Leadership for Personalised Care

Developing leaders to focus on what really matters

December 2020

> *The programme has helped me bring ideas through the development stage to reality in my location - and to be a better leader in ever changing circumstances*

Ellenor Gray – Manager Community Services Social Prescribing YOU Trust

Contents

Introduction and welcome to the programme

I would like to extend the warmest of welcomes to all the participants in our new **online leadership development programme** and hope that the insights and knowledge you acquire will inspire you to champion new ideas and approaches in your organisation and the wider community.

Giving people real **choice and control** over the way their care and support is delivered is the fundamental first principle of personalised care and our courses are designed to equip leaders at all levels with the skills and confidence to embed this as custom and best practice across the health and social care system.

This booklet is designed to complement **your learning experience** as well as providing information about the other bespoke co-produced programmes delivered by our team with national partners.

The last section contains some key questions to reflect on in your learning journey. Remember – **self-awareness is your leadership superpower!**

I hope you will find it useful and look forward to seeing you in one of our live masterclasses.

Catherine Wilton
Deputy Director in the
Personalised Care group

Introduction to the programme

Leadership for Personalised Care online is an **exciting FREE online leadership development programme, brought to you through the Personalised Care Group in NHS England and Improvement and the NHS Leadership Academy in partnership with In Control.**

This course takes the essence of what we offer in our full leadership development programmes and breaks it down into bite-size pieces. There are 4 modules each of which should take about 5-6 hours to complete.

Each module contains suggested reading materials and selected videos to give a broad overview. This is complemented by a series of **online masterclasses** during which you will have some input from speakers but also a chance to reflect on your own development as a leader.

The programme is intended to give you a foundation in leadership for personalised care. The modules will be supplemented with **online action learning sets** starting in your region in early 2021.

THE MODULES ARE:

MODULE 1: Introduction to Leadership in Personalised Care

This module provides you with the basics around personalised care and the leadership qualities you will need to make it a reality.

MODULE 2: Personalised Care in a complex system

How complex systems work, how change spreads through networks, the leadership skills this requires and how we can use this to our advantage

MODULE 3: Collaborative leadership for Personalised Care

How relationships, partnerships, collaboration and collective action are the only way to solve 'wicked' issues and what that means for us as leaders.

MODULE 4: Personalising leadership for wellbeing, equality and inclusion

Taking the principles of personalisation and applying it to ourselves, our staff and the communities we serve, in order to achieve social justice and reduce health inequalities.

The online modules are free and open to all and we encourage you to **bring colleagues from different sectors to access the course**. Acceptance onto the action learning sets will be application, but we try our best to match demand with capacity.

Section A What is Leadership for Personalised Care?

Leadership for personalised care is a person- and community-centred complex adaptive approach to leadership. The radical change required across health and social care requires this new type of leadership. It is a shift from top-down, siloed ways of working to co-productive, collaborative, cross-boundary and multi-disciplinary practice.

It is no longer enough for leader to focus solely on leading organisations efficiently. Some of the most difficult to solve problems in society need lots of people working together to tackle them. No one leader or service can solve health inequalities or obesity, and long-term conditions need long-term supports for people themselves, not a single process 'fix'.

Leaders therefore need the skill, will, knowledge and confidence to work across boundaries and systems to drive health improvements across the whole population.

In 2010, **Michael Marmot** wrote, *'Health inequalities are not inevitable and can be significantly reduced... avoidable health inequalities are unfair and putting them right is a matter of social justice.' He adds, 'The central ambition of this Review is to create the conditions for people to take control over their own lives.'*

In his **paper 10 years on**, Marmot found that health inequalities have widened. He makes specific recommendations for the health system including:

- **Focusing on preventing ill health and promoting good health as well as treating disease. That requires a paradigm shift for us, in seeing the NHS as more than simply providing reactive services and focusing on what matters to people and their whole lives.**
- **Thinking about 'place' and enabling cross-sector collaboration, rather than organisations seeing themselves as separate entities from each other. It means leaders from health, care, housing, the voluntary sector and local communities working together.**
- **Understanding the local population and providing additional resources for more deprived communities and areas.**

Leadership for personalised care is about all of this. It is about creating the conditions for these things to happen. It involves specific actions around individual care – ensuring care and support planning, social prescribing and support for self-management is in place, but also involves actions around co-production, involving and leading for and with communities, and skill in achieving change in complexity.

Focusing on what really matters to people means things do need to change. We need leaders who are confident, willing and able to work across boundaries and to put what matters to people over the needs of a single organisation.

Leadership Qualities for Personalised Care – *Being*

We have developed a framework to describe what we mean when we talk about leadership for personalised care. It should help you understand the qualities and behaviours that are needed – what to focus on yourself and what to encourage in others to achieve a system-wide shift toward personalised care.

The framework was co-produced with people who use services and carers, and draws on the expertise and practical experience of our leadership for personalised care team and partners.

The framework groups leadership for personalised care qualities into four themes.

