Understanding the Implementation and Impact of the Personalised Care Training in West Yorkshire Integrated Care Board (ICB)

Final report

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1.0 Introduction

The NHS Long Term Plan introduced the commitment to roll out personalised care with a vision to benefit up to 2.5 million people by 2024. Personalised care means giving people choice and control over the care and support provided for their mental and physical health, taking into account their individual strengths and needs[1]. At the heart of personalised care is a series of facilitated conversations with the person as an active participant, to explore the management of their health and wellbeing within the context of their whole life and family situation[2]. It is intended to help integrate the person's experience of all the services they may need to access to support their health and wellbeing.

To support the introduction of personalised care it was recognised that investment was needed to increase capacity in the workforce, including expanding the numbers of social prescribing link workers, health and wellbeing coaches and care co-ordinators, as well as training the wider health and care workforce in this approach. Quality standards for training in personalised care are overseen by the Personalised Care Institute and a range of accredited training courses are available for the workforce.

In response to Covid 19, West Yorkshire and Harrogate Health and Care Partnership Personalised Care Programme developed a training offer to upskill and support the expansion of personalised care approaches within the ICB workforce. The training programme aimed to upskill voluntary sector, health and social care workforce across West Yorkshire & Harrogate in delivering vital support to address inequalities and the needs of our most vulnerable communities during Covid 19 and beyond. Due to the current challenges of Covid 19, West Yorkshire Health and Care System had to adapt to virtual and online ways of working. The aim of the programme was to ensure West Yorkshire workforce including voluntary sector workers and volunteers are equipped with the essential online skills including virtual health coaching skills and digital and virtual technologies in supporting the health and emotional resilience of both the staff and communities during this time. One of West Yorkshire Health and Care Systems key outcomes is to support the development of the voluntary sector to embed digital approaches within their ways of working and in doing so, support and encourage more of the ICBs communities to access support online.

The aim of this evaluation was to understand how the personalised care training provided by West Yorkshire ICB had impacted staff.

2.0 Methods

2.1 Survey design and dissemination

Survey questions were designed by the researchers and presented as a weblink for participants to click on and fill out. Anonymous data was collected via Smart Survey, an online UK based survey tool. The questions in the survey covered participant demographics, their views about the training and future suggestions for development. The survey was open

[1] NHS (2028) The NHS Long Term Plan. Department of Health and Social Care.

[2] NHS (2019) Universal Personalised Care: Implementing the Comprehensive Model. Department of Health and Social Care. https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/ Accessed February 2023.

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between 1st February 2023 and 30th April 2023 for anyone who attended the Personalised Care Training delivered or commissioned by West Yorkshire ICB between January 2020 and December 2022.

The survey link was circulated to the West Yorkshire Programme Manager who disseminated the survey and supporting information to the ICBs distribution list of previous learners and to system leaders to disseminate further to ensure maximum completion rate. KERA raised awareness of this survey via the Connecting Communities Event on the 23rd of February 2023 by discussing what the survey entailed and the importance of completing it if it was relevant to individuals. KERA also disseminated the same information to their distribution list of Personalised Care Roles within the local area to ensure anyone who may have changed roles from the time of completing the training to ensure they would still be captured within the results. Due to compliance issues KERA were not able to directly distribute the survey link to the previous learners within the timeframe of this project which is the reasoning behind the support from the West Yorkshire Programme Manager and their team in disseminating the survey on behalf of KERA.

2.2 Focus groups

Three focus groups were held with different groups of staff across the West Yorkshire ICB during March and April 2023. Managers from three areas of the workforce were invited to take part in a focus group to explore views of the roll out of the personalised training programme. This included questions about their involvement in the roll out, and if applicable, the perceived value of the offer and impact of the training on staff and/or patients. They were also asked about gaps in the programme and any other views. Eleven people participated in total, with the three groups intended to represent: each of the 5 places in West Yorkshire (place leads); the voluntary, community, faith, social enterprise sector working in personalised care across the ICB, as well as ICB workforce managers and secondary care organisations.

Potential participants were given an information sheet and consent form to sign. The three focus groups were held online and were led by the research team from Meaningful Measures. Each focus group lasted up to one hour and was recorded for the purposes of analysis.

2.3 Data Analysis

All data from focus groups was transcribed, cleaned and anonymised to ensure no participants were identifiable. Researchers thoroughly familiarised themselves with the data before analysing it based on a qualitative framework approach set out by Gale et al. (2013), to identify main themes and findings.

For the survey, where quantitative data was collected, the frequency of responses were analysed. Where open questions were asked and qualitative data was provided, this was analysed by content analysis to identify the main themes.

2.4 Ethical considerations

Informed consent was provided by all people taking part in the focus groups, all data was stored in password protected files and checked to ensure anonymity of participants. All recordings of focus groups were deleted once the transcripts were created and anonymised.

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3.0 Results

In this first part of the results, the survey responses will be reported with qualitative data added from the focus groups where this added further insight or context. In the second part of the results the remaining qualitative data will be reported.

In total, 92 people responded to the survey and of those, 10 people stated that they didn't receive personalised care training. Survey responses relating to the training are therefore based on 82 respondents unless stated otherwise. The data presented in this report, therefore, is not fully representative of everyone who completed training in the ICB and analysis should be viewed with caution.

3.1 Employment statistics for survey respondents who completed training (n=82).

Table 1 below describes the key employment statistics of people who completed a training course. The majority of people were working full-time. This could suggest that possibly it is more difficult to take time out to do training when you are already part-time and, in a patient-facing role. Respondents had spent a range of time in their roles, no particular category dominated this. The top three employers were Primary Care Organisations, VCFSE organisations and Local Authorities respectively. There was still, however, representation from Community Service Organisations, Secondary Care Organisations and West Yorkshire Integrated Care Board.

Employment Information	Response Category	%
Working hours	Part-time	78
	Full-Time	12
Time in Post	Over 3 years	28
	2-3 years	9
	1-2 years	30
	Less than 1 year	33
Employment sector	Primary Care Organisation	43
	VCSE Organisation	23
	Local Authority	23
	Community Service Organisation	8
	Secondary Care Organisation	6
	West Yorkshire Integrated Care Board (ICB)	2
Proportion of time of role delivering Personalised	100% of their time	59
	75% of their time	21

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Care approach	50% of their time	19
	25% of their time	1

Table 1 - Employment related statistics of respondents (n=82). NB n=5 worked across two different sectors - a mixture of local authority, primary care and VCFSE sectors.

3.2 Which roles were represented at training course and barriers to attendance

Role at time of the training.

The majority of respondents (n=73, 89%) were made up of the roles shown in Fig 1 below - three quarters being the Social Prescribing Link Workers, Health and Wellbeing Coaches and care coordinators (or similar roles).

