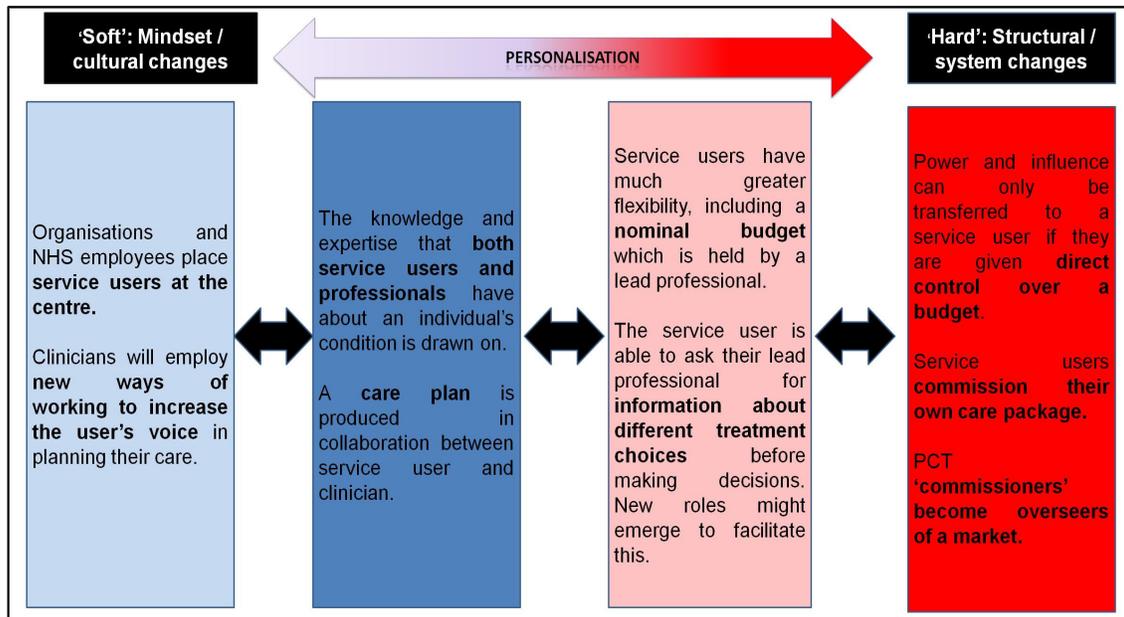
- **cultural changes / changes in the 'mindset' of health professionals:** personalisation involves changing the relationship between the individuals who deliver services and service users; both health professionals and service users will have to change the way they think. In this report, these have been called '**soft**' changes; and
- **structural or system changes:** some respondents argued that personalisation can only occur if changes are made to the structure of services and the system in which they are delivered. In this report, these have called '**hard**' changes.

Policies aimed at 'personalising' healthcare may lie at one end of the spectrum, or (more likely) include both 'soft' and 'hard' elements. Some examples of policies are given in the diagram below. For instance, in this model, a cultural change programme would be considered a 'soft' form of personalisation (which is where the focus lies in Scotland, for example), whereas giving service users direct payments would entail major changes in systems and structures, and would be considered a 'hard' form of personalisation.

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<sup>5</sup> <https://www.shop4support.com/S4S/UI/Content/>

**Figure 2.2: Personalisation as a spectrum**



## 2.4 Finding a shared language

The word 'personalisation' has been used in this study and it is a word that respondents from the health sector used and understood. However there are a number of related or similar phrases, which overlap with 'personalisation', and which have been used to describe policies or ideas reflecting the agenda.

This lack of a 'shared language' is evident across both health and social care, and here the experience of social care is illustrative. The Social Care Institute for Excellence has produced a useful list of terms<sup>6</sup> which is commented on here:

- **Person-centred planning:** introduced in 2001's Valuing People Strategy<sup>7</sup> - this approach focuses on helping an individual (in this case, people with learning disabilities) to live as independently as possible;
- **Person-centred care:** this is very similar to person-centred planning, although the phrase tends to be used in the field of dementia care and services for older people. The phrase was also widely used in the health sector in the early part of this decade to cover a multitude of ideas, from treating patients with dignity to giving them a more 'seamless' experience of services through improved partnership working;
- **Person-centred support:** a term used by some service user groups in social care to describe the goal of supporting people to make choices and be included in the design of their care;
- **Independent Living:** this is a goal of personalisation for people with disabilities and highlights the importance of choice and control over the facilities and care needed by people to go about their daily lives;
- **Self-directed support:** this phrase was coined by the 'In Control' pilots, which have been operating throughout the country in social care in an effort to encourage Local Authorities to develop better ways of 'personalising' their services.

<sup>6</sup> *Personalisation: A Rough Guide* (2008), Sarah Carr with Rachel Dittrich, Social Care Institute for Excellence, p. 4-6.

<sup>7</sup> *Valuing People: A New Strategy for Learning Disability for the 21<sup>st</sup> Century*, 2001, DH

## 2.5 Which service user groups will be affected?

Most respondents emphasised that personalisation would only benefit or affect specific user groups. In particular, it was thought that personalisation was most suited to improving the care of people with complex needs or chronic, long-term conditions. When service users have complex needs, no single health professional is likely to have a detailed knowledge of all the different needs of the user and treatment options available. There is a need to share large volumes of information between different services, and there may be duplication or confusion for both the user and the delivery agencies. In these cases, respondents argued that service users would be most likely to have a better knowledge of their condition as a whole. One academic respondent defined the following key areas of health care which may be relevant to personal health budgets, most of which address complex conditions or straddle the health and social care boundary.

### Seven types of care most suited to personal health budgets

**1. Mental health:** people who are engaged with mental health services often have deep knowledge of their own condition and a desire to engage with a wider range of care provision than those that are provided by one service alone. Service users could receive a 'recovery budget' where they would exercise choice over what treatments would meet their own needs for recovery.

**2. Out of area placements:** people with learning disabilities may be placed in care far from home because of a lack of suitable local provision. Increasing control over their care might enable them to access services closer to home.

**3. Long term conditions:** people who have had a condition for a long time, sometimes since childhood, will have a deep knowledge of their condition. Giving them greater control over their treatment may mean that they can avoid acute episodes of care, when they have to go to hospital.

**4. Continuing healthcare for older people:** older people may not want to move into a nursing home and personalised care policies may enable them to put together a package of care which allows them to stay in their own homes.

**5. Palliative care:** people are likely to want greater control over the services they use when they are dying.

**6. Children with disabilities:** many children with disabilities need complex care packages with both health and social care elements. Many service users in this group already have access to 'personalised' ways of delivering social care.

**7. Maternity services:** in many ways, improving the 'softer' aspects of the relationship between women and maternity services has been important for many years. However many women still do not have access to the care they want and personal health budgets may help them to make the choices that they want.

The theoretical rationale behind personalisation is that when service users have a greater say in their care and have more control and responsibility over their care planning, they will be able to access the treatment options that best meet their individual needs, and **outcomes should improve**. However, in healthcare, the consensus view is that this has yet to be proved in practice.

There is limited evidence from the United States, where some states are introducing greater choices of treatment and individual budgets in their mental health systems, which suggests that *"Self-direction significantly improves satisfaction with services"*.<sup>8</sup> Similarly, the evaluation of the Individual Budgets pilot for social care concluded that: *"People receiving an IB [individual budget] were more likely to feel in control of their daily lives ... Overall,*

<sup>8</sup> Alakeson, V (2007). *Putting Patients in Control: The case for extending self-direction into the NHS*, p. 28

*holding an IB was associated with better social care outcomes*". However, it is important to note that there were differences between groups in the social care evaluation. Mental health service users reported the most significant improvements in quality of life, while older people believed the process of planning and managing their budget and support was a burden<sup>9</sup>.

Respondents also pointed out that **not everyone may want more personalised services**. A number of respondents argued, for example, that personal health budgets would not be suitable for the majority of service users. An NHS respondent cautioned against over enthusiasm for such policies: *"Personalisation will not be as profound as many believe it will be."* A union respondent argued that one of the key issues to be resolved during the pilots is who personalisation is for: *"The definition of who personalisation is for in the health service is far too wide – using the term 'chronic conditions' means there's just too many people who may be relevant."*

For a minority of service users, who feel that they have benefited from direct payments in social care, it is frustrating that the control over their care is limited by a line between what is defined as health and social care by local agencies, which seems arbitrary as it varies from place to place. Therefore agencies will have to take account of service users' views when deciding who is 'suitable' for more personalised healthcare – some users may prefer no change; some may be open to the 'softer' aspects of personalisation and collaborative care planning, others may wish to control a personal budget.

## **2.6 Key drivers for personalisation**

One academic respondent noted that so far, personalisation in health has been mostly *"'top down', which is interesting because it emerged in social care as a 'bottom up' movement"*. Other respondents agreed that the policy, to this point, has been developed centrally within the Department of Health. There was some consensus evident within the interviews of other external drivers of personalisation. The main drivers identified by respondents are described below.