Each theme includes a foundation of systems leadership behaviours with additional qualities specific to leadership for personalised care as follows:

- **Being**
- **Relating and communicating**
- **Leading and visioning**
- **Delivering**

SYSTEMS LEADERSHIP BEHAVIOURS

AUTHENTICITY:
Honest and genuine, true to self and own values, clarity about what they are there for, what they say they are aspiring to and why; sense of purpose

MINDSET:
Open-minded, curious, encourages learning and a lack of defensiveness in self and others insight and affiliation with others

RESILIENCE, COURAGE AND BRAVERY:
Boldness, bravery and courage to take calculated risks, reflects and learns from failure and success

LEADERSHIP FOR PERSONALISED CARE

Leadership for Personalised Care

Personal commitment and connection to personalised care

Remains positive, resilient and focussed on purpose in the face of challenge, uncertainty and setbacks

Sees people and communities as assets and health creators and not just 'patients' or 'service users' with needs who require services

Genuine commitment to co-production and partnership working – embodies the value 'nothing about us without us'

Flexible, demonstrates humility and openness to new ideas, willing to change direction and to share power

Empowers and enables people to speak out and participate, so that organisations and the local community are engaged

Leadership Qualities for Personalised Care – *Relating and Communicating*

SYSTEMS LEADERSHIP BEHAVIOURS

RELATIONSHIPS AND ADVOCACY:

Engages and builds relationships at all levels and across organisations, enables citizens to take charge of their own health, with the right support

COLLABORATION AND CO-CREATION:

Involves communities, embraces diversity and works across differences and agencies to establish what collectively needs to be achieved for quality, cost-effective service provision

TRUST:

Builds trust to promote empathy, care and open communication (e.g. around why decisions are made)

LEADERSHIP FOR PERSONALISED CARE

Leadership for Personalised Care

Builds networks and connects people and organisations to each other in the system; able to build relationships and energy for change

Collaborative and inclusive; engages genuinely with a wide range of people, champions equality and maintains a link to the front line – staff, people who use services and local communities

Warm and empathetic with a high degree of emotional intelligence; politically aware

Listens, hears and acts on what others have to say, and is transparent about decision-making

Sees the big picture and joins the dots between personalised care and other requirements of the NHS Long-Term Plan

Self-aware and committed to creating a culture of reflective practice and learning, and improvement

Leadership Qualities for Personalised Care – *Leading and visioning*

SYSTEMS LEADERSHIP BEHAVIOURS

COMMUNITY / HOLISTIC THINKING:
Starts with place in mind, understands wider area structures and associated challenges, clarifies alignment, has a community focus for the greater good

VISION/SHARED DIRECTION:
Has consistent and clear vision which involves common goals and shared direction for quality, effective service provision

SYSTEM INFLUENCE:
Leads from place, makes gateways and breaks down divides to enable system outcome beyond own service, to serve communities. Plays an active role in shaping policy nationally

LEAD/ENABLE OTHERS:
Provides opportunity for others to develop around them, gives opportunities to others to solve problems, make decisions, take ownership; supportive and agile

LEADERSHIP FOR PERSONALISED CARE

Leadership for Personalised Care

Deep knowledge of the local community in terms of the people and communities who live there and what personalised care could mean to them, as well as the organisations that operate there

Able to paint a consistent and clear vision and a compelling narrative for personalised care, bringing staff, stakeholders and the wider community together

An ability to connect organisations, groups and other aligned initiatives to the personalised care agenda and build a coherent sense of a common purpose throughout the system

Adaptive leadership which includes a 'hosting' style, to create momentum for change through networks

Understanding of the link between population health, social capital and personalised care and how they relate to reducing health inequalities

Ability to challenge established ways of working effectively and create a culture of learning and innovation

Actively seeks opportunities to connect to national personalised care agenda and feed back learning about what works

Skills in dealing with large groups, ability to relate to people from all walks of life and work with people

Leadership Qualities for Personalised Care – *Delivering*

If you would like to undertake a 360 assessment, please email **england.leadership@nhs.net**
There is a small cost to this.

SYSTEMS LEADERSHIP BEHAVIOURS

OWNERSHIP AND ACCOUNTABILITY:

Holds self and others (across the system) to account for quality, effective service provision, recognises how to work with shared accountability for the benefit of the population

DELIVERY:

Has clear structure and steps for delivery, knows where to invest energies and takes action, making best use of available resources

DOING THINGS DIFFERENTLY:

Doing things differently to facilitate delivery. Trying new ideas and enabling self and others to explore creative approaches.

LEADERSHIP FOR PERSONALISED CARE

Leadership for Personalised Care

Knowledge of personalised care – the requirements in the LTP, the six 'components', the evidence base and what needs to be achieved at all levels of the system

Understanding of how to achieve change in complex adaptive systems; networks theory, social movements, spread/adoption of innovation

Understanding of the psychology behind behaviour change, motivation and knowledge transfer through networks

Creates the conditions for others to lead and take ownership of personalised care, co-production and community-building

Actively seeks opportunities to build co-production into every level of the system, creating spaces to build a shared understanding of what matters most to people and using that understanding to drive service development and delivery

Removes organisational obstacles to change, galvanising people to work collaboratively to innovate and find solutions

Section B What is Personalised Care?