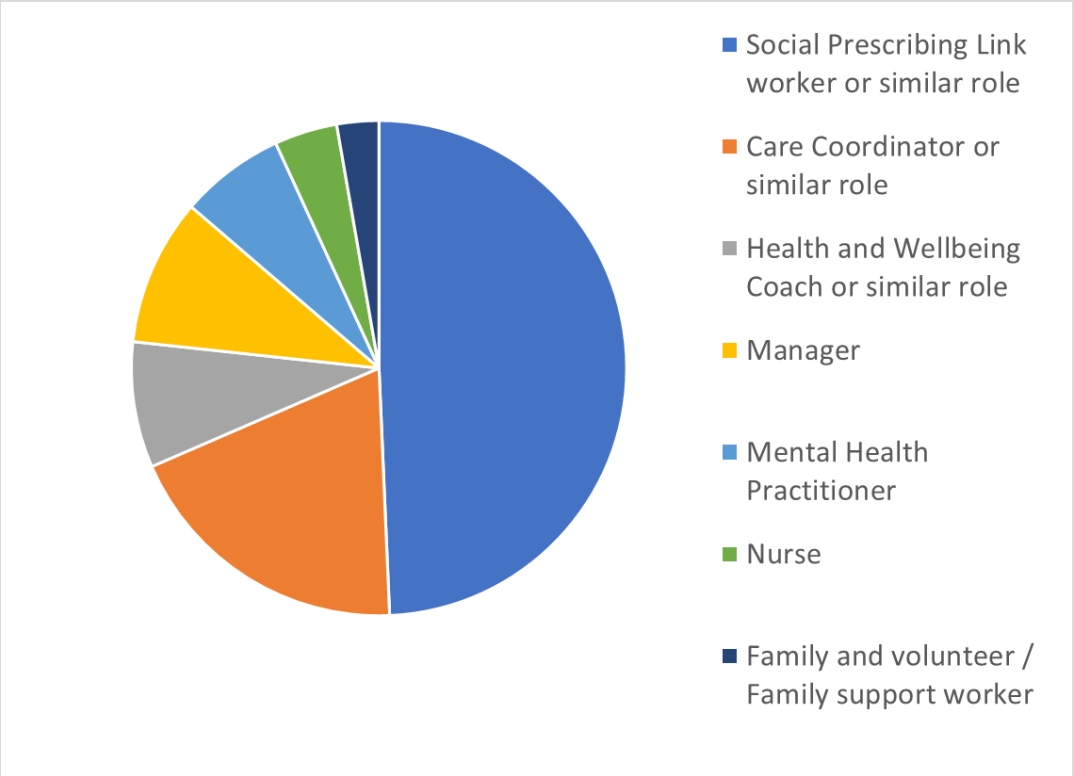

Figure 1 - Role at time of the training (n=82)

The remaining 10% of respondents were made up of Exercise referral Practitioners; Marketing and Communications staff; Medical Consultants, Personalised Care Team Leads, Physiotherapists, Third sector organisation workers and Voluntary sector trainers and facilitators.

Which professionals were not represented in the survey responses?

The following roles were not represented by respondents in this survey.

- Advanced Nurse Practitioner
- Clinical Pharmacist or Pharmacy technician
- Dietician
- GP
- Nurse Associate or Trainee in this position

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- Occupational Therapist
- Paramedic
- Physician Associate
- Podiatrist
- Volunteer

Why some people changed role/professions?

Six people (7%, n=82) listed that they had changed the professional role they were in. We have only included people who moved to a different type of professional group, not people who changed jobs but stayed in the same area (e.g. remained in a personalised care team but was promoted to a manager). There are no obvious concerns present that any one particular professional group was moving out of their role more than any others.

Reasons for not attending the training

Five people weren't aware of the training or don't recall any training being offered to them; Their roles included Care Coordinators, Health Care assistants, Managers, GPs, Nurse Specialists and Palliative Care support workers.

One person stated that they didn't have time in their role to do the training over the last 2 years, due to Covid-19 pressures; one person worked in the VCFSE sector and said there was no funding for this training;

Data from the focus groups may shed light on this issue. This highlighted a problem around awareness of the training among staff. Although managers in all the focus groups were helping promote the training, this was only as good as their own knowledge about the opportunities, which they admitted could be patchy. In particular, the workforce managers felt that awareness of the training among staff was poor which is likely to be affecting the uptake of training.

The problems with awareness were linked to another theme in the qualitative data (see section 3.9 below) about the lack of a shared vision and culture around personalised care. One person linked their own lack of knowledge about the training to a system-wide issue about a lack of clarity about who the personalised care agenda was targeting:

> *"Who is anybody that's doing personalised care? Because that should be the whole of the NHS." (FG3).*

There was general agreement among all the staff in the focus groups that the training was relevant to everyone. It was not, however, embedded consistently across the system e.g. it was well embedded in ARRS roles but not among VCFSE staff, due to problems like capacity and lack of backfill (these are topics that are discussed in more detail in section 3.9). Furthermore, there was the issues of scale and communicating training to the VCSE sector comprising over 14,900 registered and unregistered groups supporting people within the whole of the West Yorkshire ICB.

The focus groups also highlighted an issue around booking/admin of courses which may have affected course uptake. The place leads reported that there had been problems with giving only short notice of courses, sometimes as little as a week which had affected uptake. It was perceived that the chain of communication in the ICB for getting messages out had added to the delay. One manager explained how this was a particular barrier for staff working in PCNs

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because they have caseloads with appointments already booked in, so they need adequate notice of training courses. Sharing dates and booking information well in advance, such as 3 months, would increase bookings and support planning of schedules.

A problem with non-attendance was also highlighted by the workforce managers. One focus group participant attended training when they were the only person at the session, so it was cancelled and there was no information about the new rearranged session. This was put down to administrative challenges of the organisation that was delivering the training. But more broadly this was known to be an issue:

> *"from seeing the numbers booked to the numbers who attended is it's probably about half. So there is there's lots of waste going on there and I think there's probably waste going on because people don't necessarily realise that it's being paid for and who's commissioned it and the value of what it costs."* - focus group participant

It was suggested it could be helpful in future to reiterate the fact that the training is being paid for and the value of the offer, to ensure people commit to it when they book on; and also, to overbook and expect fewer to attend.

Advantages and disadvantages of the personalised care approach

Seventy-three people (89%, n=82) responded to the survey question asking for up to two advantages of taking a personalised approach. This generated 141 advantages showing the strength of positive views about personalised care. These were grouped and are displayed in Table 2 below:

Advantage	**%**
Patient-centred, empowerment and autonomy	42
Patient engagement/ownership, more like to achieve goals	7
Patient feeling listened to/valued	6.4
Builds relationship/rapport/trust	5.7
Increased patient choice and flexibility	5.7
Achieves better outcomes	5.7
Holistic approach	4
Patients as equal partners/inclusive/joint agreement	4
Allowing creative solutions/drawing on range of resources	3
Takes pressure off practitioner/provides tools/models to use with patient	3
Building on skills/strengths	2
Builds patient confidence	2

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Goal setting	1.4
Other	8

Table 2. Advantages of a personalised care approach (n=73, 89%)

Forty-seven people (57%, n=82) responded to the question asking about the disadvantages of a personalised approach (although only 40 of these listed disadvantages). This generated 58 disadvantages grouped into the categories shown in the table below, indicating that staff also have some negative views of personalised care:

Disadvantage	**%**
Client readiness/appropriateness/attendance	22.4
Practitioner skills/knowledge of person or resources	14
Poor understanding, knowledge or awareness of personalised care (patient)	12
Can take more time	10
Resource issues (capacity, accessibility/embedding into service provision)	10
Issues with staff culture – getting funders/providers to understand approach	8.6
Lack of follow up	3.5
Physical barriers/needs come first	3.5
Patient becomes too dependent	3.5
Other	12

Table 3. Disadvantages of a personalised care approach (n=47, 57%)

3.3 Ratings for the training courses attended

There were 13 courses offered as described in Figure 2 below.

