Supported self-management

Summary Guide

NHS England and NHS Improvement

Contents

Introduction

Supported self-management (SSM) is part of the NHS Long Term Plan's commitment to make personalised care business as usual across the health and care system.

Personalised Care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths and needs. This happens within a system that makes the most of the expertise, capacity and potential of people, families and communities in delivering better outcomes and experiences. Personalised care takes a whole-system approach, integrating services around the person. It is an all-age model, from maternity and childhood through to end of life, encompassing both mental and physical health support.

This represents a new relationship between people, professionals and the health and care system. It provides a positive shift in power and decision making that enables people to feel informed, have a voice, to be heard and be connected to each other and their communities.

Personalised care is implemented through the Comprehensive Model for Personalised Care (see Figure 1). The model has been co-produced with a wide range of stakeholders and brings together six evidence-based and inter-linked components, each defined by a standard, replicable delivery model. These components are:

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

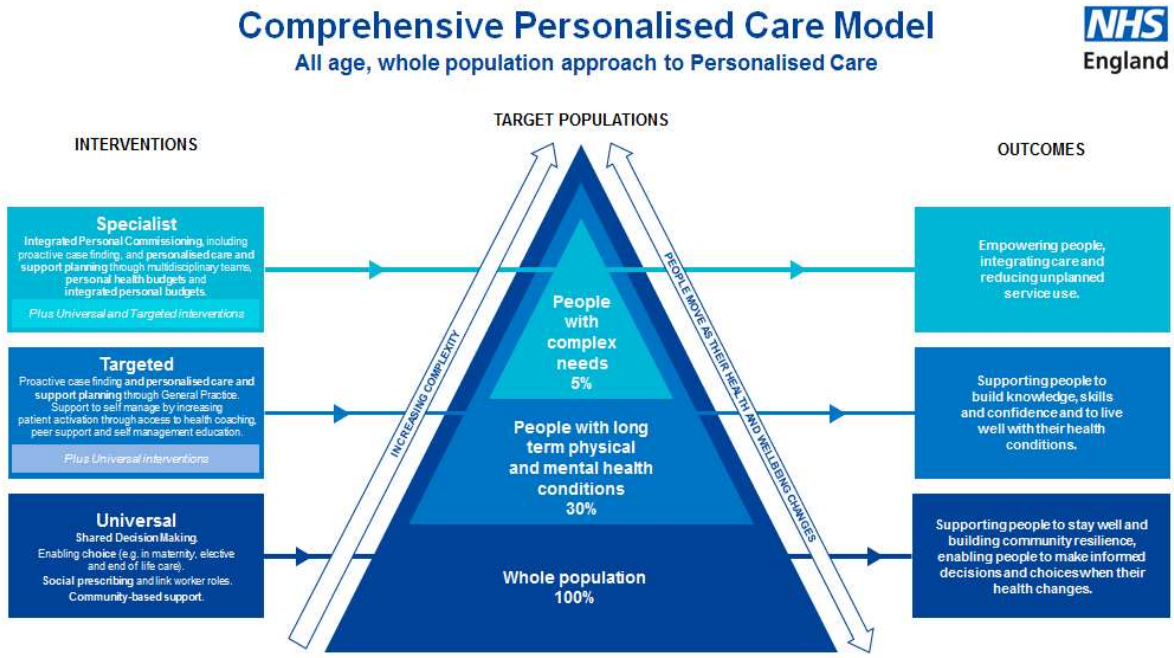
The deployment of these six components will deliver:

- whole-population approaches, supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build

community resilience, and make informed decisions and choices when their health changes;

- a proactive and universal offer of support to people with long-term physical and mental health conditions to build knowledge, skills and confidence to live well with their health condition; and
- intensive and integrated approaches to empower people with more complex needs, including those living with multi-morbidity, to experience co-ordinated care and support that supports them to live well, helps reduce the risk of becoming frail, and minimises the burden of treatment.