### **2.6.1 Integration of health and social care pathways**

Most respondents believe there is a general trend towards the integration of – or, at least, closer working between – health and social care. This applies across the UK. Some respondents in England argued that this is partly because of the introduction of individual budgets in social care. As one said, *"once personalisation had taken hold in social care it seemed the rational thing to extend it into health ... it is a pragmatic development"*.

These comments are reflected in the academic literature. A study by Glendinning et al<sup>10</sup>, published in 2000, highlighted how the (then) new policy of direct payments for social care service users was being used to fund tasks traditionally classed as healthcare, for example, injections, dressings and footcare. This suggests that putting budgets in the hands of service users drives the integration of health and social care. Glasby's work<sup>11</sup> agrees, arguing that service users *"do not distinguish between 'health' and 'social care' needs, but see both as part of overall 'personal care' or 'support' needs"*.

### **2.6.2 Service user demand**

Just as personalisation emerged in social care as a result of service user demand – primarily among people with learning disabilities – and the subsequent 'grass roots' movement, some respondents have argued that this is one of the main drivers behind the increasing prominence of personalisation in health. There has been demand for more

<sup>9</sup> IBSEN (2008a). *Evaluation of the Individual Budgets Pilot Programme: Summary Report*, p. 2

<sup>10</sup> Glendinning et al (2000), *Buying Independence: using direct payments to integrate health and social services*

<sup>11</sup> Glasby, J (2008), *Individual Budgets and the interface with health: A discussion paper for the Care Services Improvement Partnership*, p. 5.

personalised and tailored services across health for many years, leading to initiatives on service user choice in England, or the 'Better Health, Better Care' agenda in Scotland. However as yet, many respondents pointed out that this has not translated into widespread demand for personal budgets (some of the possible reasons for this are explored in the subsequent chapter).

### **2.6.3 Demographics**

Respondents identified three demographic trends which are increasing the number of people who might fall into one of the service user groups associated with personalisation of the health sector. These are:

- an **ageing population** because of better health in older age;
- an **increase in the number of people with profound disabilities** as a result of better health care at birth and beyond; and
- an **increase in the number of people with long-term conditions**, partially because of lifestyle changes and conditions associated with sedentary lifestyles e.g. type 2 diabetes.

### **2.6.4 Financial pressures**

Some respondents argued that one of the reasons why politicians of all parties have shown an interest in personalisation is because they believe that it will lead to efficiency savings at a time when health care costs have been rising for many years, and public spending is being tightened. However most respondents did not think that personalisation would lead to overall cost savings; or they said that the argument that personalisation would lead to cost savings was at best an unproven thesis: as one respondent stated, "*personalisation is no economic panacea*".

Nevertheless, other respondents remarked that in social care, budget holders tend to spend their money wisely: "*the experience in social care is that patients are frugal*". As one individual said, "*there is a lot of money wasted in health and social care. You could sometimes be given five different wheelchairs because no one had properly assessed the needs of the service user*". Some evaluations of direct payments in social care have shown that there is a greater likelihood of lower costs in the longer term (perhaps decades in the future); however there is no evidence for health. Focussing on self-directed care programmes in the United States, Alakeson<sup>12</sup> suggests that personalisation may move service users towards more cost efficient preventative practices, thereby reducing the need for more expensive acute interventions later in the service user's life. While the evidence for this claim is weak at present, as acknowledged by Alakeson, the theoretical basis that personalisation might lead to more focus on preventative practices is sound.

### **2.6.5 Political thinking**

There appears to be cross-party agreement that public services need to become more 'personalised'. However, as noted earlier, there is no agreed definition, and furthermore, the policies associated with personalisation are different between the four nations of the UK. In England, both main political parties are committed to the introduction of personal health budgets. In one of the main Conservative health policy documents<sup>13</sup>, two key commitments are made to "*enable patients to exercise a choice of GP and primary care commissioner*" and to "*offer individual budgets for those with stable predictable long-term conditions*". These commitments lack detail at this stage; however, they do not differ greatly from the government policy.

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<sup>12</sup> Alakeson, V (2007), *Putting patients in control: The case for extending self-direction into the NHS*, p. 31.

<sup>13</sup> 'The patient will see you now doctor: How the Conservative Government will create an NHS personal to all', Conservative Party, p. 2.

In addition, there has been a wider agenda for personalisation across all public services which has been apparent for many years; terms associated with this way of thinking include the 'rights and responsibilities' agenda or 'active citizenship'. In this world view, the public are seen as active consumers of services and participants in the welfare state, rather than passive recipients of services. It was exemplified in a 2007 report from the Prime Minister's Strategy Unit which argued that the role of the state should be to: "*Empower citizens to shape their own lives and the services they receive*"<sup>14</sup>.

A small number of respondents also argued that given the scale of the personal health budget pilot, the policy would not be reversed whatever the evaluation finds: "*There are too many people with too much invested in it [personal health budgets].*" Given the proclivity of political parties to change policy commitments<sup>15</sup>, it is perhaps unwise to draw firm conclusions from the consultation in this area. However, one respondent in SfH argued that while the philosophy of personalisation in the health sector seems to be inexorable, its method of implementation may alter with a new government. This is perhaps the best way to view the coming years.

## **2.7 Where is the process now in England?**

In England, most respondents stated that personal health budgets were the policy that they most identified with the personalisation of health. The personal health budget pilots are going to be integral in shaping future policy, and the Health Bill – which will allow direct payments (one of the proposed models of personal health budgets) to come in to being – was given Royal Assent in November 2009.

The personal health budget pilots are due to begin in summer 2010. There are approximately 70 provisional pilot sites across England, all of which are due to take part in a national evaluation; about 20 of these sites will be evaluated in depth. All the sites will be receiving technical and financial assistance from the Putting People First team within the Department of Health. The evaluation will aim to feed back findings and recommendations from as early as six months into the pilots. The Department of Health is taking a flexible approach on the detail of how Trusts are to implement the personal budgets. This makes an ongoing evaluation even more important, as learning and good practice will need to be exchanged between sites. Part of the purpose of the pilots will be to determine what the workforce development needs might be, and how those might be addressed.

The pilot sites appear to be the most important forum for the development of shared learning connected with personalisation in the health sector.

## **2.8 Personalisation in Scotland, Wales and Northern Ireland**

A Scottish respondent prefaced her comments by stating that: "*I would argue that we do not have a UK national health service*". This report has viewed personalisation as a development which is happening across the whole United Kingdom and as is shown, the central tenets of the agenda exist in three out of the four nations. The exception is in Northern Ireland, where one respondent argued that personalisation was unimportant. A senior official dealing with education, training and workforce at the Department of Health, Social Services and Public Safety in the Northern Ireland Executive said that, "*personalisation is simply not on the agenda here ... the agenda is very much alive in social care but health and social care are even more separate than in England*". This is an opposing viewpoint to that put forward by an internal stakeholder who commented that the services are thought of as more integrated in Northern Ireland.

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<sup>14</sup> 'Building on Progress: Public Services' (2007), p. 33.

<sup>15</sup> The government white paper setting out individual budgets in social care, 'Our health, our care, our say', published in 2006, stated that "*We do not propose ... to extend the principle of individual budgets and direct payments to the NHS*", p. 85

In Wales and Scotland, respondents described “a more holistic approach to personalisation”. In Scotland respondents described personalisation as clinicians engaging with the service user: “Not doing to but with the patient ... The patient is viewed as an expert – they will be given a range of options and then will choose from them”. This is language that would not be considered unusual in relation to personalisation in England as well. However the key difference is that personal health budgets are not being piloted in Scotland, Wales or Northern Ireland. Respondents talked about a slower approach trying to bring health and social care together without the use of personal budgets. This places these nations on the ‘softer’ side of the spectrum of personalisation (Figure 2.2). Both Scottish and Welsh respondents also argued that a key aspect of personalisation was a shift towards preventative medicine.

*Better Health, Better Care*<sup>16</sup> outlines NHS Scotland’s approach to creating, a “mutual NHS”. It emphasises public involvement in the running of the NHS (for example through direct elections to NHS Boards). Another emphasis that resonates with the personalisation<sup>17</sup> agenda in England is placing patients at the centre of decision making. ‘Supported self-management’ is the model used for achieving this patient-centred approach. It lays out the steps which need to be taken in order for a person affected by a long-term condition (again, resonant with personalisation in England) which include a lay-led self-management programme and tele-health.

Given that direct payments exist in social care in each of the nations (to different extents), it will be interesting to see whether personal health budgets will be taken up outside England, particularly if the pilots in England are judged to be successful.

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<sup>16</sup> *Better Health Better Care* (2007), NHS Scotland

<sup>17</sup> N.B. The word ‘personalisation’ is not used in *Better Health Better Care*

## 3 RISKS AND BARRIERS

### 3.1 Risks of a more personalised service

While most respondents thought that personalisation would lead to positive health outcomes and increased user satisfaction, many expressed concern about some or all of the following potential risks. These are explained in more detail in the section below, which concludes with a summary of the main lessons learned from the social care sector on the barriers to bringing about more personalised services.