Of the 82 respondents, 28 attended more than one training course, a few attending up to 8 of them.

The proportion of attendance of courses is broken down below. There was a relatively even frequency of attendance amongst the majority of courses provided, except for the Top-Up courses and enhanced communication course.

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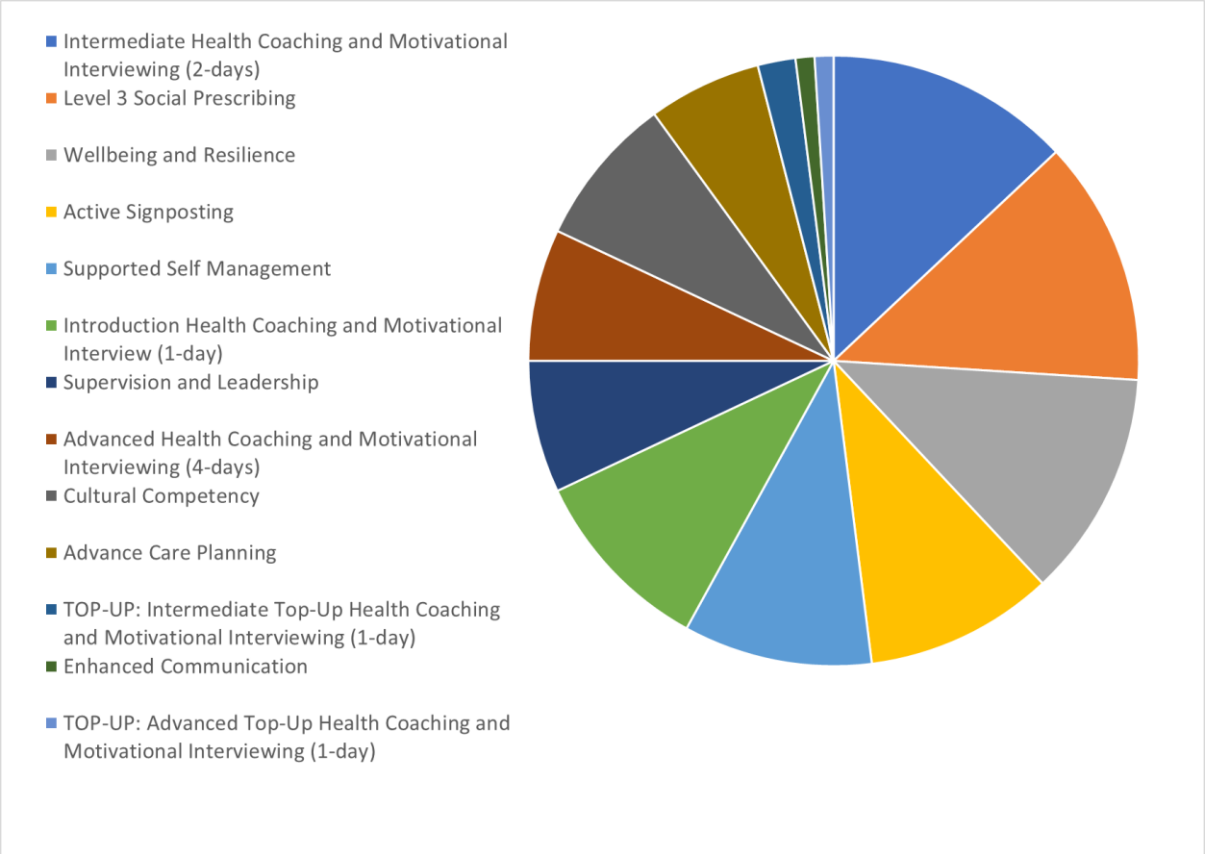

Figure 2. Which courses were attended and how frequently (n=82). Some respondents (n=28) attended multiple courses.

Would you recommend this to your colleagues? The Net Promoter Score (NPS):

The NPS is a market research metric that is internally used and asks people to rate the likelihood that they would recommend a service or product to a friend or colleague on a 0-10 scale, where 0 is "Not at all likely" and 10 is "Extremely likely".

The personalised care training received a result of 9.3/10 – a very strong result. The modal response was 10 (n=33).

A selection of feedback about the courses was also given in the focus groups. Both place and workforce leads reported generally very positive feedback when staff had engaged in the training. In both groups, the level 3 social prescribing course featured from which staff had fed back that there was real benefit and value. One manager explained that the course had also provided valuable opportunities to connect to other social prescribers from different areas and share good practice which was helpful to their development and gaining new ideas. Being in a role that uses personalised approaches, such as the ARRS roles, for 12 months before the level 3 course meant they could bring some real-life experience to the training and make it really meaningful.

> *"I started the level 3 Social Prescribing course a few months into being promoted to Personalised Care Team Lead within the Lower Calder Valley PCN of Calderdale, having been a Social Prescribing Link Worker within Pennine GP Alliance for 2 ½ years. The course is giving me fresh ideas to take back to my team such as reviewing current supervision offers and utilising population health data to proactively*

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find patients who may be appropriate for social prescribing support. It is also beneficial to link with others outside of your region to gain perspective and reflect on your service along with sharing good practice. I hope that the ideas I have shared will help others who are also completing the Level 3 course." - (Personalised Care Training Participant)

Quality of training

Attendees of courses were asked to rate the quality of the courses they attended as excellent, good, neutral, or poor. The percentage of attendees rating each category is shown in Table 4 below.

Please note that some courses were attended by very few people, and hence does not yet portray an accurate representation of the quality of the course and further data should be collected before drawing conclusions.

No participants rated any of the courses as poor or very poor, in fact the majority of courses were rated as good or excellent. Three courses had a proportion of ratings in the neutral category.

Course	N rated	% excellent	% good	% neutral
TOP-UP: Advanced Top-Up Health Coaching and Motivational Interviewing (1-day)	1	100	0	0
Advanced Health Coaching and Motivational Interviewing (4-days)	10	80	0	20
Introduction Health Coaching and Motivational Interview (1-day)	16	75	25	0
Level 3 Social Prescribing	18	72	28	0
Supervision and Leadership	10	55	36	0
Intermediate Health Coaching and Motivational Interviewing (2-days)	21	52	48	0
TOP-UP: Intermediate Top-Up Health Coaching and Motivational Interviewing (1-day)	2	50	50	0
Advance Care Planning	10	40	60	0
Active Signposting	15	33	67	0
Wellbeing and Resilience	19	31	57	10
Supported Self Management	11	27	27	45
Cultural Competency	11	17	50	17
Enhanced Communication	5	0	100	0

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Table 4. Survey participants rating of the quality of the courses they attended (n=82). Courses are ranked in order of highest level of quality.

Satisfaction with training

As shown in Table 5, of the 4 courses that scored the highest level of satisfaction, only 1 or 2 participants of this survey had attended them, hence this does not yet portray an accurate representation of the satisfaction levels of these courses. Further data should be collected before drawing conclusions.

Most courses had the majority of the ratings fall in the 5/5 or 4/5 options, indicating that participants were generally satisfied with the courses. Eight courses had a proportion of ratings as ⅗, which was deemed neutral.