Table 1: Comprehensive Model for Personalised Care



More information about the Comprehensive Model for Personalised Care and supporting summary guides for its successful implementation are available on the personalised care pages of the NHS England website.[1]

[1] https://www.england.nhs.uk/personalised-health-and-care/

Who is this document for?

This summary guide is aimed at people and organisations leading local implementation of supported self-management. It enables:

- increased understanding of what good supported self-management looks like and how it ensures that high quality personalised care tailored to the needs of individuals with long term conditions is commissioned and delivered
- primary care networks, clinical commissioning groups (CCGs) and local authority commissioners, integrated care systems (ICSs) and sustainability and transformation partnerships (STPs) to have a shared understanding of what supported self-management is and so proactively plan how they work together and deliver effective supported self-management
- enhanced understanding that health and care professionals have a role in supporting people with long-term conditions to self-manage, alongside more specific interventions including health coaching, self-management education and peer support
- increased understanding of the opportunities of supported self-management, as one of the six components of the comprehensive model for personalised care, to improve health and wellbeing outcomes and NHS sustainability.

The guide provides best practice advice, not statutory guidance.

What is supported self-management?

People want to have choice and control over the way their care is planned and delivered, based on ‘what matters’ to them and their individual strengths, needs and preferences.

Self-management is the usual care for people living with long term conditions. Although they tend to spend relatively little time in contact with the health and care system, more than four in ten people living with a long-term condition do not have the knowledge, skills and confidence to manage their health and wellbeing on a daily basis.[2] As a result, they often have a lower quality of life and make more use of primary care and emergency services than those who are more knowledgeable, skilled and confident.

The interventions which are described in this guide can improve people’s ability to self-manage, so it follows that we should measure knowledge, skills and confidence by using tools such as the Patient Activation Measure® (PAM®) and provide tailored interventions to improve activation for those who would most benefit.

Support for self-management is part of the shift in relationship between health and care professionals and people represented by personalised care. This means a person not being seen as a patient with symptoms or different conditions that need treating, but rather as a whole person with skills, strengths and attributes, as well as needs that need to be met.

It means health and care professionals tailor their approaches to working with people, based on the person’s individual assets, needs and preferences, as well as taking account of any inequalities and accessibility barriers, and so working in a personalised way based on ‘what matters’ to the person.

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[2] https://www.health.org.uk/publications/how-engaged-are-people-in-their-healthcare

Finally, supported self-management means ensuring approaches are systematically put in place to help build knowledge, skills and confidence. These approaches include:

- health coaching – helping people gain and use the knowledge, skills and confidence to become active participants in their care so that they can reach their self-identified health and wellbeing goals
- self-management education – any form of formal education or training for people with long-term conditions focused on helping them to develop the knowledge, skills and confidence they need to manage their own health care effectively
- peer support – a range of approaches through which people with similar long-term conditions or health experiences support each other to better understand the conditions and aid recovery or self-management. Peer support may be formal or informal: it can be delivered by trained peer support staff and volunteers, or through more informal, ad hoc support among peers with lived experience.

This way of working significantly increases the likelihood that people will adopt behaviours and approaches that contribute to their health and wellbeing. For example, a literature review of over 1,000 research studies found that peer support can help people feel more knowledgeable, confident and happy, and less isolated and alone.[3]

There is also good evidence that supported self-management has a positive impact on the health and care system. An independent evaluation found that people who had the highest knowledge, skills and confidence had 19% fewer GP appointments and 38% fewer A&E attendances than those with the lowest levels of activation.[4] This finding was corroborated by a Health Foundation study which tracked 9,000 people across a health and care system.[5] There is an emerging evidence base that indicates peer support is cost-effective for different areas of healthcare.[6]