It should be noted that most of the comments below relate to personal health budgets and an anticipated increase in self-directed approaches to care planning in England.

#### 3.1.1 *The potential to exacerbate inequalities*

Some respondents expressed concern that personal health budgets may lead to 'top ups' in the NHS, whereby those with the means might 'top up' their personal budget with their own money, leading to some people having a better standard of care than others and breaking a fundamental principle of equality<sup>18</sup>. This may also lead to the emergence of insurance companies in the health sector taking advantage of this, their role being to insure an individual's potential need to pay top-ups for their care. One trade union argued that: *"personalisation is the conflation of a really good progressive policy of the collaborative formation of care packages, with the marketisation of health through budgets."* Other commentators stated that social care and health were always fundamentally unequal: *"The better off have louder voices, they have also have better contacts and sharper elbows"*<sup>19</sup>.

In contrast, other respondents argued that it was possible to design a system of personal health budgets where users are discouraged from 'topping-up'. This could be done by restricting users from accessing their full personal budget if they buy additional services which form part of the same episode of care, much as direct payments are managed in social care. Other respondents also argued that:

- personal budgets may help to highlight where inequalities lie, by making budget setting more transparent (equal resources for people with equal needs) and exposing unjustified differences in spending on people with the same conditions. This would then lead to service commissioners being able to target funding towards those with greater support needs;
- 'top ups' are a separate policy issue from the mechanisms of personal health budgets – it is entirely possible to have one without the other.

#### 3.1.2 *Adjusting to a more diverse provider 'market' – impacts on service providers*

One intended consequence of personalisation is to increase diversity in the market of service providers. Some respondents were concerned that this might lead to a "chaotic" market where different employers across the private and third sector would employ workers under different terms and conditions. Unions expressed concern over exploitation and de-skilling of workers, and some employers' poor record on the way in which workers were treated.

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<sup>18</sup> The NHS Constitution enshrines this principle of equality: *"The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief ... At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population ... Access to NHS services is based on clinical need, not an individual's ability to pay"*.

<sup>19</sup> Le Grand, J (2007), *The other invisible hand: Delivering public services through choice and competition*, p. 32-33.

Other respondents were concerned about turbulence for providers of healthcare services, as responding to changing user demands would be expensive. For example, there may be demand for services for which there is not the capacity or the workforce to deliver at the current time (such as a projected increase in demand for ‘talking therapies’ in mental health).

On the other hand, some respondents expected that a more diverse provider market would result in greater choices for service users (so there would be a greater likelihood of being able to choose the kind of service they want). Inefficient providers or those that were unable to provide services that service users want would leave the market. This would lead to commissioners having a very different role (see below).

### **Potential implications of personalisation on the third sector**

Respondents from leading third sector organisations (social enterprises, community interest companies, and voluntary sector organisations) raised the following key concerns as they respond to a model of personalised care and more fragmented commissioning of services (i.e. many service users ‘commissioning’ as individuals)

**The need to improve marketing.** *“As the diversity of providers increases, the third sector will need to become better at marketing the services it provides. We’re not always good at this”.*

**The role of brokers.** As the market is stimulated and the number of providers increases, there will be a need for brokers with an understanding of different services. As well as market knowledge, they will require specific knowledge of health conditions, such as mental health conditions.

**Brokerage or development of new services?** The third sector will have to make a decision about whether to develop their services so they are more flexible and tailored to user needs or whether they take on a brokerage role instead.

**Changes to business planning and organisational structures.** While third sector bodies are currently likely to receive block funding from PCTs and local authorities to deliver specific services, under personalisation there will be a shift to individuals in receipt of personal budgets purchasing a diverse range of services. As one respondent noted, *“this means a greater level of uncertainty in terms of business planning, which has major cash flow implications”*. To mitigate this risk and to reduce unsustainable overheads, third sector organisations may have to adopt a business model that relies on using a ‘bank’, or pool of individual workers.

**Development of leadership skills.** There is currently uncertainty about how the personalisation agenda will develop. In the face of this uncertainty, the third sector considers developing strong leadership skills within the existing workforce to be a priority.

#### **3.1.3 Adjusting to a more diverse provider ‘market’ – impacts on commissioners**

Respondents who have an interest in commissioner organisations also identified additional risks in moving towards a more diverse provider market. These included financial risks in moving towards a role in shaping the market rather than commissioning large volumes of services. This means that commissioners might fulfil their role by monitoring the quality and governance of providers. In addition, such commissioners would also help to develop a local market by promoting competition (assisting new providers to enter a market) or by helping to shut down poor providers, whilst maintaining the standard of care expected by the public.

Some respondents perceived a risk for confusion in trying to meet irreconcilable objectives because some employers in the NHS – such as GPs – are not only being encouraged to think strategically by commissioning services for their entire population, but will also have to work with individuals to help them commission individual services. In addition, services will

have to be able to meet a number of different demands for personalised services – from ‘harder’ models of personalised care where individuals are given money to spend on their care; to ‘softer’ models where there is joint care planning, or where a lead professional holds a nominal budget on behalf of a service user.

Many respondents were unsure of the eventual impacts of personalisation on the role of health commissioners and the competences they require, and thought that this was one of the most important issues that the personal health budget pilots in England ought to examine.

### **3.2 Barriers to personalisation**

There are a number of challenges that health employers will face in implementing personalisation policies. Those identified by respondents as most important are described below.

#### **3.2.1 Lack of information**

One challenge outlined by respondents was the lack of information available on what is likely to happen: “*A lot of people within the NHS are simply very confused*”. The personal health budget pilots will be crucial in finding out the information needs of commissioners, providers and individual service users (and their carers) as the policy is implemented.

For commissioners, information on how to set appropriate budgets is vital, as there is currently no consensus over how this ought to be done. There are models that can be taken from social care (for instance, budgets were set according to what patients used in the previous year). However no one really knows if this will be applicable or possible in a health setting due to the different structures, as well as the complexity of services and needs of service users.

Service users will also need information on the availability, quality and cost of different services so that they can make meaningful comparisons and informed choices. In social care, the evaluations of direct payments showed that users themselves had many skills needs, for example in decision making. This is explained in greater detail at the end of this section.

#### **3.2.2 Professional mindset**

All respondents mentioned that for personalisation (of whatever kind) to be implemented successfully, it would require a deep cultural and psychological change. As one respondent put it, “*there needs to be a culture change so that clinicians are no longer elevated to a position above that of a normal person*” or “*in consultations, doctors and the medical profession in general are not used to having to explain to patients about their options*”.

For shared decision making to be a reality, both service users and health professionals would need to think differently about what constitutes ‘expertise’, so that the user’s expertise on their condition can be considered alongside the knowledge of the clinician. One of the main third sector proponents of personalised social care services, In Control, goes further than this suggesting that, “*at the heart of the reform process is an attempt to re-think the contract that exists between citizens and the NHS.*”<sup>20</sup> Given that In Control is well regarded throughout the health and social care sector, this commentary should be considered important.

Many respondents used the language of change management theory to describe different strategies that they were trying or wanted to implement in order to bring about cultural change.

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<sup>20</sup> *Citizenship in Health: Self Direction Theory into Practice*, In Control Discussion Paper, p. 28.

## Managing change

A number of respondents reported that it will be important to identify **early adopters** (those enthusiastic about the policy). Early adopters can be individuals or organisations who may become 'peer leaders' to advocate personalisation among their professional colleagues. E-survey respondents emphasised this strongly, arguing that it will be vital for there to be strong *clinical leaders* as well as non-clinical leaders promoting personalisation. An example provided by senior managers of mental health providers was that some of their clinicians may be most comfortable with applying personalised policies as they have more experience of engaging service users in discussions about their options and choices. It is important to recognise, though, that "*early adopters are often atypical ... they are often enthusiasts given more resources*". Conclusions from the pilot sites should be tempered with such considerations.

Respondents also talked about **blockers** who might actively obstruct the policy's implementation. This may be individuals or organisations resistant to change. "*The key to tackling these individuals or groups is leadership, both at the top and throughout an organisation*" said one respondent who had been closely involved with the implementation of personalisation in social care.

### 3.2.3 **NHS approach to risk**

When thinking about major mindset changes, the NHS's approach to risk is also an important challenge to overcome. As one respondent stated, "*the NHS is very good at risk assessment but very bad at risk management*". At the present time, health employers tend to have a process-driven approach to assessing risk, and many notions of clinical governance, clinical safety and quality itself stem from having an optimum procedure in place for reducing risk to an absolute minimum. In this way of thinking, certain options or actions will be considered inappropriate for service users. Some respondents said that such an approach to risk was being *increasingly* emphasised in health (and in some cases, rightly so – given recent concerns over unacceptable variations in clinical outcomes). In this respect, implementing personalisation in health care is likely to be different from the experience of social care.