Course	N rated	% 5/5	% 4/5	% 3/5	% 2/5
TOP-UP: Advanced Top-Up Health Coaching and Motivational Interviewing (1-day)	1	100	0	0	0
Introduction Health Coaching and Motivational Interview (1-day)	16	100	0	0	0
TOP-UP: Intermediate Top-Up Health Coaching and Motivational Interviewing (1-day)	2	100	0	0	0
Intermediate Health Coaching and Motivational Interviewing (2-days)	21	95	5	0	0
Advance Care Planning	10	80	10	10	0
Advanced Health Coaching and Motivational Interviewing (4-days)	11	73	0	17	0
Active Signposting	15	73	14	13	0
Level 3 Social Prescribing	18	66	28	6	0
Wellbeing and Resilience	19	63	16	21	0
Cultural Competency	10	60	10	20	10
Supervision and Leadership	11	55	45	0	0
Supported Self-Management	8	38	25	37	0
Enhanced Communication	5	17	35	35	0

Table 5. How satisfied were you with the training? (N=82), where 5/5 is excellent. Courses are ranked by highest level of satisfaction.

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3.4 Training format

As much of the training took place during the Covid-19 pandemic, the vast majority of courses (87%) were virtual. Only 4% of courses were face-to-face and 7% were a hybrid of virtual and face-to-face. People's preferences for course format is now understandably different and survey participants were asked for their preferred training format and to explain why. The breakdown of responses is in Table 6 below.

Format	% Preference	Additional comments summarised
Face-to-face	18%	• Enable people to focus on the training as opposed to doing the training whilst doing other work such as emails. • More interactive, engaging and easier to follow, less clunky and awkward. • Suits personal style of learning compared to virtual learning for some • Prefer less screen time • Support trainer to judge the moods of the room and adapt delivery accordingly. • Interactions feel more genuine, and it allows for more networking.
Virtual	32%	• Easier/ more likely to do training around existing workload, particularly for part-time staff. • Convenient and fits in with working from home. • Helps keep travelling time to a minimum, especially for non-drivers. • Useful to have the recorded session to refer to later on • More accessible and easy to participate in, particularly if need to drop-off or pick-up children from school
Hybrid	23%	Comments made reflect those already mentioned in the face-to-face and virtual sections.
No preference	27%	Comments made reflect those already mentioned in the face-to-face and virtual sections.

Table 6. Understanding people's preferences for future training formats (n=82)

The format of training was a theme that also arose in the focus groups with managers. Consistent with the above findings, it was generally agreed that there was value in a mixed training offer of both in-person and virtual training. Virtual training was felt to have advantages and should remain, being cost effective and inclusive. It was suggested by one workforce manager that virtual learning may not carry the same kind of importance in people's minds as face-to-face and it's easy to prioritise other meetings, but it was felt there was still value in doing some things virtually which as well as being more inclusive also saves on travel costs. One detail about virtual training raised by one of the place leads, was that a lot of the courses

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had been on Zoom and some NHS providers don't allow the use of Zoom in NHS buildings so staff had had to work from home when participating in remote training. Using a different platform in future such as Teams, would be better for NHS staff.

Overall, shorter online courses (e.g.1.5 - 2 hours), was suggested by the workforce group to be a good length of time for an online course - as long as this suited the topic of the training - and was less intrusive to a working day than a half or full day course. They felt it could also mean backfill is more easily available.

The managers agreed that face-to-face training was appropriate for certain courses where more interactivity was needed and there was value in working with colleagues. This came with the caution, however, that the value of the training needs to be made clear at the beginning to ensure attendance. A whole day was felt to work best for face-to-face training as it allows staff to say they're out all day (half days can take up most of the day anyway, if travelling is involved). It was also agreed for all training that avoiding lunchtime was important for staff wellbeing.

Two managers highlighted that using scenarios or case studies in training was beneficial rather than 'training without something that they can relate to', and having videos that people can go back to for refresher training.

3.5 Impact of the training

In this section we report how the training has impacted on staff's ability to do their roles and their wellbeing.

Level of knowledge of personalised care

Of the 82 respondents, 75% agreed or strongly agreed that the training led to them feeling that they had a good level of knowledge about personalised care. Only 17% were neutral on this question and 7% disagreed. For a few people the training was a reminder or refresher, as opposed to providing new information.

Confidence to practice personalised care

Respondents were then asked to rate whether the training had given them confidence to deliver personalised care at work. Again, good ratings were achieved as 83% of respondents agreed or strongly agreed, 15% were neutral and only 2% disagreed.

Skills in personalised care

Similar ratings were also received when respondents were asked if they felt they had good skills in personalised care as a result of the training. Of the 82 respondents, 74% agreed or strongly agreed with this, 17% were neutral and 8% disagreed. Furthermore, 85% of respondents felt they were more able to deliver personalised care in their role as a result of their training and 82% felt the training had a positive impact on how they interact with their service users. Examples of how respondents explained the impact of the training are below.

> *"I am much more knowledgeable in my role now and deliver it with more confidence the more appointments I have. The training allowed me to see the difference between teaching someone and coaching them and ensure I am coaching each time…through both the Health Coaching and Self-Management training I have a*

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small toolbox of skills and questions I can ask to prompt the patient where needed and encourage their thought process." **- (survey participant)**

"I am more knowledgeable and competent overall. I am clearer with boundaries and expectations so service users are not disappointed by unrealistic expectations. I can listen to them compassionately and creatively help them find solutions." **- (survey participant)**

"Undergoing health coaching training has changed everything for me personally and well as professionally as I've stopped doing all the physical work for them and instead, I'm able to guide them through, set simple goals and providing information so they can achieve whatever they need. Also it helped me to gain the right skills to be able to manage my team." - **(survey participant)**

Respondents were then asked how often they applied these personalised care skills in their day-to-day role.

As shown in Figure 3 below, the combination of having knowledge, and confidence has enabled two thirds of respondents to apply their personalised care approaches either every time they see a patient or client, or frequently.