Personalised Care is best thought of as a social movement which builds on basic human needs for agency and self determination. It has a long history in social care where it is commonly called personalisation. In the NHS new approaches and disciplines have been developed to form a new model called personalised care which, at its best, compliments and enhances the way personalisation works in social care.

For more about the origins of personalised care see **here**.

Watch this helpful animation here:

Personalised care requires a new way of working in the NHS, in which people have more options, better support, and properly joined-up care at the right time. Most importantly it means that people get an equal voice in planning the care they receive and get support to manage their health and wellbeing, rather than just receiving treatment when they get ill. It means a new relationship between people, professionals and the health and care system, shifting power and ensuring that people feel informed, have a voice, and are connected to each other and their communities.

Principles of personalised care:

- **It starts with the principle of 'What matters to you?' as opposed to 'What's the matter with you?'**
- **It's about shared power and collaboration between people, families and health professionals**
- **It enables people to have choice and control over their lives**
- **It moves people from passive recipients of services to active citizens**
- **It's about getting a life, not a service**

The components of personalised care and support planning

There are six components to personalised care:

- Personal health budgets – giving people with the most complex needs direct control over their care
- Personalised care and support planning – so everyone with a long-term condition has the chance to have a conversation about what matters to them, in the context of their whole life
- Shared decision-making – equal partnerships and better conversations between people and those supporting them
- Social prescribing – connecting people to their communities and non-medical supports
- Support for self-management – health coaching, self-management education and peer support
- Choice – have choice over your treatment and the services you can access.

Personal health budgets

A personal health budget is an amount of money which is identified to support a person's health and wellbeing needs. It isn't new money, but a different way of spending health funding.

Personal health budgets give people with long-term conditions and disabilities more choice and control over the money spent on them and the support they receive.

A personal health budget may be used for a range of things, including therapies, personal care and equipment.

- **In the video below Dylan talks about how his personal wheelchair budget has saved money and given him independence.**

- **For more about personal health budgets follow this link to the NHS website.**
- **For guidance on Personal Health Budgets for professionals follow this link.**
- **Read how a personal health budget changed Jackie's life on the NHS website.**

Personalised care and support planning

Personalised care and support planning is a process that enables someone with care and support needs to have a **structured conversation** about **what matters to them**, what they can do to manage their health and what support they need from formal and informal services. The process results in a plan which sets out their health and wellbeing goals and how they will be achieved. The ambition is for everyone with a long-term condition to have the opportunity to **co-create their own plan**.

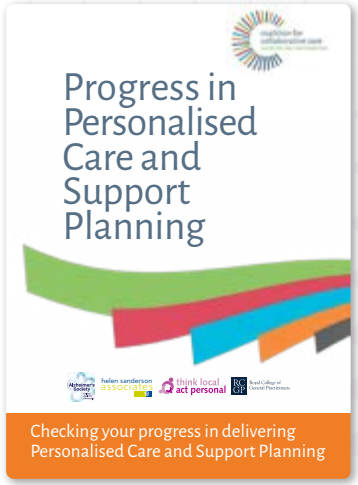
Care and support planning brings together contributions from family, friends, community, health and social care and sometimes education and housing. **It is the opposite of slotting people into service spaces** – it determines how services will be designed and organised around the person.

If appropriate, the plan will also detail how the person's **personal budget** will be spent. The plan is reviewed on an annual basis to reflect on what is working and not working and to make changes.

- **Watch the RCGP Collaborative Care and Support Planning Guidance video and visit their page for more information.**

- **In this video for the Personalised Care Institute, Zainab describes why care and support planning is important to her.**

- **Visit the Think Local Act Personal website for a guide on care and support planning.**
- **Progress in Personalised Care and Support Planning checklist has been developed by Helen Sanderson for the Alzheimer's Society and Coalition for Collaborative Care, to help you assess how well you are doing implementing personalised care and support planning. Download the PDF here.**



Shared decision-making

Shared decision-making describes a process in which people and health professionals work together to select tests, treatments, management or support packages, based on evidence and what the person thinks is right for them. **Like Personalised Care and Support planning it means a better conversation.**

Shared decision-making is appropriate when someone needs to make a decision about treatment when there is more than one option (including the 'no treatment' option) such as:

- **Decisions about diagnostic and screening tests**
- **Decisions about starting medication**
- **Decisions about undertaking surgical procedures (shared decision making is an important component of the consent process)**
- **Selecting maternity care and delivery plans**
- **Advance care plans for mental health and end-of-life decisions**

The acronym BRAN can help people to prepare and for a shared decision-making conversation;

- **What are the Benefits?**
- **What are the Risks?**
- **What are the Alternatives?**
- **What if I do Nothing?**

What if I do Nothing? In this video, Claire Valsler talks about the difference a shared decision-making approach has made to her.

More information about shared decision making

- **More information about shared decision-making can be found on the Choosing Wisely website read here**
- **Training in shared decision-making is available at The Personalised Care Institute website**
- **The General Medical Council has updated its guidance on decision-making and consent read here**
- **The NICE Guidelines on shared decision-making read here**
- **More about personalised care and shared decision-making read here**

Social prescribing

Social prescribing is when GPs and local agencies refer people to **community supports and groups instead of traditional services**. This happened in some places in the past but has been made more universally possible through the funding provided through the long-term plan for social prescribing linkworkers, based in local primary care networks.