[3] National Voices and Nesta (2015), Peer support: what is it and does it work? Available online: https://www.nationalvoices.org.uk/publications/ourpublications/peer-support (accessed 22 October 2018)
[4] Barker, I. et al. (2017), Patient activation is associated with fewer visits to both general practice and emergency departments: a cross-sectional study of patients with long-term conditions, Clinical Medicine, 17(3), p.15
[5] Deeny, S., Thorlby, R., Steventon, A. (2018), Briefing: Reducing emergency admissions: unlocking the potential of people to better manage their long-term conditions. London: Health Foundation
[6] Realising the Value (2016), At the heart of health: realising the value of people and communities. Available online: https://www.nesta.org.uk/report/at-the-heart-ofhealth-realising-the-value-of-people-and-communities/)

What good supported self-management looks like for people

- Supported self-management focuses on ‘what matters’ to the person, so they are seen within the context of their whole life, including their relationships and interests.
- People are valued as an active partner in conversations and decisions about their health and wellbeing. This means people are recognised as experts in their own lives, and conversations draw on the knowledge, skills and confidence that people bring.
- People are supported to find solutions, make plans and break down their health and care goals into manageable steps. Supported self-management focuses on a person’s goals, not what professionals think those goals should be.
- Supported self-management means the steps to supporting people manage their lives, including their symptoms. This means people actively managing their life with the challenges that go with their condition(s).
- Supported self-management encourages people living with long-term conditions to access information and to develop skills to find out what is right for their condition and, most importantly, right for them.
- People can access peer support from other people with similar conditions or health experiences, and support each other to better understand the condition and aid recovery or self-management
- People can access support to self-manage in a variety of ways, including a one-to-one basis, in pairs or in small groups. Support can be delivered in person, by telephone or online.
- People are supported to potentially improve in a range of clinical outcomes and physical wellbeing, e.g. blood pressure and behavioural outcomes such as improved diet or frequency of exercise and taking their medication.

What good supported self-management looks like for staff and the system

- Understanding people’s activation levels can support commissioners to understand better the needs of the local population (i.e. segmentation and

stratification). It is therefore a key element of population health management approaches.[7]

- Related to the above, understanding people's activation levels can support commissioners to put in place approaches to meet their population's needs more appropriately. This can include targeting and allocation of resources more appropriately to provide more in-depth support to those people with low knowledge, skills and confidence to self-manage.
- Supported self-management approaches – health coaching, self-management education, and peer support – are commissioned by CCG and local authority commissioners, working closely with the voluntary, community and social enterprise (VCSE) sector and people with lived experience.
- The workforce is trained – through e-learning, webinars and group training – in administering the PAM or other specific approaches to identifying a person's level of knowledge, skills and confidence
- Understanding of people's activation levels enables members of the workforce to tailor approaches to people to best support self-management. Related to this, the workforce is more able to raise awareness of supported self-management and enable people to take ownership and responsibility for their health.
- The workforce receives appropriate training and support to work in ways that support self-management, including health coaching as part of their existing role.
- Typically, there may be additional roles alongside the traditional workforce, such as Health and Wellbeing Coaches, Care Coordinators, and Social Prescribing Link Workers. Health coaching would average over 6-12 contacts, which can be done in a variety of ways, depending on people's preferences.
- Supported self-management can impact on the wider economy with people getting back into employment or volunteering and managing their whole life, such as finances and housing.

