

Personalised Care and how it can help to support young carers and adult carers

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NHS England and NHS Improvement



Presentation title



The NHS Long Term Plan - People will get more control over their own health and more personalised care when they need it.

Personalised Care is one of the top 5 Priorities

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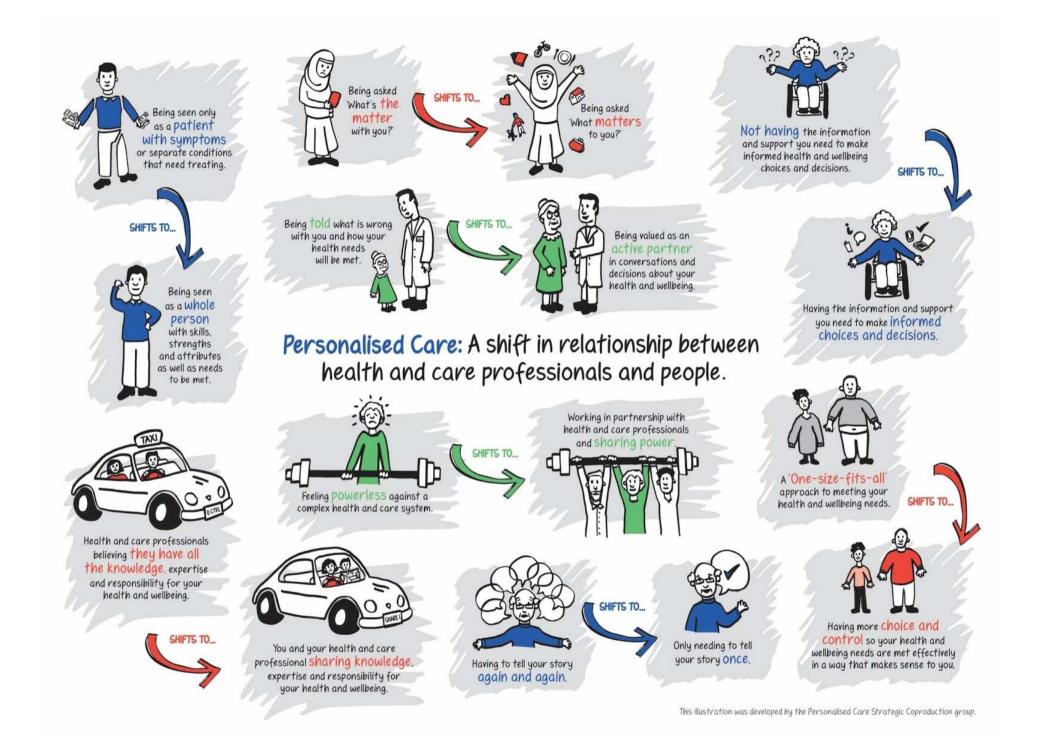




What is Personalised Care?

Personalised Care Video







6 Components of Personalised Care

- 1. Shared decision making
- 2. Enabling choice, including legal rights to choice
- 3. Social prescribing and community-based support
- 4. Supported self-management
- 5. Personalised Care and Support Planning
- 6. Personal health budgets and integrated personal budgets





Personalised Care Commitments in the Long Term Plan

- 1. People will get more control over their own health, and more personalised care when they need it
- 2. Personalised care a part of **business as usual** for the health system
- 3. Roll out a comprehensive model of personalised care to **2.5 million people** by 2023/24

Personalised Care & Support Planning – over 750,000 people expected to benefit with a shift to a different conversation
Social Prescribing – 900,000 people to benefit by 2023/24
PHB - up to 200,000 people will benefit from a PHB by 2023/24

Health inequalities: personalised care can be **targeted** to meet the needs of individuals who experience health inequalities <u>click here</u>



What does this mean for Carers ?

Personalised Care implementation plan has three actions specifically that focus on carers:

- Action 2 take a whole family approach
- Action 13 explore new rights to have personal health budgets for carers
- Action 14 test, gather best practice and build the evidence for PHBs for carers; Identify actions on how the Personalised care model works for carers, working with relevant representative organisations.

Personalised Care and support planning – a different conversation !