Linkworkers provide an important 'bridge' between services, the local community and voluntary sector, individuals and mutual aid groups. They spend time **talking to people and finding out what matters to them** and how they want to interact with and participate in their local communities.

Read more about social prescribing on the NHS website **read here**

A programme of support and development is available to social prescribing link workers and primary care networks **read here**

Read this case study about social prescribing from The You Trust in Portsmouth.

Toby

Toby was referred by his Physiotherapist as he required hip replacement surgery but was unable to access it due to his life situation. As he was homeless he could not secure a surgery date (as risk of infection) nor access Adult Social Care without the surgery date. Toby had stayed in hostels and used the day services but did not feel comfortable being there, so his situation was not improving. In addition to this, it was very difficult to contact Toby as he had no credit for his mobile. We paid for credit for the phone to support his ongoing communications with services.

The first step was to complete his housing application and secure temporary accommodation. With this, he would be a step closer to being in a suitable situation to have his surgery and receive the care he would need for the recovery. Through working together with The Society of St James, his physiotherapist, and housing options, Toby is now in a secure hostel that he feels safe in, has finalised his benefit claim, and enquiries have now been made as to when he can be put onto the surgery waiting list. In the mean time we look for permanent accommodation.

Supported self-management

Supported self-management is about helping people with long-term conditions to increase their **knowledge, skills and confidence** to better manage their health and wellbeing. This includes support such as health coaching, self-management education and peer support.

Health coaching is a supportive, structured, goal-focused conversation that aims to increase someone's confidence to manage their own health. Health coaching usually takes place over a number of sessions. Read the guidance on rolling out health coaching **here**

Peer support describes a range of formal and informal mutual help, advice and mentoring that people give to others who are going through similar life experiences. This can range from online forums, to more formal 1-2-1 peer support services provided by charities.

This initiative by Reading Voluntary Action demonstrates the key role the voluntary sector plays in enabling peer support and mutual aid to flourish and the importance of leaders recognising and working with communities to provide peer support and mutual aid **read here**

Find out more about dementia cafes which are providing valuable peer support for people with dementia and their families. Visit Alzheimer's Society website **to read the study.**

Self-management education courses are structured learning opportunities for people with long-term conditions – these could be offered when someone is newly diagnosed with a condition or later on. Watch Stephen's Story from The Personalised Care Institute – gaining skills and knowledge to ensure a better healthy lifestyle.

Download and read Nesta's 'People Helping People' peer support review PDF.

Read the Supported Self-Management summary guide **here** with links to lots of resources for training, quality standards and how to commission support for self-management. Just don't forget the voluntary sector!

Choice

In many cases there is a legal right to choose where you have your NHS treatment. By 2020, NHS England wants everyone treated by the NHS to be able to say:

- **I have discussed with my GP or healthcare professional the different options available to me**
- **I was given an opportunity to choose a suitable alternative provider because I was going to wait longer than the maximum waiting time specified in my legal rights**
- **Information to help me make my decisions was available and accessible for me**
- **I was given sufficient time to consider what was right for me**

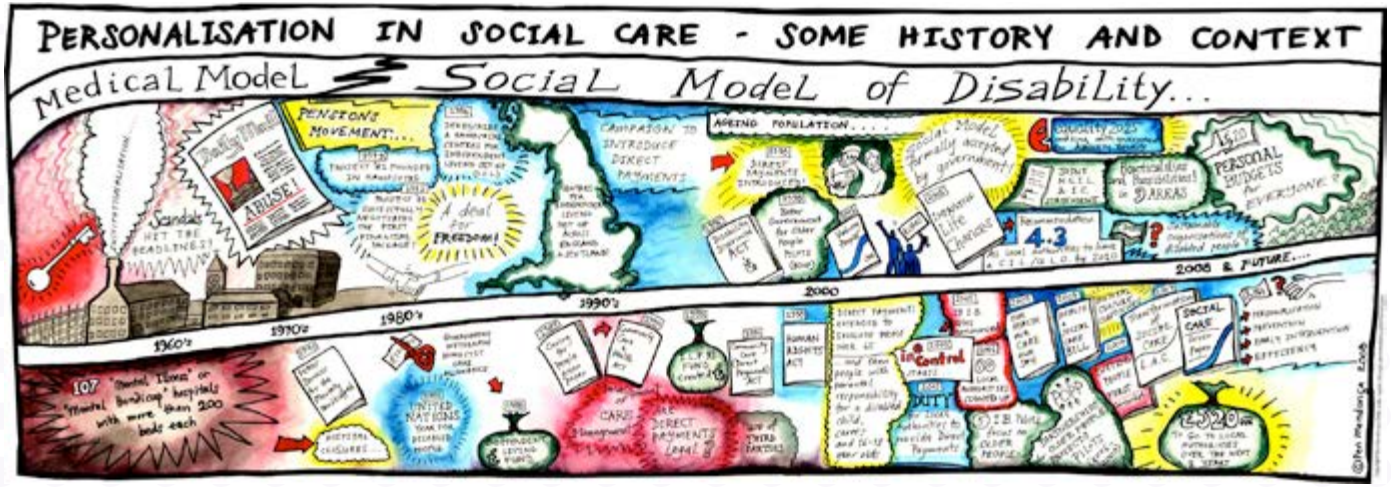
For more information on choice **read here**

Origins of Personalised Care

Personalised care in medicine has its roots in the **humanistic psychology** of Carl Rogers. Rogers saw people as whole and unique. A person-centred approach to care requires listening, '**congruence' or a sense of connection** between those giving and receiving support. George Engel later proposed the **'biopsychosocial' model**, to describe the complex interconnecting factors around a person that impact on their health. Wagner's **Chronic Care Model** later recognised that people who feel a sense of control or 'agency' over their health have better outcomes.