Many respondents argued that a more risk-enabling culture would be needed: "*One of the main competences we [the NHS] do not get right is personalised positive risk management*". For service users to have meaningful choice and control, health professionals would need to move from assessing risk on behalf of individuals, to explaining the risks of different options to individuals and allowing them to make their own decision. Service providers and commissioners would need to design systems that mitigated and controlled risk to a level that was acceptable, while allowing service users the freedom to argue for, and obtain the services that would be appropriate for them. For instance, local authorities managing social care have developed 'risk enablement panels' where service users who wish to take an action which is perceived as unusually risky or unproven, can explain and discuss their rationale for their choice with a panel. The skills implications of changing approaches to risk management will be outlined in the next chapter.

### 3.2.4 **Time and resources**

The evidence base for assertions about the implications of personalisation on time and resources is quite poor. Nevertheless, respondents commented that the time which professionals have to deal with service users may prove to be a particular barrier. As one trade union representative remarked: "*Personalised care should be empathetic. This involves spending more time with patients, discussing advantages and disadvantages of different options and spending more time assessing their needs*".

It is also possible that personalisation may have significant impacts on administration resources. There is lack of knowledge about whether personal health budgets will require

more management resources. Respondents expressed particular concern about difficulties which would be caused by managing resources which crossed over health and social care boundaries. However, some respondents reported that in spite of current restrictions, some local authorities and PCTs who have implemented 'pooled budgets' for health and social care had succeeded in offering 'virtual' personal budgets for users, crossing health and social care. There were numerous difficulties because of the different ways in which health and social care account for spend, which had to be resolved.

### 3.3 How significant will 'personalisation' be in future?

Respondents' views on the future importance of personalisation depended on the degree to which they were 'enthusiasts' or advocates of personalisation policies. Many of the enthusiasts thought that policies aimed at creating a more personalised health service would become more prominent in future years. However, many of them differed in their view of whether personalisation was primarily a cultural / mindset change, or whether 'harder' policies were also important.

While there was consensus among respondents across the UK on the importance of cultural changes, responses from employers and their representatives suggest that fewer employers are enthusiasts for policies such as personal health budgets. Reflecting the flexible, developmental nature of the personal health budget pilots, many English employers are adopting a 'wait and see' approach because the health benefits for service users and possible cost savings remain unproven. There are many issues that remain to be resolved and the implications for organisations and their workforce are not yet known, as the next section will show. Therefore, while personalisation will undoubtedly continue to be an ongoing aspect of future policy developments, it is unlikely that (in the short term, at least) it will be the main priority for health employers.

Perhaps most importantly, according to respondents, employers and senior managers across the UK are keen to see that lessons are learned and changes to service delivery are thoroughly evaluated, as personalisation policies are implemented.

#### Key lessons from social care

The experience of social care is one of the richest potential sources of learning and guidance available to the health sector on what the impact of personalised policies might be – and the ways in which barriers were encountered and overcome. Respondents from the social care sector had a number of suggestions, but they were unanimously prefaced with the caveat that health and social care, while closely related, had major differences. One respondent from a Trust that worked closely with the social care sector explained:

*“Social care is essentially a two-tier workforce – those that are social workers and those that aren't. The NHS is multi-layered with many different professions. This means that implementing personalised policies will be much more challenging – different approaches will be required for the different professions”*

However, respondents from social care and the literature on the topic remain confident that some learning can be transferred. Key lessons that may be relevant to health are:

- Leadership: social care respondents stated that strong leadership throughout an organisation was vital. It is vital for driving through the cultural change which will be required to ensure personalised policies are implemented. In social care, these skills were often lacking, and addressing the gap in leadership skills was one of Skills for Care's roles;
- Social care saw the new role of Personal Assistant emerge. The health budget pilots should concentrate on whether this role emerges, and if it does, whether it is desirable;
- As well as assessing the need for new or altered qualifications, it is important to

embed the principles of personalisation into CPD, appraisals and other development opportunities;

- The pilots of the individual budgets had varied success for different service users. Service users with the most positive collective outcomes were those types of people with mental health needs, who reported a significantly higher quality of life. Physically disabled adults also reported receiving higher quality care than under the traditional model, while people with learning difficulties were more likely to feel that they had control over their daily lives. Older people, however, reported lower psychological well-being, often because of the extra burden of managing a budget and the extra burden of becoming an employer;
- The evaluation of individual budgets in social care also reported that the process of empowerment and confidence building in self-directed care planning was time consuming, requiring extra staff to help facilitate the process;
- The skills needs most evident from the personalisation of social care are still at an early stage of understanding but the IBSEN<sup>21</sup> evaluation states that the most significant gaps were advocacy, planning, brokerage and knowledge of different services.

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<sup>21</sup> The *IBSEN Evaluation of the Individual Budgets Pilot Programme* (2008) is the source for commentary in this text box.

## 4 WORKFORCE IMPLICATIONS

*“The vision is of people who use services, empowered with advice, support and information, having choice about the services they want, being able to take more responsibility for their health and their lives and a more active role in managing their own care if this is what they want. This will only be achieved by significant cultural change and changing the attitudes, behaviours and skill base of all people working in health and social care.”*

*Ann Keen and Ivan Lewis (Parliamentary Undersecretaries of State, Department of Health, in Common Core Principles to Support Self-Care)*

*“The workforce not only accounts for 80% of the total expenditure in social care, it also counts for 100% of the service user’s experience of social care.”*

*Hudson, B & Henwood, M, Working for People: The workforce implications of Putting People First*

Interviews yielded a great deal of comment and debate on what the likely impacts of personalisation on the workforce will be. In England, respondents expressed uncertainty about the results of the pilots for personal health budgets, so were unsure of the workforce implications. Moreover the flexibility afforded to the pilot sites by the Department of Health in implementing personal health budgets means that a great deal of variation is expected across the sites. This flexibility was set out in the original DH document introducing the pilots which declared subsidiarity as one of the guiding principles for the implementation of Lord Darzi’s Next Stage Review (of which personalisation is an element).

*“Subsidiarity means ensuring that decisions are taken at the right level of the system, with an enabling role for the centre. Personal health budgets follow the trend to make decisions as close as possible to the individual, but within the ongoing responsibilities and principles of the NHS, as set out in legislation and guidance.”<sup>22</sup>*

The pilots will “enable PCTs and their partners to be innovative and to explore the opportunities offered by personal health budgets.”<sup>23</sup> A number of respondents concurred believing that this flexibility in the provision of personal health budgets is driven by the devolved structure of the NHS which gives Trusts autonomy in a number of areas. This is bolstered by the argument that local staff are best placed to judge local conditions and adapt.

### 4.1 Skills

Interviews suggest that the skills needs of the health workforce will be affected significantly. **Figure 4.1** outlines the differences between the traditional service model and a personalised service model. The third column illustrates potential skills impacts and comments respondents have given us about what they expect to happen to the workforce.

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<sup>22</sup>DH (2009d), *Primary Care & Community Services: Personal Health Budgets: First steps*, p. 11.

<sup>23</sup> *Ibid*, p. 6.

Figure 4.1 Skills impacts of personalisation

Traditional service model	Personalised service model	Skills impact
Assessment by professionals	Early self and multi disciplinary assessment	Workforce will need greater knowledge of other services and the ability to work flexibly and in a multi-professional way. Changes in the competences required to carry out assessments (they will be carried out together with the user and/or other agencies) <b>“The NHS will need a change in mindset centred on equality not pity ... so professionals see themselves as no different or more valuable to an ordinary person”</b> Expert in Personalisation
Lack of transparency – budget and resource allocation	Transparent allocation against clients/patient individual need	New skills in formulating and explaining budgets to users will be required. <b>“The ability to set appropriate budgets for patients is a critical area of skills development”</b> Expert in Personalisation <b>“New competences will not be required but it will be a case of re-emphasising listening skills and empathy”</b> Union Senior Policy Analyst
Care plans developed by professionals	Support and care plans designed by the individual with people/professionals of their choice	Cultural change from direction to advice giving and collaborative working with users will have to be fostered through training. Skills required for care planning rather than care delivery. Health professionals will have to develop motivational questioning skills as a means of effectively ascertaining a service user’s true aspirations. <b>“The interface between clinician and patient will change requiring more advocacy and listening. Social workers have said, ‘it just feels different’”</b> Expert in Personalisation <b>“There is no systematic approach in place to capture what an individual’s main goals or expectations are”</b> Expert in Personalisation <b>“The process will have to be seen as a meeting of two experts”</b> Policy Adviser in Department of Health
Money managed by care organisation (NHS Trust provider/ commissioner or local authority )	Money managed by the individual or nominated agent	New skills in purchasing services will be required. This will require knowledge of the local market.
Services commissioned by NHS or Local authority	Services commissioned by the individual	Commissioners take on a different role as the managers of the market rather than direct purchasers of services. Service users themselves will need new skills as commissioners of services and possibly in managing their own staff. <b>“Service users will need to know how to manage brokers”</b> Third Sector organisation
Tendency to one off planning with periodic review	Reflective ongoing process, responding to evaluation of support and care given and the learning this generates	Clinicians will need new skills in self-reflection and ongoing evaluation. <b>“Research and evaluation are seen as key competences and these competences need to be fleshed out more in the career framework”</b> Expert in Personalisation
Limited flexibility in spending	Enhanced spending flexibility	Increased complexity of clinical pathways involving care plans crossing health and social care. Potential for innovation in terms of roles as well as innovation from new providers. <b>“We have to stop people working in silos”</b> Expert from Social Care <b>“The time needed to be dedicated to comprehensive care planning is a barrier”</b> Expert in Personalisation
Responsibility for risk lies with the commissioner/provider of services	Responsibility for risk shared by the individual and the commissioner/provider of services	New skills will be required in the (systemic) management of risk; professionals will need to balance this with service users’ autonomy <b>“We need to be able to support service users to make a ‘bad’ [less than what health professionals’ perceived ‘best’ choice] and support them to learn from it”</b> Learning Disabilities Senior Manager
Limited incentive for innovation	Considerable opportunity for innovation in line with individuals wishes and needs	Workforce will need to be more flexible and capable of managing a wider range of services. Carers will require knowledge of a wider range of care. <b>“New roles will have to develop that combine competences from both health and social care”</b> Expert in Personalisation
Tendency toward mechanistic approach – individual subsumed within the corporate approach	Individual empowered as part of an active community	The user will gain influence relative to the care deliverer – a change in mindset which will have to be promoted from the top. Different leadership skills may be required. <b>“The doctor/patient relationship will change ... doctors’ soft skills will be vital”</b> Senior Policy Analyst, BMA