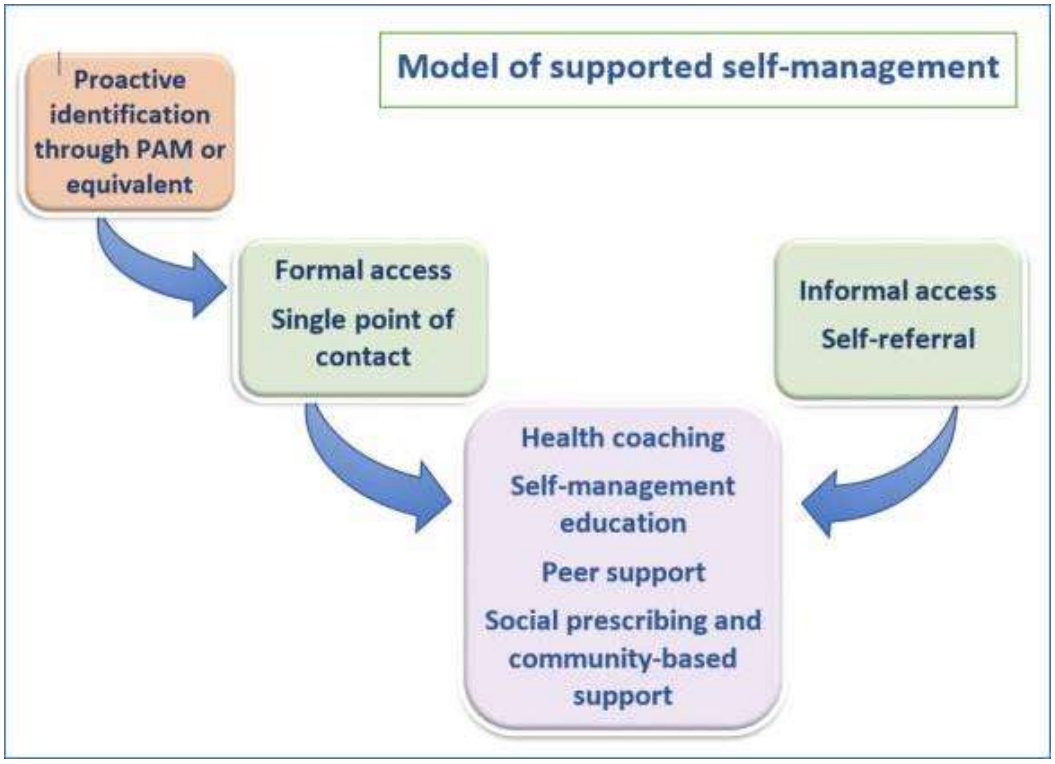
[7] Population Health Management is an approach aimed at improving the health of an entire population and improves population health by data driven planning and delivery of care to achieve maximum impact for the population. https://www.england.nhs.uk/hssf/background/

Implementing supported self-management

What needs to be in place locally?

NHS England has engaged a wide range of stakeholders – including people with lived experience, GPs, local authority commissioners, CCGs, the VCSE sector and national partner organisations – to set out the standard model for what makes good supported self-management and what needs to be in place locally.

Table 2: Model of supported self-management



This standard model for supported self-management includes:

- understanding a person's level of knowledge, skills and confidence (patient activation), using tools such as the PAM or equivalent

- health and care professionals tailoring their approaches to people's assets, needs and preferences, supporting people to increase their knowledge, skill and confidence through a 'what matters to you?' conversation
- supported self-management approaches being systematically in place: health coaching, self-management education and peer support. Social prescribing,[8] another component of the Comprehensive Model for Personalised Care, should also be available. All of these approaches can be focussed on, though not limited to, those with low activation to build knowledge, skills and confidence, and take account of any inequalities and accessibility barriers.

The rest of this section sets out more detail of what each of these elements requires in practice.

Patient activation

'Patient activation' describes the knowledge, skills and confidence a person has in managing their own health and care. Evidence shows that when people are supported to increase their knowledge, skills and confidence (i.e. become more 'activated') they benefit from better health outcomes, improved experiences of care, fewer unplanned care admissions and a reduction in GP appointments.

Patient activation is of importance to people living with long-term conditions who often use the health and care system. By understanding people's levels of knowledge, skills and confidence, the health and care system can support those people with long term conditions in ways appropriate to their individual needs.

The PAM is a tool that enables healthcare professionals to understand a person's level of knowledge, skills and confidence (their 'activation' level) to manage their long-term condition.

The Patient Activation Measure is not suitable for all cohorts including people with severe and enduring mental health issues, dementia and learning disabilities.