For people and citizens, the idea of choice and control grew out of the personalisation movement, which in turn was borne of the **independent living movement** (ILM). The ILM is a worldwide movement led by disabled people aimed at ensuring that disabled people have the **same rights and opportunities** as everybody else, including choice and control over where they live, the support they receive and other decisions about their life.

The graphic below shows the history of the movement from the 1960s to 2008.



The History of the Independent Living Movement in the UK

By John Evans OBE

The origin of the Independent Living Movement in the UK goes back to the late 1970s as disabled people, unhappy about the paternalistic and out of touch services offered to them, began to campaign for change and organise.

The pioneers of 'Project 81', including myself, took inspiration from the establishment in California of the first Centre for Independent Living and wanted to adopt that alternative model as part of the UK Welfare State.

It was a mission to get disabled people out of institutions – we were all in a Cheshire Home in Hampshire – and into their own homes.

Changing hearts and minds

Local authorities needed to be persuaded to change their mindset to adopt this alternative approach and it did not prove easy, but within three years came the first key milestone.

The Project 81 group negotiated a financial 'package' to move out of the home and use the money to employ their own personal assistants.

Independent Living in the UK had started and would **change the lives of generations of disabled people** to come.

The movement grows

Links were made with other disability groups and a **national movement formed** – forging links with other activists in Europe and the USA.

The European Network on Independent Living (ENIL) was established in 1989 by over 80 disabled people from 14 different European countries, campaigning for a common goal.

Campaigning for change

In the UK, campaigns focused on the need to overturn 1948 legislation (The National Assistance Act) which made it illegal for local authorities to offer cash instead of care.

This greatly hampered the widespread roll out of independent living schemes so in response the Direct Payments campaign was started in 1989 by the British Council of Disabled People (BCODP) with its primary objective to change this law.

Joining forces with Spinal Injuries Association, the campaigners took their fight to Westminster, gaining support from MPs, including a Conservative member, Andrew Rowe. He twice introduced Private Members Bills on Direct Payments Legislation and although both attempts failed it laid an important marker.

The campaign was also backed by the Association of Directors of Social Services, while policy research commissioned by the BCODP strengthened the case for Direct Payments and significantly found it was on average between 30 and 40 percent cheaper than the equivalent service-based support.

From pioneers to policy-makers and onwards!

After five years of intense lobbying, the government announced its intention to legislate and the **Direct Payments Act 1996** was born, a huge achievement for the disability movement.

It has proved the catalyst for other areas of self-directed support, with the charity In Control developing the concept of **personal budgets** and running successful pilots across England.

This work strongly influenced government policy and resulted in 'Putting People First', which helped to transform adult social care. **The personalisation agenda has expanded across other sectors, including health, and is a key element of the NHS Long Term plan.**

This would never have happened if it wasn't for the early pioneers of Independent Living, but we have to keep tapping into that spirit to make sure it is enshrined as an equal right in legislation. **Our strength lies in our unity to be able to work together**, lobby and campaign together to maintain control.

More about co-production

> *The only way the…world is going to address…social problems…is by enlisting the very people who are now classified as clients and consumers and converting them into co-workers, partners and rebuilders of the core economy.*

Edgar Cahn, 2011

What is co-production?

Co-production means '**delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours.'** (New Economics Foundation 2009)

Co-production is more than just consultation or involving people as consumers of services. It is not another word for 'patient and public involvement' or volunteering, or about professionals or organisations engaged in partnership working.

It is not about inviting people into professional meetings as a 'representative' or just to tell their story. It means a **genuine partnership between publicly-funded services and those that use them.**

The Nobel Prize-winning economist Elinor Ostrom, who is credited with coining the term, said: 'No market can survive without extensive public goods provided by governmental agencies. No government can be efficient and equitable without considerable input from citizens.'

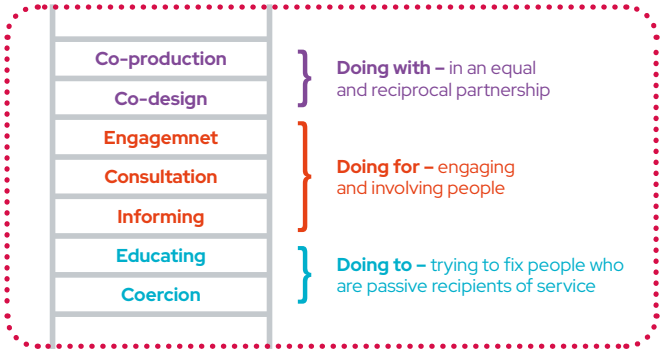
She coined the phrase to explain why crime rates rose when police stopped walking the beat and started patrolling in cars instead, losing the relationships and informal knowledge base they had built through community connection.