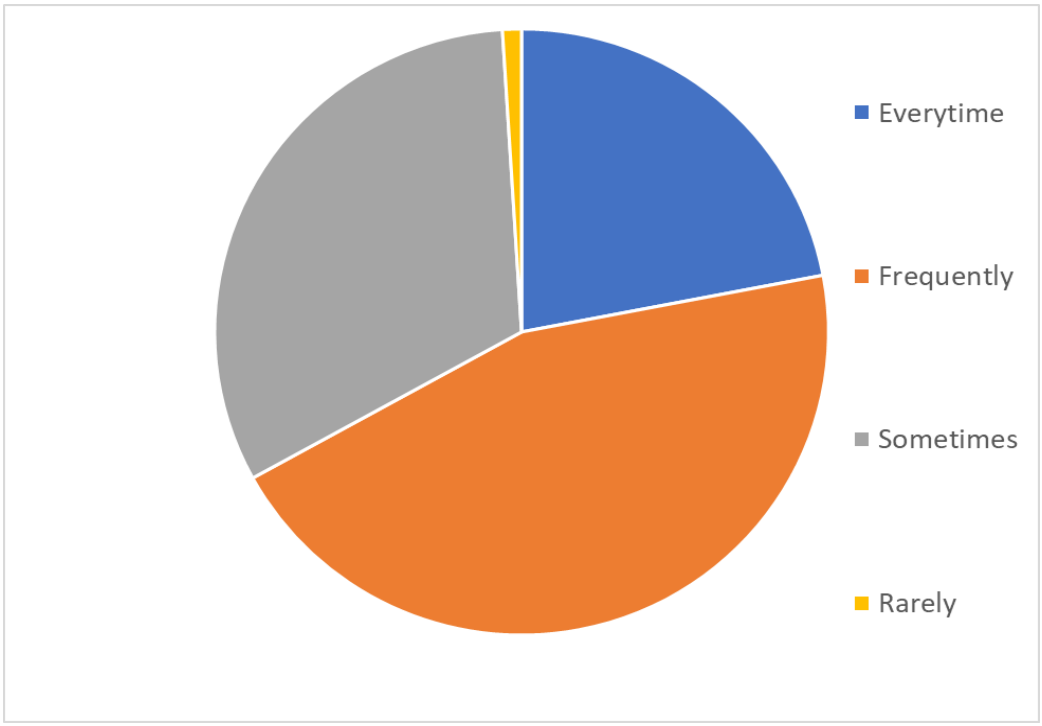

Figure 3 How often do survey respondents apply their personalised skills in their day-to-day roles (n=82)

Respondents were also asked if they applied their skill to specialised areas.

Figure 4 below shows results, with mental health, long-term conditions and health inequalities being areas that skills were most frequently applied. Some respondents also identified that the training helped with housing issues, with care home residents and with parent carers.

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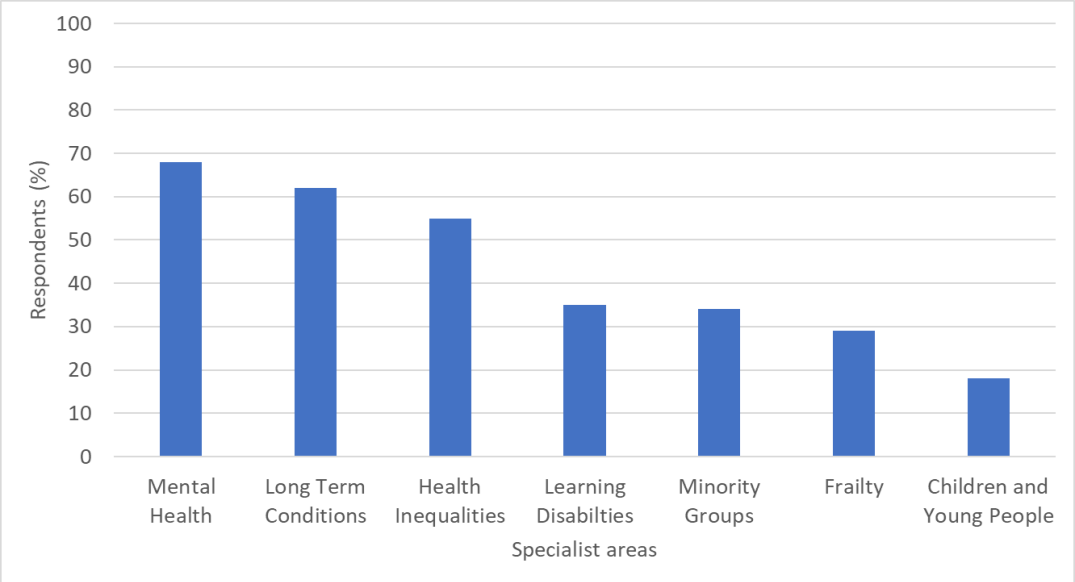

Figure 4. Proportion of respondents (n=82) who applied their personalised care skills to specialist areas.

The survey further asked people to select key aspects of personalised care that they do differently as a result of the training.

As Figure 5 shows, over 50% of respondents have increased the amount of shared decision making happening in their consultations, over one third have an increased understanding of and have adapted their approaches to minority groups, and 30% of respondents have increased the use of multidisciplinary team approaches. There was little impact on increasing the understanding of and adapting their approaches to LGBTQ+ groups or using personalised health budgets.

> *"Shared decision making is integral to the support we provide to families. As we have a safeguarding responsibility to all our families the MDT approach is equally as vital. I have very little experience of working with LGBTQ+ groups and would be interested in training in this area."* ***- (survey participant)***

> *"I work within a PCN, we have been using more MDT approaches when support patients."* ***- (survey participant)***

> *"I have learned the value of MDT approaches when trying to support people with multiple long-term conditions, when a range of different professionals from healthcare and social care are all involved in supporting the person. I also have more awareness of how to engage with and support people who may be struggling to interact with a service such as non-English speakers, or those who have suffered abuse and have a gender preference of the person they work with."* ***- (survey participant)***

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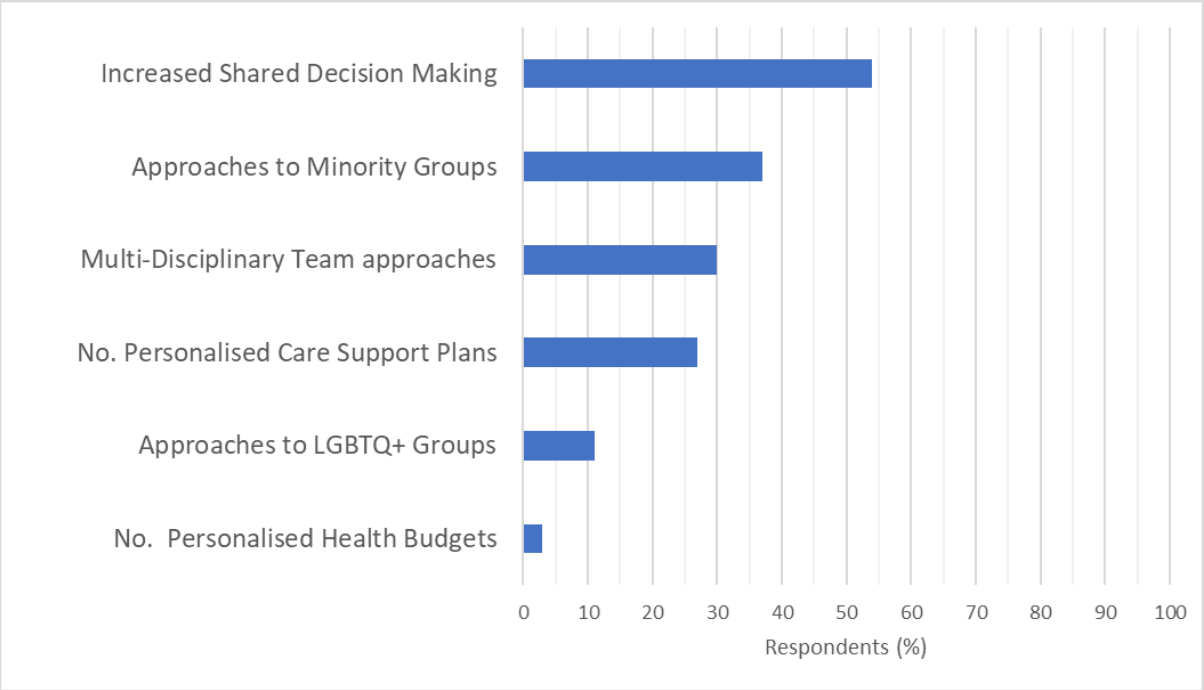