The steps to putting the PAM in place in a local area include:

[8] [8] https://www.england.nhs.uk/publication/social-prescribing-and-community-based-support-summary-guide/

- Proactive identification of people's knowledge, skills and confidence, paying particular attention to those who may have low levels, within the population through:
  - routine review of hospital discharge
  - risk stratification and segmentation
  - review of priority groups of people
  - review of local data and demographics and the wider determinants of health
  - tacit knowledge of health and care professionals.
- Create the conditions and culture that ensures that people who will be using, implementing and benefiting from the PAM are key partners in its implementation, including people with lived experience, senior managers, staff and carers. Involve people, ensuring senior managers and staff are kept informed and engaged. Services should provide an information sheet including what the PAM is, who will be targeted and why, benefits and how it can improve outcomes for patients. This should be done in collaboration with people with lived experience.
- Staff are trained in administering the PAM or other specific approaches through e-learning, webinars and group training, understanding that PAM is a tool that supports understanding about how to tailor support for people to increase their knowledge, confidence and skills.
- Staff also need to be trained in how the IT system will support the PAM process and how it can be implemented into numerous pathways effectively and without unnecessary repetition. There should be some means of connecting PAM scores to a patient's clinical condition(s), risk scores and a record of attendance at the planned intervention.
- A person's support needs are identified through shared decision making or personalised care and support planning. These are carried out by relevant staff, which could be healthcare assistants, Care Coordinators, Social Prescribing Link Workers, health trainers, general practice nurses, district nurses, specialist nurses or GPs, depending on the person's level of activation and complexity.
- Monitoring and evaluating the implementation of the PAM and related interventions is essential to understand delivery of the project, the outputs of the PAM project (e.g. number of licences, patients, practices), impact

and outcomes (e.g. the effectiveness of the project in achieving desired outcomes).

For more information on implementing patient activation measure, see the PAM Quick Guide.[9]

Health coaching

Health coaching is a partnership between health and care practitioners and people. It guides and prompts people to change their behaviour, so they can make healthcare choices based on what matters to them. It also supports them to become more active in their health and care. Health coaching is defined in Universal Personalised Care[10] as:

"Helping people gain and use the knowledge, skills and confidence to become active participants in their care so that they can reach their self-identified health and wellbeing goals."

NHSEI have published a health coaching implementation and quality guide which covers two distinct approaches to using health coaching:

- Health coaching services - health coaching as a new stand-alone service targeting a specific group e.g. supporting healthy behaviour changes in diabetes
- Health coaching skills - training health and social care staff and voluntary sector representatives or carers to use health coaching skills as part of their consultations or conversations, as an approach to practice or mind-set. Health coaching skills can be used to enhance an existing service, as part of a patient activation intervention or to introduce a coaching culture.[11]

Self-management education

Self-management education includes any form of formal education or training for people with long-term conditions that focuses on helping them to develop the

[9] https://www.england.nhs.uk/publication/module-1-patient-activation-measure-implementation-quick-guide/
[10] https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/
[11] https://www.england.nhs.uk/personalisedcare/supported-self-management/supporting-tools/

knowledge skills and confidence they need to manage their own health care effectively.

It is important to do 'mapping and gapping' for self-management education based on what exists in local areas and local priorities. This includes:

- **Generic structured education courses** - these focus on the common experiences of people with any long-term health condition and their carers, such as working with health care professionals, coping with pain and managing fatigue. Examples include the Expert Patient Programme (EPP): a six-week course, usually delivered by volunteer tutors who themselves often have a long-term condition, that supports people to take more control of their health by learning new skills to manage their condition[12] and Skilled for Health: the national evidence-based health literacy resource.
- **Condition-specific structured education courses** - these cover specific skills and knowledge needed to manage different conditions. For example, within the NHS Long Term Plan, the NHS will support people who are newly diagnosed to manage their own health by further expanding provision of structured education and digital self-management support tools, including expanding access to HeLP Diabetes an online self-management tool for those with type 2 diabetes.[13] This is in addition to courses, such as, DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) courses for people with diabetes. These can be helpful in encouraging behaviour change and technical skills.
- **Educational** – booklets, leaflets and DVDs have all been found to improve knowledge about people's condition and self-management.[14] However, used alone such materials may not motivate people to change their behaviour.
- **Digital** – there are multiple ways of accessing self-management education digitally. These include:
  - online courses - these are generally worked through by the individual at their own pace/ time and some will include access to online forums or a health coach