Research shows that there are skills implications, arising from:

1. **Broad mindset changes** embodying a person-centred approach to health care.
2. **More specific skills gaps** required to implement specific personalisation policies.

These are described in more detail below.

#### 4.1.1 **Mindset changes**

As set out in the previous section, a key finding from interviews was that respondents believe that for personalisation to be successful, the culture of all health professions, including managers, will have to change: *“personalisation is more than a funding system, it’s an ethos”*. It will be important for clinicians at all levels to shift towards a mindset which sees service users and practitioners as equal partners. One respondent suggested that for this to be achieved, two sets of competences need to be defined:

*“One will be a set of competences that relate to specialist and expert knowledge and understanding that a practitioner has for the benefit of a service user, while the other will be competences related to listening to an individual and adapting to their needs”*

This will be a difficult process, because as one respondent commented:

*“It will be challenging to embed a person-centred approach because it is difficult to tell clinicians they don’t do this already”*

Respondents to the e-survey (representing a very important group for the development of personalisation in the shape of Workforce and HR managers in NHS Trusts and Boards) emphasised one mindset change which will be required – the need to end silo working in the NHS: *“There will need to be greater flexibility within defined boundaries”*.

#### 4.1.2 **Specific skills gaps**

Throughout the consultation, respondents in the stakeholder consultation and e-survey pointed to a number of specific areas where skills gaps would be evident. The main areas identified are listed below:

**Leadership:** good quality leadership from the top of each organisation and across each level is seen as vitally important for the success of the personal health budget pilots and personalisation policies in general: *“However personalisation pans out, strong leaders will be required to implement the policies in practice”*. The leadership of Chief Executives of both provider and commissioner Trusts, and Health Boards will be vital. Leadership development is seen as a priority for both Skills for Care and Skills for Health, and both organisations perceive an increased demand for leadership skills that can cope with the demands of increasingly integrated services. Respondents to the e-survey agreed with some seeing it as the vital requirement for delivering personalisation: *“Unless there is genuine leadership commitment to make this work it won’t happen”*.

**Advocacy:** Charles Leadbeater has argued that under a more personalised system, *“professionals should act as advocates for users, helping them to navigate their way through the system ... The relationship should be continuous rather than the service user engaging in a series of disconnected transactions”*<sup>24</sup>. Many respondents agreed with this, arguing that skills in advocacy and information, advice and guidance provision will become vital to existing health professionals, as well as any new roles which may emerge. This is so that service users can be assisted in navigating through the wide variety of services available. E-survey respondents agreed, seeing advocacy skills as one of the major skills needs under more personalised services, particularly for service users that may have difficulties in navigating the system.

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<sup>24</sup> *Personalisation through Participation: a new script for public services* (2004), Charles Leadbeater

**Motivational questioning:** some respondents remarked that health professionals' abilities to glean information from a service user will be an important competence. Professionals are likely to need the ability to use motivational questioning with service users in different situations, who may have varying degrees of communication skills and levels of understanding, without unduly influencing them. One method is articulated in a think tank pamphlet: *"Making comparisons between alternatives helps people to articulate their preferences. This is very hard to do from a blank sheet of paper"*<sup>25</sup>. Such skills will be important in care planning.

**Ongoing evaluation:** while the care planning stage of engaging with service users will be important, various respondents pointed to the value of *"practitioners encouraging people to give feedback on why a treatment is not working ... At present there is a culture of people waiting until after a treatment is complete to make a complaint"*. Respondents stated that this concept of exchanging feedback and evaluating progress in an ongoing way may be relatively new for some health professionals. A small number of respondents went further, suggesting that entirely new means of assessing 'wellness' will be required.

**Commissioning:** respondents working in senior mental health management argued that *"commissioners are threatened by language such as 'complex care pathways'"*. As one academic described it, there will be, *"a shift in mindset from 'providing services' to 'shaping the market'. Instead of 'commissioners' and 'providers', commissioning and providing, these actions may take place at different levels in the system."* If service users hold and use personal health budgets, they will be commissioning their own care. It follows that service users will then need competences in purchasing services or employing workers effectively. Glasby<sup>26</sup> has argued that *"knowledge of the costs of different community services [is] underdeveloped"*.

## 4.2 New roles

A major debate that is evident in both the literature and amongst respondents in this study is whether new roles will emerge within the health sector as a result of personalisation and, if so, what they might be. Among English respondents, comments were largely speculative given that personal budget pilot sites are still developing their plans.

A small number of respondents argued that new roles would not necessarily emerge, and that such responses were unhelpful to the overall aims of personalisation: *"there is little evidence for [new roles]...such new roles will derive out of a perceived complexity that the new system will have. The idea is that the system will be simple enough for the service user to 'navigate' themselves, or with the help of their family"*. Another respondent from the social care sector argued that, *"perhaps the Personal Assistant role [a worker who assists the service user with decision making and coordinating an individual's care package] is an assumption propagated by people who aren't experts"*. The same respondent warned of replicating mistakes made in social care: *"[In social care] they may have only taken on Personal Assistants because the providers aren't giving them what they want."*

However, many respondents argued the opposite: that new roles would emerge with a focus on **supporting service users rather than directly delivering services**. According to one respondent, new roles might be *"workers who can cross the boundaries of the NHS ... they would be very well trained but not necessarily professionally qualified"*. Feedback from the e-survey agreed with a number of respondents, suggesting that any new roles would cut across the health and social care sector. Another significant conclusion from the e-survey (which was answered by individuals who may be considered expert in the workforce developments) was that the Assistant Practitioner role would become much more

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<sup>25</sup> Ibid., p. 58

<sup>26</sup> Glasby, J (2008). *Individual Budgets and the interface with health: A discussion paper for the Care Services Improvement Partnership*, p. 11

important in a personalised health sector. Skills for Health contributed to the development of the role as a means of introducing flexibility into the workforce and relieving the caring workload of their professionally trained superiors (who may be free to focus more on developing care plans, for example). **Figure 4.2** details two roles that may emerge based on, and supported by, comments from the stakeholder consultation.

**Figure 4.2: Potential new roles**

Role	What does it involve?	Comments
Care Assistant	Given the scope for health – social care crossover afforded by personal budgets, this “ <i>complex domiciliary role</i> ” might combine many competences suited for a particular service user. This type of role might be most suited to rural areas where the accessibility to a range of services is poor.	<p><b>“Taking personalisation to its logical conclusion means that each patient needs a carer with a unique set of competences”</b></p> <p><i>Senior internal stakeholder</i></p> <p><b>“There has always been some tension between health and social care and this job would have to cross the boundary”</b></p> <p><i>Union Policy Advisor</i></p>
Navigator / Broker / Advocate	Under a personalised system, there is likely to be a far more diverse market of service providers responding to service user demand. In order to help service users navigate this complex market, many believe that a new role will emerge which will involve shaping a care plan and then commissioning, on an individual basis, a range of health and social care services.	<p><b>“More brokers may be required and they will need to understand not only local market and options available but to have an understanding of mental illness”</b></p> <p><i>Third Sector Mental Health Organisation</i></p> <p><b>“The navigator needs to be senior, not a band three administrator ... the navigator has to have clout to deal with a number of senior individuals.”</b></p> <p><i>Internal Stakeholder</i></p>

If new roles do not develop in the personal health budget pilots, then it is likely that the competences involved will be attached to an existing role. Alternatively, Trusts taking part in the pilot may see the Care Assistant role as one which involves the navigation and brokerage aspects as well.