- Carers are entitled to request a carer's assessment, which is separate to any assessment of the person they care for and takes account of their needs, as a carer.
- Following the assessment, a carer can hold a support plan in their own right to support them in their role of providing care
- Personalised Care and support planning is a opportunity for the carer to identify their needs and the outcomes most important to them.
- It is crucial that this plan is based on what matters to the carer !
- Once the outcomes have been agreed they should agree the best solutions or actions to achieve these outcomes.
- The actions or solutions in the plan maybe be different to what has traditionally be offered!



Personalised Care and Support Planning - Changing the relationship

If the person they care for has a Personalised Care and Support Plan the carers should be fully involved, as far as the person wants them to be,

in line with criteria 1: people are central in developing and agreeing their PCSP including deciding who is involved in the process.

Personalised Care and Support Planning Best Practice Example



Portsmouth Carers Service

- The assessment and support planning model they use is in line with the Key Features of Personalised Care and Support Planning
- They also offer personal health budgets via prepaid card direct payment

Support to Carers includes:

- Wide range of breaks options e.g. weekly coffee, break away, hair/beauty services, sports/crafting/hobby equipment, part payment for gym membership, kindle, TV subscriptions
- Replacement care includes 6 hours a week sitting service or equivalent via direct payment,
- Telecare/tech based solutions





Social prescribing- Connecting people to help and support in the community

- Carers should have access to social prescribing in all areas of England through referral to a social prescribing Link Worker from primary care and other agencies such as local authority social care teams. This includes both adult carers and young carers.
- Carers should be proactively identified as a group that may benefit from social prescribing approaches.
- Social Prescribing Link workers should understand what a carer is, the challenges they may face with managing their health and wellbeing, and understand what services exist in their local area that cater explicitly to carers, alongside wider services, groups and activities that may be of benefit.

Social prescribing



Best Practice Example

- A 70 year old man was referred by his GP to the Social prescribing link worker; suffering with anxiety, fatigue, sleeplessness, he was the main carer for his wife who was registered blind.
- The primary concerns were issues with preparing meals, his wife refused to attend local luncheon clubs as she did not want anyone to see her drop food on herself,
- As a consequence her husband was missing social interaction as he had always been extremely socially active and a member of his local church
- They developed a plan focused on the main cause of anxiety which was meal preparation.
- They arranged for the local lunch club to prepare meals for collection to be eaten at home they also sourced a local organisation who provided daily freshly prepared meals on a china plate which just need re-heating.
- They also supported the patient to search for additional meal purchasing/preparation options online.

Personal Health Budgets

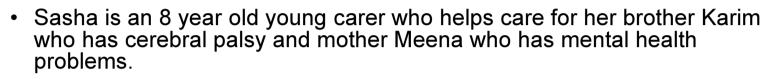


- To give people greater choice, flexibility and control over the health care and support they receive
- An opportunity for people to work in **equal partnership** with the NHS about how their health and wellbeing needs can best be met
- Personal health budgets are not about new money, but about using resource differently
- This could range from a small one off payment or a much larger budget to support ongoing care needs



Personal Health Budget

Best Practice Example



- Sasha has to spend a lot of time helping at home and with the Covid-19
 pandemic there have been even fewer opportunities to play with friends and
 have time to just have fun.
- The family's care coordinator talked with Sasha about what's important to her and what's working and not working for her.
- She said she missed going to playgrounds and spending time outdoors. She said there was little to do that's fun at home and in their garden.
- The care coordinator discussed with the family how they might use a small amount of money to help the family spend time together playing and have fun.
- They agreed that some garden play equipment would make a big difference to them all and allow them to have more fun together.
- A personal health budget was used to purchase a playhouse and swings that both Sasha and Karim could use.
- This has helped support the health and well being of the whole family.



Personal Health Budget



Best Practice Example

Mrs W cares for her husband who has dementia and a heart condition, he has no formal support and she has her own health issues and has recently had two knee replacements.

As the caring has become hard for her to manage alone, they had moved in with their daughter and her family for support.

A carers personal budget of £300 was awarded to create a garden area for them so she has somewhere to get away from her husband if she needs a break but is still within earshot if needed.

Having her own space to potter and relax will increase her emotional and physical wellbeing, and gives their current living situation more chance to work out long term, reducing the need for formal support eg a package of care or full-time dementia specialist care home.