Co-production with individuals is as essential in health as it is for community policing. **We know that informed, activated 'patients' get better health outcomes and use services less.** (Taylor S et al 2014)

More activated patients are less likely to visit emergency departments, less likely to be obese, less likely to smoke, and less likely to have breast and cervical cancer. (Greene, J & Hibbard, J H 2012)

The ladder of participation (this version taken from the Think Local Act Personal (TLAP) website) shows the difference between 'patient involvement' and genuine co-production.

As you move up the scale there is potential to move from surface level, one-way engagement to having a more profound and radical impact on systems and places and ultimately people's health and wellbeing.



See the **TLAP co-production quiz** for examples.

Co-production in practice means involving people with lived experience as equal partners in all aspects of commissioning, service design and how services are delivered.

At a 1-2-1 level that means ensuring that person-centred conversations happen, and that people with long-term conditions have the opportunity to co-create a care and support plan with a GP, nurse, or social prescribing linkworker.

These conversations **start with the question, 'What matters to you?' not, 'What's the matter with you?'** This happens in some places but not everywhere and studies have shown about a third of people do want to be more involved.

At a strategic level, co-production means having people with lived experience on decision-making groups and sharing power with them, building community capacity and widening representation.

Co-production also means working at a community level and **engaging with what matters to local people collectively, through community development** and other methods of getting to know and building relationships between the statutory sector and the communities it serves.

Why Community Matters

The NHS Long Term Plan promised that more than 1,000 Social Prescribing link workers would be in place by the end of 2020/21, rising further by 2023/24, with the aim that more than 900,000 people are **connected to their wider community in order to improve their health and wellbeing.**

This historic commitment recognised that 'community' – in the form of the personal and social support networks that people have, the groups they interact with, how valued they feel by others and whether they have a voice and feel **a sense of belonging – is intrinsic to wellbeing**.

People with stronger social networks are healthier, happier and less likely to die than those with little social connection. **Higher levels of social capital within communities are associated with lower mortality rates.**

Growing and nurturing community capacity is a **key means to improve local health and wellbeing.** This requires action by the NHS and other public services.

Marmot wrote, *'It is vital to build social capital at a local level to ensure that policies are both owned by those most affected and are shaped by their experiences.'*

He continued, *'our vision is of creating conditions for individuals to take control of their own lives.*

'There needs to be a more systematic approach to engaging communities...moving beyond often routine, brief consultations to effective participation in which individuals and communities define the problems and develop community solutions.'

Done well, community development strengthens the capacity of local people and groups and that of local agencies - private, public and voluntary – to deliver things that matter to people and build local resilience and wellbeing, growing trust and relationships at a local level from the ground up.

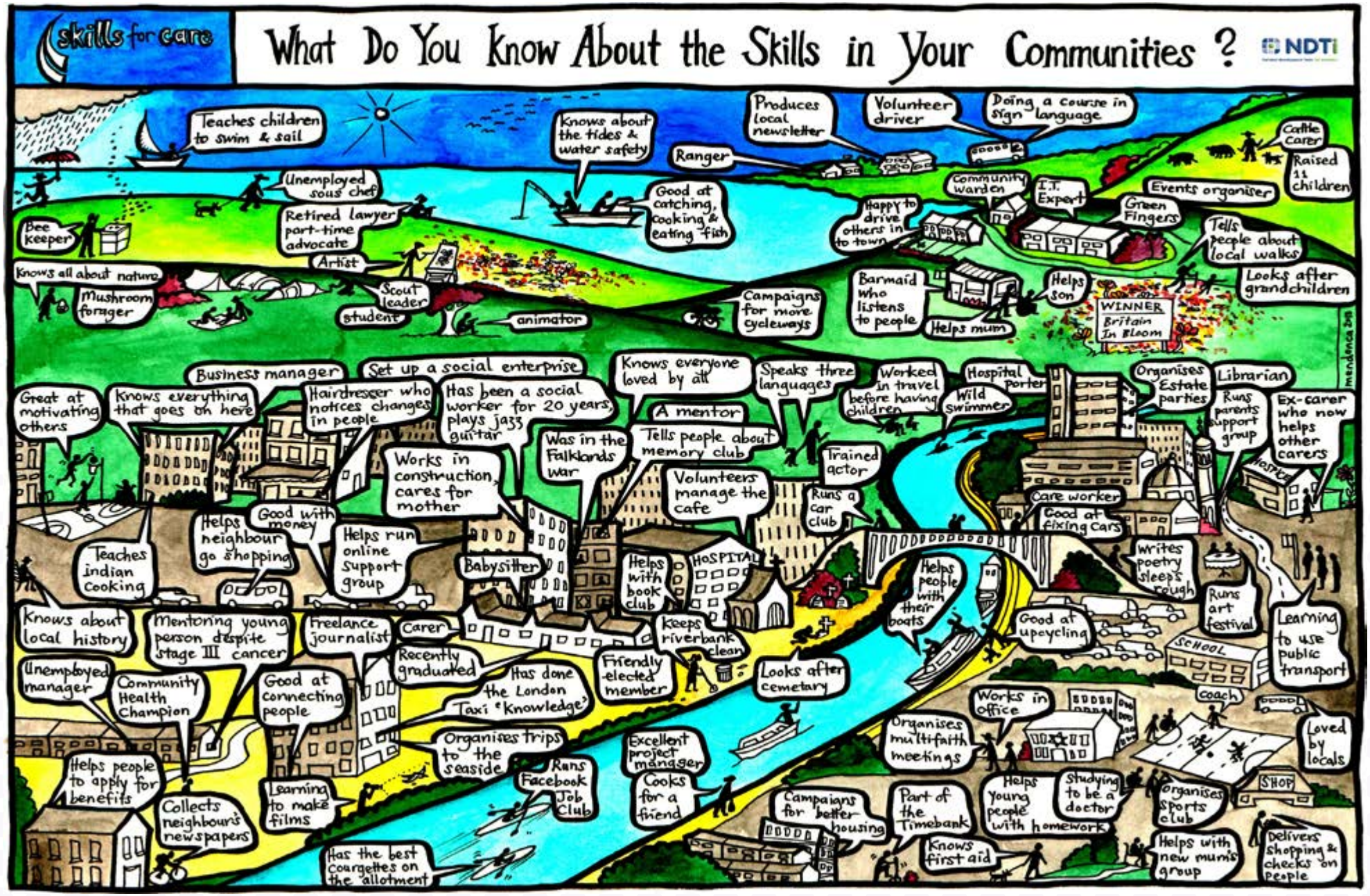
For good practice, it means ensuring that there are **conversations with people at a neighbourhood level**, asking questions such as:

- **What makes this a good place to live?**
- **What do people and the community do to help each other or improve things around here?**
- **What skills and talents do you have that (could) contribute to making this an even better place to live?**
- **Could you help us by asking a few people these questions too?**

The illustrated 'skills' map by Pen Mendonca for the National Development Team for Inclusion and Skills for Care shows the **wealth of assets** there are in a community that can be harnessed for improving health, if only we took time to look and ask.

As well as performing a pivotal function in reducing health inequalities by building and growing the social networks that are vital for health, **community development** can support linkworkers, health champions, care coordinators and others to understand what supports are available locally for the individuals they are supporting.

They can enable linkworkers to **encourage active participation**, rather than just 'prescribing' supports provided by others. Doing something to help others, through volunteering and community participation is associated with increased wellbeing.


skills for care
What Do You Know About the Skills in Your Communities ?
NDTi
Teaches children to swim & sail
Knows about the tides & water safety
Ranger
Produces local newsletter
Volunteer driver
Doing a course in sign language
Cattle carer
Raised 11 children
Unemployed sous chef
Retired lawyer part-time advocate
Good at catching, cooking & eating fish
Community warden
I.T. Expert
Events organiser
Green Fingers
Bee keeper
Artist
Happy to drive others in to town
Tells people about local walks
Knows all about nature
Mushroom forager
Scout leader
student
animator
Campaigns for more cycleways
Barmaid who listens to people
Helps son
Helps mum
WINNER Britain In Bloom
Looks after grandchildren
Business manager
Set up a social enterprise
Knows everyone loved by all
Speaks three languages
Worked in travel before having children
Hospital porter
Wild swimmer
Organises Estate parties
Librarian
Great at motivating others
Knows everything that goes on here
Hairdresser who notices changes in people
Has been a social worker for 20 years, plays jazz guitar
A mentor
Tells people about memory club
Runs parents support group
Ex-carer who now helps other carers
Works in construction, cares for mother
Was in the Falklands war
Volunteers manage the cafe
Trained actor
Runs a car club
Care worker
Good at fixing cars
Helps neighbour go shopping
Good with money
Helps run online support group
Babysitter
Teaches Indian cooking
Helps with book club
HOSPITAL
Helps people with their boats
Writes poetry sleeps rough
Runs art festival
Knows about local history
Mentoring young person despite stage III cancer
Freelance journalist
Carer
Keeps riverbank clean
Good at upcycling
Learning to use public transport
Unemployed manager
Community Health Champion
Recently graduated
Has done the London Taxi 'Knowledge'
Friendly elected member
Looks after cemetary
SCHOOL
Good at connecting people
Works in office
coach
Organises trips to the seaside
Excellent project manager
Organises multifaith meetings
Loved by locals
Helps people to apply for benefits
Runs Facebook Job Club
Cooks for a friend
Campaigns for better housing
Part of the Timebank
Helps young people with homework
Studying to be a doctor
SHOP
Organises sports club
Collects neighbour's newspapers
Learning to make films
Knows first aid
Helps with new mums group
Delivers shopping & checks on people
Has the best courgettes on the allotment

Section C My Learning and Development

Leadership was summed up neatly by Steve Radcliffe with three words:

Future – Engage – Deliver!

In other words, being a leader starts with you as an individual deciding to do something, getting others on board, then doing it!