[12] There is a cost to obtaining a licence to running the Expert Patient Programme

[13] https://www.england.nhs.uk/long-term-plan/ (para 3.79)

[14] Stoilkova A, Janssen DJ, Wouters EF. Educational programmes in COPD management interventions: a systematic review. *Respir Med* 2013;107(11):1637-1650.

- smart apps - typically condition-specific, e.g. MyCOPD supports people with chronic obstructive pulmonary disease to better manage their condition.[15]

Diabetes self-management education: a healthcare profession resource[16] is a quick guide that details eight steps commissioners can take to improve the provision and uptake of diabetes self-management education.

Pulmonary rehabilitation offers a structured exercise programme for those with lung disease of breathlessness. 90% of patients who complete the programme experience improved exercise capacity or increased quality of life.[17] As part of the NHS Long Term Plan, the NHS will increase the number of patients who are referred to pulmonary rehabilitation where this is appropriate through the use of the COPD discharge bundle.[18]

QISMET is the national body for Quality Institute of Self-Management Education and Training interventions,[19] an independent not-for-profit body that supports self-management providers and commissioners to achieve the highest possible quality service for people living with long-term health conditions. It does this by developing quality standards, defining good practice and certificating providers against these standards.

Peer support

There are many factors which have an impact on the successful implementation of peer support. Below is an adapted version of these factors taken from the Releasing the Value Programme,[20] which was commissioned by NHS England.

1. Be clear on purpose of the support	There are a number of approaches to use, e.g. mutual learning within intentional peer support, setting SMART goals or introducing workshop topics to groups.

[15] https://www.nhs.uk/apps-library/mycopd/ It can support inhaler technique, improve breathing, reduce exacerbations, track medication and more
[16] https://diabetes-resources-production.s3-eu-west-1.amazonaws.com/diabetes-storage/migration/pdf/Diabetes%2520self%2520management%2520education%2520%28November%25202015%29.pdf
[17] Royal College of Physicians (2017) National Asthma and COPD Audit Programme (NACAP). Available from: https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap
[18] https://www.england.nhs.uk/long-term-plan/ (para 3.85)
[19] http://www.qismet.org.uk/
[20] https://media.nesta.org.uk/documents/making-it-happen-practical-learning-from-the-five-realising-the-value-partner-sites.pdf

2. **Create links with statutory services**	Positively UK's peer support is integrated into 11 HIV clinics across London. Many factors have helped make this relationship succeed in practice: identifying a champion in the clinic, being clear on the role of peer supporters and when people should be referred to the service.
3. Plan a clear selection and induction process	Clear selection process for appointing suitable peer supporters as it may not be appropriate for everyone. Start with a clear role description and interview based on the skills needed for the role. Ensure training provides clarity on the role. Further assess the person's peer support skills, through practical and interactive activities. Be clear up front about the amount of time and numbers of people peer supporters can commit to. Also ensure time and space for peer supporters to share their own experiences, solve problems, receive feedback and support each other.
4. **Set boundaries and limitations**	The boundaries need to be clear and people need to understand the nature of the support on offer. Set out confidentiality boundaries, who the peer supporter should go to for safeguarding concerns and the right point to refer to additional support.
5. Make peer support accessible and flexible	Peer group members may have difficulties attending regular face-to-face meeting, because of things such as location, timings and accessibility. Online support can be preferable to some but could limit access for others.
6. Ensure there is ongoing support and supervision for peer supporters and peer support groups	The breadth of knowledge and skills involved in providing peer support means it is important that those providing support have access to structured and ongoing training, possibly linked to professional qualifications such as NVQs. Continuous professional development will enable people to keep their knowledge and skills up to date and to acquire new skills. Make sure you make it easy for people to access training. For volunteers, you may want to provide training at different times to allow people to attend around other commitments.
7. **Ensure that building social networks is part of the support**	The social aspect of peer support is important for many people. Ensure that your project planning builds people's social networks so that they are in a position to carry these on once the structured peer support has come to an end. Ensuring that time is provided at group meetings for individuals to talk and socialise over breaks or food, for instance, can support this process.