Figure 5. Have you increased the use of any of these personalised care approaches? (n=82)

Data on the impact of the courses from the focus groups further supports these results. One manager from the place leads group explained how the training in multi-disciplinary/agency meetings had been very positive for the care coordinators helping them to make these meetings a lot more person centred. This manager shared further feedback from a member of staff who had previously not included the patient so much in the MDT meeting and had felt daunted by the senior clinical professionals who were present, but now:

> *"the training has given them the confidence to run that [MDT meeting] in a really well structured way, making it more person-centred so it's focused around the patient that they've been supporting…and they've had the confidence then to explain it to the patient in the middle…have the confidence to say OK, one second, so what you know the Community matron has just said there, means this for you the person."* ***- (Focus group participant)***

Positive feedback on the impact of the personal self-management training also featured in two of the focus groups. This training by the health and well-being coaches and run by the ICB had been excellent according to one of the place leads in terms of what staff had been able to go on and deliver, and this was supported by a manager in the workforce group:

> *"it did influence the way they worked as a team. They were all on the same page and it did influence some behaviour change or some culture change in the way that they delivered the service."* ***- (Focus group participant)***

3.6 Gaps in training provision

The focus group data also provide insight into gaps in the training programme as identified by managers - these are listed below. Two of these echo feedback above around working with LGBTQ+ groups and understanding of personal health budgets:

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- the SNOMED coding as people are unsure what needs coding;
- Other level 3 courses not just for social prescribing;
- Personalised health budgets to help people deliver a better service that meets requirements;
- More training on self-care and resilience and how people look after themselves;
- Training on running group health coaching sessions;
- Health inequalities and maybe adding something about the Core 20 + 5;
- Co-production of services and service developments;
- Population health management;
- Skills to encourage patients to have more health literacy;
- Training for clinical partners to support their understanding of ARRS roles to ease these relationships;
- Expansion of suicide prevention training especially in primary care to support staff in taking a personalised approach to every health encounter;
- Training for peer support workers in personalised approaches;
- Training to support working inclusively with different communities where there are known barriers such as LGBTQ+, different groups dealing with mental health such as older people and young people, as well as migrant communities and asylum seekers;
- Short session on 'what is personalised care?' to bring all staff on board with the personalised care agenda and how to make the connection between mental and physical health part of their conversations.

3.7 Impact of Wellbeing and likelihood of staying in post.

At a time when the pressure and stress related to working in personalised care, whether in Health Organisations, Local Authority, or VCFSE sector has never been higher, the survey asked respondents whether the training has helped them to stay in their role or had an impact on their workplace wellbeing.

For many respondents (51%) the training had made them want to stay in their role. Many of the comments received from these participants link the increased knowledge, skills and confidence to feeling better able to cope with their role and as a result, experiencing less stress and anxiety.

> *"it is incredibly rewarding and each bit of training has helped my confidence to develop with this. It's lovely to see how each patient has developed and changed over time, and see how their own confidence has improved too as they are in charge of the changes they're making."* ***- (survey participant)***

> *"I have learned to focus more on what my patients want to help them to reach their goals through personalised care, but also what my limitations are and how I can support myself and increase my resilience in what can be a difficult role."* ***- (survey participant)***

> *"I feel like I am progressing and learning, rather than stagnating. I also feel more and more competent and able in my work, therefore less stressed/anxious about it."* ***- (survey participant)***

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The remaining respondents felt either that the training didn't impact on whether they would stay in their role (20%), some commented that they would have stayed anyway and were passionate about their job; 24% were unsure and 5% preferred not to say. Interestingly, several people mentioned that it didn't impact on their view of their current role, but did make them feel more able to apply for higher roles.

> *"In some ways the training has upskilled me and encouraged me to consider a higher role."* **- (survey participant)**

When asked directly about the impact of the training on their wellbeing at work, 61% stated it had a positive impact.

> *"Personalised care has also helped me to focus on what my needs are and when I need to ask for help."* **- (survey participant)**

> *"It made me realise I should look after myself better"* **- (survey participant)**

> *"By helping me to understand the current ethos and expectations of my role in statutory and third sector organisations, then yes, it has impacted on my wellbeing in a positive way so that I can carry out my role"* **- (survey participant)**

No negative impacts of the training were reported on wellbeing, 6% preferred not to answer the question and 33% stated it had no impact on their wellbeing. One explanatory comment highlighted the continual stresses people face in their roles,

> *"We still hear a lot of distressing things that clients are experiencing day to day"*

3.8 Support to attend and access training.

Being able to access the training and being supported by a line manager are crucial enablers. In this section we explore how much respondents felt they were supported by their line managers to attend the training and then apply the skills they had learnt.

The vast majority of respondents (86%) felt supported by their manager to attend the personalised care training. 3% of respondents did not feel supported, 9% were unsure and 2% preferred not to say. It was noted in comments that not everyone had a current line manager in place hence could not state yes to the question. Additionally, a few people comments that their course was mandatory training, and hence the attitude of the manager was not a factor in their attendance. There were several additional comments that demonstrated how managers had supported their staff to attend training:

> "*Was given reduce allocations/workload to allow time to attend"* **- (survey participant)**

> *"Fully supported by management team in the council and the PCN to expand my knowledge as required"* **- (survey participant)**

> *"I have been given the time in my schedule to attend and review the training."* **- (survey participant)**

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Despite 86% of respondents feeling supported by their manager to attend training, only 66% agreed that they were supported to implement their new skills around personalised care. A further 20% said no, 9% were unsure, and 2% preferred not to say. The remaining few noted as previously that this was either mandatory training or they had no manager in place.

Further insight into the barriers and enablers to attending and accessing training are provided by the qualitative data reported below.

3.9 Challenges at the organisational or system level.

In addition to the qualitative findings cited in earlier sections, the focus groups generated further insight into the wider context of the personalised training roll-out.

In this section a number of challenges at organisation/system level which are hindering the implementation of the personalised care training are explored in detail. These include a lack of shared language around personalised care across the NHS and VCSE which despite the training offer being recognised as fully inclusive of VCSE organisations, is affecting engagement of the VCSE in the training. Uptake can be further compounded by lack of staff capacity and backfill for attending training, again particularly impacting staff from the VCSE sector. Lastly, a lack of responsibility for ensuring the personalised care agenda was rolled out through training was perceived to further impact engagement of the right staff in the training programme.

Lack of shared language/vision for personalised care

There was a distinct theme in all the discussions about the language of personalised care and that this was not currently shared across the NHS and VCSE organisations.