Of course, in life things are never quite as simple as that – leadership for personalised care recognises that we are all working in complex, highly interconnected systems and that we don't have complete control over what happens, even we are the chief executive of a large organisation.

But that doesn't mean we can sit round and do nothing. Doing nothing assumes we think things are ok just as they are. If we believe that people receiving care should have choice and control over what happens to them and their health, we need to do something to lead a change in culture.

And "if you think you're too small to make a difference, you haven't been in bed with a mosquito!" (attributed to the Dalai Lama)

So over to you!

Think about what you've read, watched and experienced by participating in this module. Answer these questions and write some notes, either in a journal or print this page and write them down here.

Section A

Reflecting on the leadership for personalised care qualities in section A and how they show up for you in your life and work:

How confident are you in growing and leading a shift towards personalised care?

What are your leadership strengths?

What knowledge, skills and mindset do you need to develop further?

Section B

Reflecting on what you have learnt about personalised care in Section B:

What did you learn and what might that mean for you as a leader?

What did you learn about personalised care and what it could mean for you in your role?

What questions do you have about personalised care that you need to resolve?

How will you find out more?

What could you do next that would make a difference?

What else we offer

We have decades of experience between us in leadership development, facilitation and executive coaching and mentoring. Our mission is to create a network of leaders committed to radical change and reform in the health and care system. All our programmes are designed and delivered with people with lived experience.

We support leaders to embed the principles of personalised care, co-production and community building into systems where they live and work. We are all constantly learning and evolving our practice with the wealth of experience and expertise that we all bring.

We run leadership development open programmes at a national and regional level across the country for individuals and teams. Some of our partners also offer bespoke and place-based development and coaching.

> *This course has stretched my scope of thinking beyond traditional boundaries. I now aim to move to a way of working that ensures shared decision making and a focus on how to use expertise better, to activate collective solutions.*

Previous participant – Cohort 7

Our flagship national programme: Leadership for Empowered Communities and Personalised Care

Our national leadership programme is aimed at individual leaders and has been running for eight years. We aim to give participants on this unique, co-produced programme the knowledge and confidence to meet the personalise care challenge, building on best practice from across the country.

Cohort 9 will start in 2021 and is currently full with a waiting list but if you would like to express an interest for the next cohort please email england.leadership@nhs.net

Our regional leadership for personalised care programmes

Our regional programmes are aimed at cross-sector teams drawn from across a place e.g. a town or city (not an ICS – it's too big and is not a geographical entity). The programmes bring people together from diverse sectors, including people with lived experience. Participants explore what's working and not working in their place around personalised care and what they need to lead collectively to achieve positive change for people and communities.

The programmes consist of three face-to-face workshops, plus access to our 1-2-1 coaches and additional webinars and masterclasses. As well as content around personalised care, co-production and community-building they explore leadership in complex systems, community asset-mapping and focus on building trust and connection between and across teams.

The programmes were part face-to-face and part online in 2020/21 but we hope to recommence full face-to-face delivery in summer 21/22. If you would like to express an interest in the regional programmes please email england.leadership@nhs.net

Bespoke and place-based development and coaching

To enquire about bespoke support and leadership development please email england.leadership@nhs.net

Our Partners

We are a partnership of people and organisations with a mission to create a network of leaders committed to radical change and reform in the health and care system.

Together we provide learning and development opportunities to support leaders to embed the principles of personalised care, co-production and community-building into systems and services where they live and work.

In Control is a national charity which works in communities to help families who need support to take control of their lives, deploying innovative new ways of working to help make it happen. In Control has a long history of supporting leaders to make change happen, including through its suite of Partners in Policymaking courses.

The NHS Leadership for Personalised Care team designs, commissions and delivers support and development to help leaders meet the challenge of making personalised care a reality as set out in the NHS Long Term Plan. They are a small team but bring significant expertise in leadership development and have been supporting inclusive change over the last 10 years.

Skills For Care is an independent national charity which supports adult social care employers to recruit, lead and train staff at all levels from entry level to senior leaders to the highest standards as required by regulators and commissioners. Skills for Care has been a partner of the programme since it began in 2013.

The NHS Leadership Academy teams provide a range of local leadership development supports and have helped develop the regional leadership for personalised care programmes which are particularly focussed on supporting leaders in primary care.

Think Local Act Personal (TLAP) is a national partnership of over 50 organisations who are committed to transforming health and social care through personalisation and community-based solutions. TLAP has been a partner of the programme from the beginning, supporting co-production in design and delivery.

Coalition for Personalised Care is the single largest partnership of people and organisations in the country which comes together solely to focus on personalised health and care.

Being part of the very first cohort many years ago has genuinely influenced my practice, my career and personal journey ever since.

Guy Stenson – Director of Housing Operations Stonewater UK

The programme is a constant reminder of what is possible and achievable with good will, energy and the right focus. It also helped me renew my commitment to supporting our local vibrant community, voluntary and faith sector who do such fantastic work in successfully empowering communities and individuals for such limited resource.

Fiona Taylor – Chief Officer, South Sefton CCG

Leadership for Personalised Care

Developing leaders to focus on what really matters

england.leadership@nhs.net