#### 4.2.1 **Management of New Roles**

If new roles do become a feature of any successful personal health budget pilots, respondents also speculated on how such a development would be managed. Some respondents thought that care assistants or navigators might be privately employed, while others suggested that third sector organisations might be most suited to manage them. Some of the personal health budget pilots are considering contracting with large third sector organisations as potential providers of the navigation service and care assistant role. Trust in the new role was considered to be the most important aspect of the relationship with the service user, which led other respondents to suggest that the NHS might be best: “*if an agency could engender this trust among the service users then it could succeed ... the NHS would be ideal because people trust this*”.

#### 4.3 **Training and qualifications**

There was even greater uncertainty among respondents as to how training and qualifications might be affected. Some respondents suggested that new approaches to training and qualifications will have to be designed; others thought that it was too early to give a reasoned view. Respondents talked about designing bespoke training packages for particular roles, such as tailored leadership and management programmes.

Some respondents argued that traditional methods of training were inadequate: “*traditional qualifications are not necessarily the way forward. New ways of collecting evidence of*

*competences will have to be devised to avoid a ritualistic training regime*". This would also have implications for how job descriptions are written (for example, basing them on outcomes for service users rather than tasks required) and how workers are managed. For instance, one respondent stated that it would become more important to embed *"the principles of personalisation into CPD, appraisals and other development opportunities for people who are already qualified"*.

In a system which values flexibility, as personalisation is likely to do, the **skills passport** could become an even more valuable concept. One respondent argued that personalisation was *"an opportunity to make the skills passport a key feature of the health sector"*. An advantage of this would be the transferability that it would afford, allowing an individual to gather an array of competences.

Another respondent suggested that a more flexible NVQ which would have *"a core section and then specialisms for each job role"*. Some respondents suggested that the unit-based Qualifications and Credit Framework created a good opportunity to re-examine the competences that all health professionals might need to deliver person-centred care.

#### **4.4 Service users as employers**

One of the most profound potential impacts of personalisation is that service users themselves may become employers. Respondents also commented that there may be a need for service users to be trained as employers. As an employer representative organisation, SfH may have to think about how best to engage with these employers as well.

Among the respondents in this study, health unions and professional bodies (Royal Colleges) had particular concerns about how service users would gain the skills to become 'employers' in a personalised system. They raised a number of questions as to how service users might:

- draw up job and person specifications for personal assistants;
- understand HR issues such as paycales;
- deal with workers' pension provision;
- deal with health and safety;
- deal with training and CPD;
- define boundaries between work and rest time; and
- whistle blow if an employee witnesses a budget holder mispending their allowance (the final two comments are especially relevant in a situation when the budget is being used to employ a friend or relative).

These are by no means problems under all models of personal budget holding, and there are alternative models in which service users do not directly employ people. However under the model of personalisation whereby a service user takes control of a budget, they will effectively become employers themselves and therefore will have skills needs.

#### **Strategic Health Authority (SHA) Workforce Plans**

For this study, the current workforce plans or strategies in each SHA were also examined. SHA publications on workforce show a varied degree of engagement with personalisation. One reason for this is the difference in publication dates of the SHA workforce strategies. As personalisation in health is a relatively recent development, many SHAs published their last strategies too long ago for personalisation to have made much of an impact. An alternative explanation is one which suffused stakeholder interviews: that certain areas of the country are more prepared for, and interested in, personalisation. In the East of England, for example, workforce leads are engaging with the SHA Boards in an effort to

prepare the workforce for Personal Health Plans (which are called personal care plans in this report).

*“Workforce will act as a key enabler to the process of personal health planning to ensure the key worker and other key stakeholders are competent to support, navigate and advise individuals on the development and realisation of their plan.”<sup>27</sup>*

The North East SHA has identified that new roles, such as Personal Assistant, have emerged in social care as a result of the individual budgets. In *A portrait of the health and social care workforce in the North East* published in 2008, the workforce team acknowledge the existence of these roles (quoting work by Skills for Health and Skills for Care in doing so) but also state that they have no way of knowing how many people are working in such roles. This indicates a demand for the type of Labour Market Intelligence produced by Skills for Health, which describes how many people are employed in roles which cross health and social care.

Personalisation, as part of the overall Darzi reforms, has begun to feed into SHA Workforce Strategies. The north west SHA’s strategy<sup>28</sup>, for example, contains pledges on key elements of personalisation such as to *“Develop collaborative approaches, which better enable joint strategic workforce planning between NHS organisations and local authorities”* and to *“Ensure the sustainable commissioning of new roles”*.

London SHA has committed to a potential 29% increase in the number of Assistant Practitioners (APs) over the next ten years, which links in with the e-survey which highlighted how important workforce directors at Trust level thought APs might be in a more personalised workforce.

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<sup>27</sup> Agenda item, East of England SHA Board Meeting, 15/06/2009

<sup>28</sup> *The Workforce, Education Commissioning and Education Learning Strategy* (2008), NHS North West

## ANNEX A: STUDY METHODOLOGY

This section describes the methodology of the study.

### ***Phase 1: Inception and policy review***

Phase 1 of the study consisted of a wide ranging policy review. A literature review previously commissioned by Skills for Health was used as a basis for this and extended the search further through this research. Finally, a number of interviewees directed GHK to documents that they saw as important to the study. A bibliography detailing this research is in Annex C. This policy review informed a scoping report which was completed in August 2009.

The documents reviewed can be broadly categorised as follows:

- **NHS / Department of Health:** reviewing the various recent policy papers produced by the Department of Health (and other central government departments and agencies, such as the Cabinet Office) enabled us to chart the development, key policy drivers, and future direction of personalisation in health, social care and across government.
- **Implementing personalised policies:** the implementation of policies associated with personalisation is further advanced in the social care sector than in the health sector. As a result, there is a wealth of material available, including in-depth evaluations and tools, guidance documents and commissioned studies produced by Skills for Care (some in collaboration with SfH).
- **Position papers:** as policies associated with personalisation are implemented, both interest groups (e.g. trades unions and social enterprises) and government agencies (e.g. regulators such as the Social Care Institute for Excellence) have published documents stating what the agenda means for their particular client base.
- **Research:** academics and think tanks have written extensively on the topic of personalisation in public policy in general and in health and social care more specifically. A number of these documents were reviewed.
- **Skills for Health and Skills for Care-published documents:** a range of documents, tools and frameworks produced by Skills for Health and Skills for Care were examined.

### ***Phase 2a: Stakeholder interviews***

The second phase of research involved a broad consultation with a wide range of internal and external stakeholders listed in Figures A.1 and A2. The consultation took the form of depth interviews of up to an hour in length which took place over the phone. The different groups of stakeholders interviewed could be broadly categorised as follows:

- **Internal stakeholders:** in order to understand the differing perspectives on personalisation across Skills for Health and its importance to them, a number of employees from across the organisation were interviewed.
- **Experts:** spoke to a number of external experts on personalisation were also interviewed. These people were mainly academics or consultants who had worked in the social care and health sectors for a number of years.
- **Social care:** a range of respondents in the social care sector were spoken to including, experts and consultants, policy makers within government and individuals working in the third sector. This included discussion on the implementation of personalised policies in social care and what the workforce impacts have been.

- Third sector: respondents from the third sector were able to comment on the particular impacts on their organisations that personalisation may have.
- Unions: a broad range of union spokespersons / research officers for the main professions within the NHS were interviewed. They commented on how personalisation will affect their members in particular and the workforce in general.
- Department of Health: this included discussion with stakeholders from within the Department of Health who are responsible for the implementation and support of the personal health budget pilots.
- Workforce leads: included individuals responsible for workforce planning and development within a number of SHAs and the nations in order to assess what key practitioners understand about personalisation and its expected workforce impacts.
- Senior NHS Managers: this was a facilitated a focus group with a senior group of NHS managers with a remit for learning disabilities provision and commissioning. GHK assessed their understanding of personalisation in their particular context and the skills needs which may arise.