> *"just the very language around personalised care. Of course that's exactly what the VCSE do. In fact, they probably do it better than anybody else. But would they call it personalised care? Never in a million years."* ***- (Focus group participant)***

This created a barrier to the participation of VCSE staff in the training which was recognised by managers in all the groups, regardless of sector:

> *"I do think a lot of people that would benefit from personalised care training don't necessarily identify as being involved in personalised care...I can understand why we use that phrase but it can also be off putting...I've been in the third sector for 30 years It wasn't a phrase that I'd ever encountered before until I joined the NHS. So if I felt like that after 30 years in the third sector, there's lots of other people in the third sector that feel exactly the same."* ***- (Focus group participant)***

It was suggested a shared language which 'strips away' NHS language and was *"appropriate person-centred and plain language"* would support the culture shift needed around this work and help to bring all sectors on board. A shared language could help build a sense of belonging and shared vision among all health partners around the personalised care agenda which was felt by all managers to be lacking:

> *"Culturally? The vast majority of this [VCSE] sector will not engage with it currently…I just don't understand what the vision is, what's the outcome they're trying to achieve with this training programme?"* ***- (Focus group participant)***

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It was felt by one manager representing the VCSE sector that telling the story around the ICB's vision for personalised care would help with VCSE engagement and understanding, for example helping them understand how it connects into the social prescribing that the VSCE sector have been brought into deliver with/for the NHS. This could help the training be better received at a time when capacity, funding and resources brought huge pressures for this sector in particular:

> *"Sometimes it's received as this is another thing that's being done to us. This is another thing that's being asked of us. Why should we do it when you're when you're not funding us and you're not helping us and we're drowning?...Sometimes when they see programmes like this, they won't see it with the good intention it has."* ***- (Focus group participant)***

Nonetheless, both managers representing the VCSE recognised a real engagement by the ICB for treating the VCSE as equal partners and were keen to work out how to make the most of the training opportunities and make them more accessible to the VCSE (see also theme 2). One manager also talked of the need for training that is truly 'transformational', by providing the tools needed to start enacting change within their work immediately after a course, to really achieve the shift to greater personalised care.

For one workforce manager, the challenge of embedding personalised care ran deeper into a culture of 'us' and 'them' among some staff. It was perceived this separation of clinical and personal identities was a barrier to taking a truly personalised approach with patients, where asking the right questions would reveal the patient's needs:

> *"[some] don't see themselves as patients...there's this weird separation of the 'us' and the 'them', which is a cultural thing...all it is getting people to think about what would I want to be asked? How do I want to talk about my life? And I think that's the whole school shift and I think the clinical leadership within the NHS sometimes doesn't get that."* ***- (Focus group participant)***

Another manager in the workforce group similarly felt that the lack of holistic approaches to care in some parts of the NHS were pervasive and highlighted the scale of the culture change needed to achieve personalised care:

> *"you hope that your GP and the nurses and everyone else will sit and listen and treat you as a holistic individual and think about your mental and your physical health. But they don't all do that yet. So we've got a long, long way to go...I had to challenge someone when they talked about the difference in mental and physical health, I said, but if you just start with the question, what matters to you, you will meet both of those things because they're fused together and the things that the person wants, you know, if you can frame something that's deliverable for them that they agree to, that will improve their outcomes. But it's got to be framed from the beginning in that way."* ***- (Focus group participant)***

Part of the solution was felt to be having key people confident in personalised care to drive that change, with training being a key part of the process of change. The problems around awareness of the training, discussed in section 3.2 above, further reflects the lack of shared vision/culture around personalised care.

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Lack of staff capacity/ability to attend training

The place leads raised the challenge around staff having adequate time away from practice to attend training and there being pressure from primary care networks for staff to be available. This had been discussed with PCNs. Two managers cited an issue with fitting the work from a course into work time which wasn't always possible, despite the service being fully staffed and in one case the individual had given up, not seeing the value in continuing despite the fact it was going to benefit them.

Another point was raised about group offers for training but it not being practical to release say 12 people at the same time for training, despite knowing the benefits this could bring. Similarly one place lead explained that insufficient course places were sometimes offered to staff due to work capacity and not releasing too many staff at the same time so some staff missed out on opportunities.

Similar issues were heard among the representatives of VCSE sector where capacity is too stretched for staff to attend training but also because the training offer can be seen as a request for help:

> *"the ICS NHS often offers training out like this and there's an ask on it. So there's like can you do, can you train up to this level? And then we want you to be able to do that. Nobody in the sector has capacity to do that...because they're too busy doing their actual jobs, which in the main are not funded by the NHS."* ***- (Focus group participant)***

Both of these managers highlighted the importance of VCSE reimbursement for time spent attending training. As they explained, although reimbursement doesn't relieve workload it would encourage staff to attend. The lack of backfill was a major problem for the VCSE staff. Without this, even free training isn't realistic:

> *"I can't take my staff off delivering X services. So I would have to pay bank staff to come in to do that and I haven't got enough bank staff to do that and it's so it's never free."* ***- (Focus group participant)***

One of these managers pointed out that it was important to take a longer-term view about the value of training, and to build in capacity to funding pots for the VCSE sector for the work afterwards:

> *"rather than just focusing on the training component and how do we ensure that what that sustainability is and looks like afterwards...how we embed that way of working"* ***- (Focus group participant)***

Responsibility for personalised care training and engagement

It was evident across all the group discussions that many of the challenges were linked to a lack of clear responsibility for embedding the personalised care agenda:

> *"unfortunately no one wants to take responsibility for it"* ***- (Focus group participant)***

This was reflected in comments in two groups about not having any feedback about the uptake of training such as low uptake or non-attendance which managers would find useful to understand. Two of the place leads linked this to having to juggle many priorities of which personalised care is only one. If no-one feels it is their responsibility to ensure personalised care is successfully rolled out then training opportunities may not be widely shared.

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The managers representing the VCSE acknowledged they had initially been involved in promoting the training but they were now working at more of a strategic level to support joint working on personalised care across the ICB so it was not clear if this left anyone ensuring the training was being shared. From the workforce group perspective, the lack of responsibility for personalised care was hindering a clear approach to engaging the right staff in the training:

> *"it's registered staff that have accessed this training and often previous training before that. But actually again the individuals who are having conversations no matter what environment whether it's healthcare and voluntary sector in the community, it's often the support staff, it's the healthcare support workers, the HP support staff that are having more conversations than for example the registered staff."* **- (Focus group participant)**

3.10 Ways to achieve wider organisational buy-in

The analysis of the focus group data also identified five areas that could build a stronger culture of personalised care across the ICB and these will be explored in detail in this section. These included greater staff engagement at 'place level' supported by greater involvement of staff in assessing their training needs and contributing to deciding the training agenda. The involvement of VCSE staff in co-design of certain courses would also encourage wider buy-in. Alongside, a staff consultation and 'visioning' exercise on the value of the training programme and how it contributes to achieving the personalised care agenda would further encourage staff participation. These activities would be further supported by changes to the marketing of courses to help staff understand what is relevant to them.

Staff engagement

One of the managers representing the VCSE felt strongly that engagement around the training should be at 'place' level rather than ICB as the mechanisms aren't there for the scale of communications needed. A different approach to communications and engagement could help bring organisations into the personalised care agenda. Giving an example of current plans for a new capacity building programme for the sector it was suggested:

> *"..if we framed it and said 'look we want to help…the work that you do is brilliant and you can't afford to access this training, we could put together a little package of capacity building training for you', that would be framed really different…rather than it feeling like it's coming from the NHS, West Yorkshire, ICB, it's actually through that wider partnership working."* **- (focus group participant)**

Training needs

The idea of involving 'places' was also raised in connection with training needs. One of the place leads raised an issue around needing to involve staff more in deciding their own training needs as well as wider staff involvement in deciding the training agenda:

> *"The people should have had the chance to discuss and agree their own training needs, rather than saying this happens to be available next week and we've got big plans for you and here you are...we've had a little bit of pushback from network saying it's all very well having this training, but who decided that that's what's appropriate for us?...so the 'places' probably would like a bit more involvement in determining what the priorities for person centred care training would be. I don't think we feel like we were particularly involved in the procurement process or the evaluation of need."* **- (focus group participant)**

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This was echoed by the VCSE representatives who explained that hardly anyone has the skills or capacity to do a training needs analysis even on an organisational basis never mind a sector basis, so training uptake is entirely ad hoc.