Supported Self Management

- Supported self-management focuses on 'what matters' to the person, so they are seen within the context of their whole life, including their relationships, interests and caring responsibilities.
- It is about supporting the person they care for to improve or maintain their health and wellbeing as much as possible

and just as important ...

- It is about supporting the carer themselves to improve or maintain their health and wellbeing as much as possible
- Where needed, it is about developing the knowledge, skills and confidence and could involve: health coaching, peer support or self-management education.

New Roles in Primary Care



Health & Wellbeing Coach

- Can work with a carer to identify what's important to them, set personal goals and appropriate steps, build skills and confidence to achieve goals, and use problem solving to work through challenges.
- They can support carers by working with them to develop their knowledge, confidence and skills to take control of their own health and wellbeing and to do more of the things in life that brings them joy.

Care Coordinator

- Can work with a carer to ease the potential burden of navigation and coordination across multiple health and care services.
- These roles will work with the carer to support them and may direct them to one of the recognised supported self-management interventions: health coaching, peer support and self-management education.

Best Practice Example

Care Co-ordinator



- A care coordinator worked with a lady with arthritis and osteoporosis which were causing her mobility problems. She also had diabetes which she seemed to be managing effectively.
- Together with her husband, she had recently moved from her previous home over 40 miles away.
- She was now a long way from her children and grandchildren and reported that she lacked in confidence and struggled with anxiety.
- The care coordinator spent time with her talking about ways to help her manage her own conditions, and at the same time, care for her husband.
- They looked at how she could batch cook, so she could heat up a healthy meal quickly without much effort if she was in pain or lacking energy.
- They also discussed using technology such as a tablet to keep her mind active.
- It would also help her to keep in touch with her family.
- In this way, she started to identify ways she could change her behaviour and develop her skills.

Best Practice Example

Peer Support

- Peer support helped a person with dementia and their carer have more honest conversations.
- Supported by a link worker they explained it was hard to even get anyone in the door because he was fearful of ending up in a care home and didn't want to be diagnosed.
- He was trying to give the impression that he was coping by hiding things from his carer.
- The carer and link worker got him along to a peer support group.
- Once he met others living with dementia, he heard about strategies to help him keep living at home.
- It opened a conversation with his carer to be able to support him better.







Active Connections: Young Carers Accessing Sporting Opportunities

The Children's Society





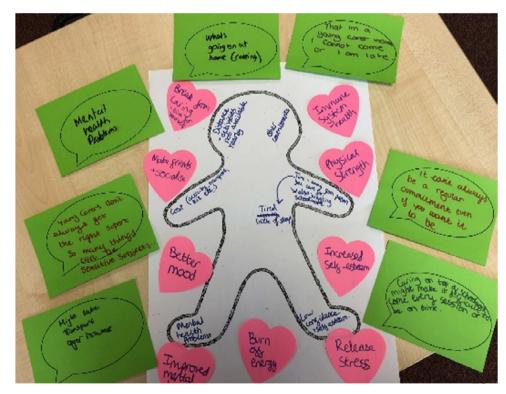
Barriers that young carers face when accessing extra-curricular opportunities

- Lack of time
- Caring responsibilities
- Unaffordable
- Lack of transport
- Anxiety, worry, lack of selfconfidence
- Having additional needs
- Struggling to make friends
- Having no energy or motivation
- Worried about being judged

I just can't juggle it all' 'I'm not able to get out that often' 'I worry about what is going on at home' 'I don't have anyone to take me' 'I'm scared something is going to happen and then I can't care or help at home' Benefits that young carers notice when regularly engaged in extra-curricular physical and group activities

- \checkmark Improved mental and physical health
- ✓ Time to myself / headspace / respite
- ✓ Make new friends
- ✓ Healthier lifestyle/fitter
- ✓ Better sleep
- ✓ A happier me!





Personal Testimonials

'Climbing has made my confidence higher because I'm around other people my age and we're challenging each other'.

'The biggest impact to me is that I talk to people more easily now'

'The biggest difference it has made to me is that I am now more physically fit'

'Climbing has taught me to push myself to do things I didn't think I could'

'I swam to the deep end, achievement of the week!'

'I like dance because it lets me get away from caring for my sisters and it relieves my stress'.