**Figure A.1: List of internal stakeholders (all Skills for Health)**

<b>Name</b>	<b>Job Title</b>	<b>Division</b>
Andrea Watwood	Divisional Manager	Workforce Development
Angelo Varetto	Divisional Manager, Competences Development	Standards and Qualifications
Bryan Kessie	Workforce Projects Director	Workforce Development
Christina Pond	Executive Director	Standards and Qualifications
Dianne Mardell	North West Regional Director	Strategy and UK Networks
Jan Parfitt	Programme Manager	Workforce Development
Jane Fox	Programme Manager	Standards and Qualifications
John Ennis	Divisional Manager, Standards Development	Standards and Qualifications
John Stephenson	Director UK Networks, Wales and Northern Ireland	Strategy and UK Networks
Karen Walker	Divisional Manager	Standards and Qualifications
Kathryn Halford	Divisional Manager, New Ways of Working	Workforce Development
Lorna Hunter	Lead Manager, Scotland	Strategy and UK Networks
Paul Blakeman	Divisional Manager, Qualifications Development	Standards and Qualifications
Pippa Hodgson	Regional Director, East Midlands	Strategy and UK Networks

**Figure A.2: External Stakeholders**

<b>Name</b>	<b>Job title</b>	<b>Organisation</b>
Alastair Henderson	Deputy Head of Employment Services	NHS Confederation
Alison Giraud-Saunders	Co-Director	Foundation for People with Learning Disabilities
Alison Mohammed	Director of Services	Rethink
Barbara Bale	Head of Workforce and Organisational Development	Welsh Assembly Government (Health)
Carol Sinclair	Programme Director	Better Together Improvement Partnerships
Debra Moore	Managing Director	Debra Moore Associates (Also a lead in the Valuing People Support Team)
Gary Kirwan	Employer Relations Adviser	Royal College of Nurses
Janet Cobb	Associate Consultant	Foundation for People with Learning Disabilities
Jeremy Clark	Chair	New Savoy Partnership
Jon Glasby	Professor of Health and Social Care	Health Services Management Centre, University of Birmingham
Jonathan Walden	Policy Officer	Policy Support Unit, Department of Health
Karen Jennings	Head of Healthcare team	Unison
Kate Moran	Head of Employment Research	Chartered Society of Physiotherapists
Lesley Barcham	Learning Development Manager	British Institute of Learning Disabilities
Lucy Dennis	Workforce Development Consultant	Workforce Directorate, NHS East of England
Lynn Elwell	National Coordinator, Family Lead	In Control
Maria Lagos	Policy Lead	Skills for Care
Mark Duman	Chair	Patient Information Forum

Peter Gregg	Head of Education and Training Unit	Department of Health, Social Services and Public Safety, Northern Ireland Executive
Richard McLennan	Programme Manager	Better Together Improvement Partnerships
Rita Brewis	Health Lead	In Control
Robin Murray-Neil	Policy Adviser, Personalisation	Putting People First Team, Department of Health
Roslyn Hope	Director of the National Workforce Programme	National Institute for Mental Health
Sally Al-Zaidi	Senior Policy Analyst	British Medical Association
Sean O'Sullivan	Head of Policy	Royal College of Midwives
Tom McLean	Quality Development Officer	Manchester Learning Disability Partnership
Tracy Morton	Policy Adviser	Long term conditions team, Department of Health
Vic Citarella	Director	CPEA
Vidhya Alakeson	Fellow in Healthcare Policy	Department of Health and Human Services, United States Government
William Snagge	Head of Advocacy and Volunteer-based services	Mind
Yvonne Cox	Chief Executive	Ridgeway Partnership NHS Foundation Trust (on secondment to NHS Confederation)
Zoe Porter	Delivery Programme Manager	Personal Health Budget Pilot Programme

### ***Phase 2b: E-survey***

Running concurrently to the interviews, an electronic survey was disseminated among workforce and HR Directors within a wide range of NHS Trusts. The survey focussed on practitioners' understanding of personalisation, their thoughts on potential workforce impacts and where they thought Skills for Health could be most useful and effective in the policy area. The detailed methodology, results and analysis of the e-survey are in Annex B.

### **Phase 3: Workshop**

Findings were presented to a group of internal stakeholder in November 2009 at Skills for Health's London office. Those present included individuals who took part in phase 2 of the research. Additionally, a workshop was held which tested and refined the final recommendations to make them more practicable. They have been included in chapter 6 of this report.

**Phase 4: Reporting**

Two versions of the report have been produced: one 'full report' which contains full findings, supplemented by the literature review, bibliography, survey results and analysis and full methodology; and, a shorter summary version for presentation at Skills for Health's Business Development Forum in early 2010.

## ANNEX B: E-SURVEY ANALYSIS

In September 2009, an electronic survey was sent to workforce development and HR Managers in a variety of different NHS Trusts and Health Boards across the United Kingdom in order to capture the opinion of a key group in relation to personalisation. The survey covered three areas:

- Respondents' understanding of personalisation and its importance to their organisation;
- What respondents believe will be the main workforce impacts of personalisation; and
- Where respondents believe that Skills for Health can most usefully help their organisations in the delivery of more personalised services.

This annex contains detailed analysis of the e-survey findings. Key findings, quotations and trends are included in the main body of the report. The document was sent to approximately 400 people, sometimes directly, and sometimes by asking others such as SHAs to pass it on on SfH's behalf. The survey was also advertised in the NHS Employers bulletin and the SfH website. 39 people responded to the e-survey. The text box below outlines the main findings followed by more detailed analysis.

### Main e-survey findings

- The three themes (service users having a greater influence in decision making; greater choice for service users; greater information for service users) which is seen as defining personalisation are all important to the future decision making of the NHS Trusts and Boards. Of the three, the need to provide more information to service users in the future is most important.
- The statements about personalisation that have gone into forming the definition of personalisation are all seen as related to personalisation by respondents. The only areas of mild disagreement were whether personalisation would lead to a greater variety of service providers and whether it would lead to a more equal relationship between clinician and service user.
- Many and varied comments were received on the workforce impacts of personalisation. In general, respondents to the e-survey are beginning to think about the implications of personalisation on their workforce; this is broadly similar to the state of readiness that was found in the course of the stakeholder consultation. If anything, the comments reveal that the workforce leads are thinking along more practical lines and gave tangible examples such as the growing importance of the Assistant Practitioner role in a more personalised health sector.
- Among respondents, awareness of Skills for Health is very good. Skills for Health's tools (particularly the competences framework) are in demand as a means of delivering a more personalised health sector workforce.

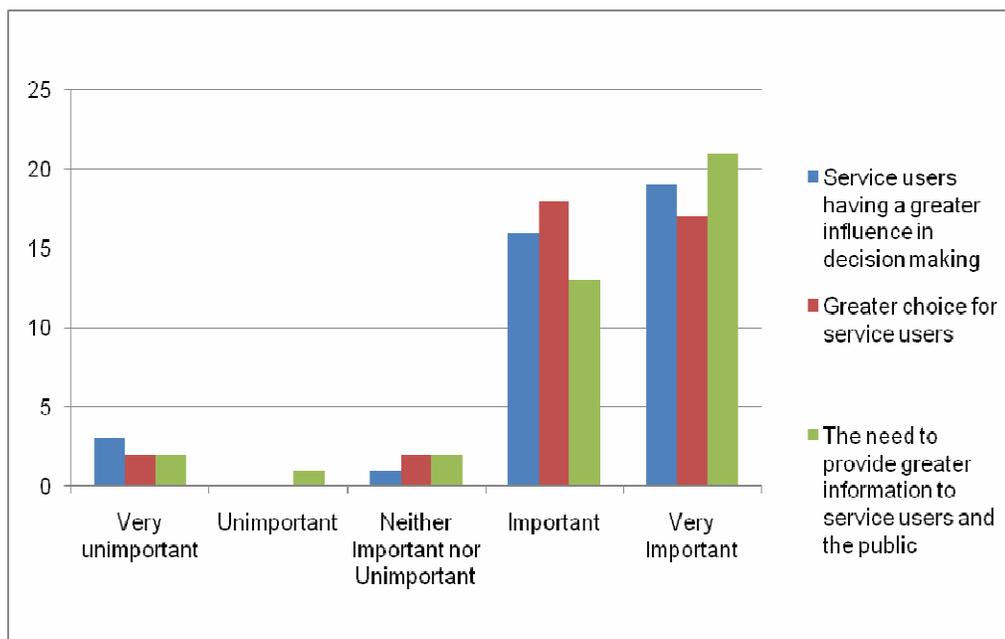
**Question: Please rate the importance of the following developments on future decision making within your organisation:**

- Service users having a greater influence in decision making (potentially through personal health budgets; care planning; and the changing relationship between clinician and service user)
- Greater choice for service users (potentially through more choice of provider; a wider marketplace of providers; care provided in a range of different settings; 'care closer to home')

- The need to provide greater information to service users and the public (potentially about the quality of service provided by your organisation; giving patients greater access to their records)

The options correspond to the three themes of personalisation outlined in the definition in section 2.2 of the main report.

**Figure B.1: Please rate the importance of the following developments on future decision making within your organisation**



The headline finding from the first question, illustrated in Figure B.1, is that respondents believe the three themes which have been argued define personalisation (service users having a greater influence in decision making; greater choice for service users; and, greater information for service users), are going to be important in the future decision making of their organisation. **The most important of the three themes is thought to be the need to provide greater information to service users and the public**, with 54% of respondents rating it as very important to their future decision making.

**Question: To what extent do you agree or disagree with the following statements about personalisation?**

- Personalisation will give service users more influence over their care
- Personalisation will lead to a more equal relationship between clinician and service user
- Personalisation will lead to a greater variety of service providers.
- Personalisation will lead to more flexible provision for service users (choice of location, provider and timing).
- Personalisation will lead to more flexible provision (choice of treatments and care pathways)
- Personalisation will lead to service users being more informed about providers
- Personalisation will lead to more innovative services becoming available
- Service users will have more information about their own conditions and treatment.