Co-design

The place leads and the managers representing the VCSE, also raised the suggestion that more co-design of the training programme would promote engagement and buy-in and help to break down barriers between sectors:

> *"[if] we have had a bit more involvement in deciding what training we should prioritise for the regions, we would be able to get more engagement and people get more value from it."* **– (focus group participant)**

One of the VCSE representatives suggested their sector could lead on and deliver some of the training as a way to begin to change the culture and relationships between NHS and VCSE, and that a co-designed package of training could then be linked to contracts:

> *"You know what would be fantastic at for me would be to you know, package up some of this stuff and be able to offer it to organisations when they win a contract. You know that there might be some minimum standards that they can access, but that would be a little bit more co-created and co-designed."* **– (focus group participant)**

Staff consultation and 'visioning'

One of the place leads also felt a wider staff consultation exercise on the value of the courses would be useful, to understand how the training is supporting staff on the bigger challenges such as how it helps people tackle health inequalities, to generate evidence of training impact on person-centred care to feed back into the programme and decisions about future investment. This same manager linked this to the earlier theme around needing a vision for personalised care and suggested work was needed at ICB level to address this:

> *"what is our vision for person centred care across the ICB and you know what are our biggest gaps, biggest potential gains and then we could look at how whether training and development is the best part of that solution. I think we could do with having a having a wider piece of work on that kind of visioning, at the moment. I feel that we're jumping straight to solutions rather than looking at what we want the outcome to be....I think we'd get better uptake, involvement and commitment if it was more of a bottom up process rather than it feels a bit top down at the moment."* **– (focus group participant)**

Marketing of courses

Across the place leads and the voluntary sector representatives there was felt to be a need for clear labelling of courses so that people understand the offer that is relevant to them and the different parts of the programme:

> *"Lots of those topics that I wasn't quite sure why they sat with the personalization programme because I know that some of those training courses are also being commissioned in other parts of the ICB. So like cultural competence for example, is also being commissioned within the mental health programme and it's also being commissioned linked to the.. race equality work… It's just not very clear."* **- (focus group participant)**

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This links back to the issues in theme 1 around needing a clear vision for personalised care that puts the training offer in its wider context, as well as the language used:

> *"let's sort ourselves out an ICB footprint and making sure that we know what we're doing and what we're offering to the sector so that we're doing a clear comms messaging around that and not duplicating what we're doing across different programmes".* **- (focus group participant)**

If the marketing covered more detail about the courses such as what is covered, the depth and length of time, this would help people choose appropriate training for their level and role:

> *"You know, the cultural competence, I'm immediately thinking, OK, well. How in depth is it? Like how long are these things? Supervision and leadership for what level of person like you know was who would be relevant for? things will feel like they may be quite ad hoc sometimes, or separated and detached from each other".* **- (focus group participant)**

The point was made again here that the language used in titles and course descriptions can be 'too clinical' and therefore off-putting for staff in the VCSE sector. One workforce manager felt the training needed to be badged so that it is fully inclusive of VCSE staff, avoiding NHS logos and using the right language, otherwise:

> *"it doesn't matter how many times you say it's for all staff they won't...think it's for them."* **- (focus group participant)**

This same manager suggested the training should be called 'training for people who work in health and social care' to be more inclusive and ensure all staff feel it applies to them. They also suggested getting the marketing done by VCSE partners. The suggestion to have more courses with accreditation was also made by one VCSE manager, citing the example of the Level 3 Social Prescribing which was popular. Having a basic accreditation was felt to be important in giving the training a badge of quality assurance.

A simple change of avoiding running training during winter pressures when staff capacity was already stretched was also mentioned by the place leads as a way to support greater uptake and buy-in.

4.0 Conclusion

This report provides a detailed insight into the provision, quality, impact and challenges of providing personalised care training across the West Yorkshire integrated Care Board. Overall, the data paints a very positive picture of the training received so far, in terms of quality, impact on work and wellbeing.

There were many additional points that were raised by survey and focus group participants that identified where further improvements could be to overcome system level barriers of ensuring everyone in the ICB is aware of the relevance of the training offers and is able to access it. Further suggestions for organisational buy-in were suggested.

There are limitations to this evaluation. As the survey analysis is based on 82 respondents, this is not a representative sample of the total number of people who accessed personalised care training between January 2020 and December 2022. Caution should, therefore, be exercised before drawing firm conclusions from the survey data. The focus groups did,

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however, corroborate many of the findings from the survey which adds a level of reassurance to the survey data.

5.0 Recommendations

Recommendations to address both practical and cultural issues identified in this evaluation are suggested below.

Format, booking and marketing:

1. It is recommended that a mixed training offer with both online and in-person elements should continue to be offered. Online training is preferable for shorter courses of up to 2 hours which also facilitates provision of backfill of staff, if needed. In-person courses should remain for topics where interactivity is important and whole day training allows staff to plan to be out for a complete day and manages expectations of other team members. All training should avoid lunchtime as part of the course, to support staff wellbeing.

2. It is recommended that all online courses are delivered using platforms that allow staff in NHS buildings to access the training at work e.g., using Microsoft Teams instead of Zoom.

3. It is recommended that training course dates are advertised at least 3 months in advance to allow adequate time for planning staff rotas, booking leave and arranging backfill if needed. To reduce wastage, courses could be overbooked on the assumption that there will be some dropouts on the day.

4. It is recommended that the marketing of courses uses language that is more inclusive of the VCFSE, as well as give more detail about content, level and duration.

5. It is recommended that the number of courses with external accreditation is expanded to further incentivise and increase uptake.

6. It is recommended that communications and engagement to staff about training should come from 'places' rather than at ICB level to increase perceived relevance to local organisations.

Encouraging inclusivity and ownership:

7. It is recommended that backfill for staff attending training is provided where possible to send a message about the value of the training to the ICB and support uptake, particularly in the VCFSE sector where capacity is very stretched. PCNs should be further encouraged to release staff to attend personalised care training.

8. It is recommended that the language used around the personalised care approach across the ICB is reviewed to be less NHS centric and more inclusive of the VCFSE sector.

9. It is recommended that relevant partners in the VCFSE sector are invited to co-design and deliver training courses to support greater inclusivity of the sector.

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10. It is recommended that a cross-ICB consultation with staff about the value of the training and how this is contributing to delivering the personalised care agenda and reducing inequalities could promote further buy-in. Similarly, promoting the ICBs vision for personalised care could support wider VCFSE engagement with the training programme. This should include training needs analysis in which staff are actively involved.

11. It is recommended that there is greater clarity on who is responsible for monitoring and managing the rollout and uptake of training across the ICB. Training Champions could further help drive the culture change needed to achieve holistic approaches in all areas of the NHS.

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