- **Service users will have more control over the way their own health budget is spent**

**Figure B.2: To what extent do respondents agree with the following statements about personalisation?**

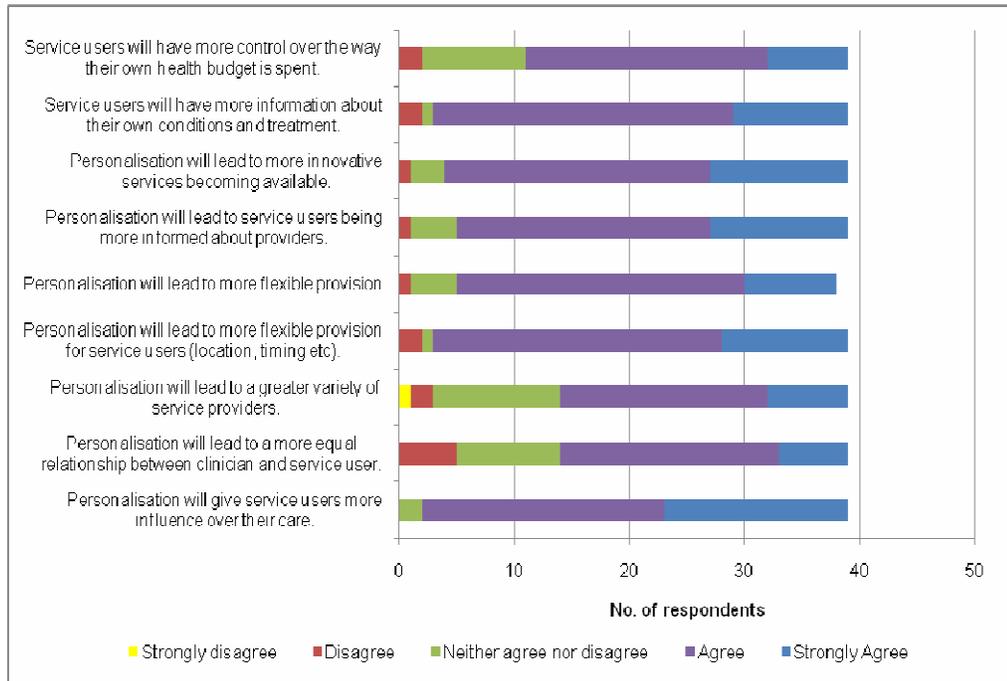


Figure B.2 shows that, in every case, the majority of respondents agree that the range of statements set out relate to personalisation. The statement that that: **“Personalisation will give service users more influence over their care”** was particularly highly agreed with; 95% of respondents either agreed or strongly agreed that the statement related to personalisation. The statements that “Service users will have more information about their own conditions and treatments” and “Personalisation will lead to more flexible provision for service users (choice of location, timing and provider)” were also well accepted with 92% of respondents agreeing or strongly agreeing that they related to personalisation.

The two statements which proved most contentious (although a majority of respondents still agreed with them) were that: “Personalisation will lead to a greater variety of service providers” and “Personalisation will lead to a more equal relationship between clinician and service user” with 36% of respondents either not agreeing or disagreeing that the statements related to personalisation. In general though, there was agreement with the statements as set out, which have informed and been included in the definition of personalisation outlined in Chapter Two.

The third question aimed to understand what respondents thought would be the key workforce impacts of personalisation. Respondents were asked to write comments under a series of headings of where the main impacts might be. This has reproduced some of the most interesting comments below.

**Question: Thinking about the statements above and your views on their importance, how, if at all, do you think your workforce will need to change in order to adapt? Please provide examples of any activities or work programmes that your organisation is carrying out under each of the following headings**

### **New Skills**

Most respondents pointed to specific skills gaps which would be evident in a more personalised health service:

- *“Multi-skilling across current professional silos; integrated care management”* (Workforce Planning Manager, NHS Health Board, Scotland)
- *“Advocacy for dementia clients”* (Occupational Therapist)
- *“Need to be more person centred and listen to what service users say competent in health and social care tasks”* (Organisational Development Practitioner)
- *“Negotiation, Contracting, partnering, networking and advanced communication skills”* (Assoc Director of Organisational Development, NHS PCT)
- *“Will need to develop more business management skills”* (Programme Director, Workforce Planning NHS PCT)
- *“Clinical leadership development, teams of multi-prof's who are multi-skilled”* (Director of HR, NHS Trust)
- *“Changing the relationship between health professionals from paternalistic to enabling and respectful is difficult. The training of new staff and that for existing staff needs to question basic assumptions about why we are there.”* (Organisational Development Facilitator, NHS Trust)

Advocacy skills and flexibility across the health and social care boundaries are seen as vital. Other frequent comments included: the need for NHS staff to improve their customer service skills and communication skills (one respondent described this as ‘advanced communication’).

### **New Roles**

- *“Potential for more new generic roles across health and social care”* (Programme Director Workforce Planning, NHS PCT)
- *“Advanced and Assistant practitioners”* (Director of HR, NHS Foundation Trust)
- *“Advocacy / increased role with isolated and vulnerable clients”* (Occupational Therapist)
- *“Specialist Practitioner in pre-hospital care (paramedic/nurse) to allow for greater decision making at the earliest point possible”* (Head of Workforce Modernisation & Development, Welsh NHS Trust)
- *“multi-skilled roles, enhanced care roles with greater freedoms and span of control”* (Assistant Director Learning & Development, NHS Trust)

Comments in this area were varied; however, a few themes were common across all responses. 4 respondents commented that a flexible role crossing the health and social care boundary would emerge. Another common comment was that a role of advocacy and brokerage would be required. One person argued that such a role would have to be focused on isolated and vulnerable service users. 4 respondents specifically mentioned the role of Assistant Practitioner as one which would emerge or grow in importance. The role, which was developed by Skills for Health, would be managed by a healthcare professional and can exist in a number of different clinical fields. Its prevalence amongst the comments warrants it being mentioned here and in the main body of the report.

## Workforce redesign

- *“Increasing use of Assistant Practitioners to deliver care designed and QAd [quality assured] by professionals”* (Workforce Planning Manager, NHS Board, Scotland)
- *“Reviewing care pathway & capacity to ensure right staff, right skill, right time along patient care pathway”* (Deputy Director Service Quality Improvement, Foundation Trust)
- *“Implemented Neighbourhood Teams”* (Director of HR, NHS Trust)

The comments under ‘Workforce redesign’ were particularly varied. Comments included more detail on the Assistant Practitioner role (that they will be more likely to deliver care under the responsibility of a professional). There were also a few comments about the need to efficiently design care pathways and match them to the staff available.

## Integrated working between health and social care

- *“This is the key area where I believe we need to put effort in to make personalisation really meaningful but it is probably the most difficult to achieve”* (Director of Workforce, NHS Trust)
- *“Integrated teams and commissioning boards”* (Chief Executive, NHS Trust)
- *“Does not appear to be sufficient boundary spanning roles at present”* (Assoc Director of Organisational Development, NHS Trust)
- *“Greater integrated working between providers -whether in the private, public, voluntary sector”* (Director of HR and OD, NHS Trust)
- *“It is a must; requires pooled budgets”* (Workforce Planning Manager, NHS Board, Scotland)

The comments in this area emphasised the importance of integrating the workforces of health and social care. However, as one respondent argued, *“It is probably the most difficult to achieve”*. Potential solutions mentioned included pooled budgets and integrated teams and commissioning boards. It is interesting that the e-survey’s respondents, who will be dealing with the workforce impacts most directly, are not just simply acknowledging the importance of integrated working but are thinking of pragmatic solutions to achieve this.

## Leadership

- *“Leadership Programmes in place to be accessed by all across the Health & social care community”* (Workforce Lead, Lincolnshire Workforce Advisory Board)
- *“Introduction of new Clinical Team Leader roles”* (Head of Workforce Modernisation & Development, Welsh NHS Trust)
- *“This will need to be strengthened at all levels in the organisation particularly clinical leadership”* (Programme Director Workforce Planning, NHS PCT)
- *“Leadership development programme for bands 6,7 and 8, improving general management competency of line managers”* (Director of HR, NHS Trust)
- *“Unless there is genuine leadership commitment to make this work it won’t happen”* (Director of Workforce, NHS Trust)

There are two major conclusions for this section. A number of respondents argued for the importance of leadership skills in the NHS, particularly at times when change is being implemented. Secondly, respondents argued that clinical leadership was especially important in driving change. Many of the respondents stated that they already had innovative leadership training programmes in place, in order to identify talented individuals and giving them responsibility.

Among other comments that were made which were unrelated to the above categories, were respondents who highlighted the need for commercial skills among staff. Another recurrent comment was the need to introduce competences related to self-directed care.

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In addition, GHK had access to a number of internal Skills for Health documents produced by the Health Policy team.