8. Plan for measurement throughout	Even with informal peer support, it is important to measure the effectiveness of the approach as this is motivating to both parties and can be useful for the organisation to demonstrate evidence of its effectiveness to potential commissioners. It is important to be clear from the outset what you want to measure and keep it simple. You should be realistic as to what you can measure and how, for example you might decide to measure people's engagement within a group through observation by staff and improvements in emotional wellbeing by asking those accessing services to score themselves at the beginning of the support programme and again at the end. There are some good resources to help you, including the NCVO's Inspiring Impact Programme.[21]
9. Be realistic about the costs	Peer support is never free, even when fully provided by volunteers. Peer supporters need to be managed, supervised and trained for the role and this will take time and resources. When budgeting, it is important to think about all the costs involved, such as salaries for both frontline staff and those supervising or managing staff and volunteers. Some peer supporters may need police checks and out of pocket expenses such as travel, there may be resources required for groups, a contribution to overheads such as premises costs and possibly costs of engaging someone to undertake evaluation. NCVO[22] have a range of tools to support financial management including budgeting.

[21] https://www.inspiringimpact.org/
[22] https://www.ncvo.org.uk/

Guidance and resources

There are many good case studies and resources on supported self-management across the country, which demonstrate where it is already being implemented effectively.

NHS England and Improvement has set up an online learning platform to share the latest resources. To join the platform, please contact england.patientactivation@nhs.net

Below is a summary:

A Practical Guide to Self-Management Support: key components for successful implementation

This guide provides an overview of self-management support and the key components for effective implementation. It explains what self-management support is and why it is important, then looks at various aspects of putting it into practice, including planning and commissioning, building knowledge, skills and confidence, and measurement and evaluation.

https://www.health.org.uk/publications/a-practical-guide-to-self-management-support

Good and Bad Help: how purpose and confidence transform lives

This draws on a well-established evidence base and worked with practitioners to understand how 'good help' is applied in practice.

https://www.nesta.org.uk/report/good-and-bad-help-how-purpose-and-confidence-transform-lives/

Person-centred approaches: a core skills education and training framework

This framework aims to distil best practice and to set out core, transferable behaviours, knowledge and skills. It is applicable across services and sectors (e.g. health, social care, local authorities and housing) and across different types of organisations (e.g. public, private and not for profit).

http://www.skillsforhealth.org.uk/services/item/575-person-centred-approaches-cstf-download

Realising the Value

Releasing the Value created a set of tools and resources, which aim to enable people to take an active role in their own health and care, in support of the NHS Five Year Forward View vision to develop a new relationship with people and communities.

The resources, which include publications and practical tools, are grounded in both evidence and practice and are directly relevant to commissioners, providers and practitioners putting person and community-centred approaches into practice, as well as to policymakers and regulators.

https://www.nesta.org.uk/project/realising-value/

Patient activation

Segmenting Care in Long term conditions for a more person-centred approach

This overview is to describe a pilot of a personalised approach to how primary care can support people living with diabetes.

http://coalitionforcollaborativecare.org.uk/wp-content/uploads/2018/06/Segmenting-Care-in-LT=Cs-FINAL.pdf

Patient Activation Measure Quick Guide

This quick guide provides practical and operational support to sites considering the use of PAM licenses. The guide focuses on why patient activation is important in managing people's health and wellbeing, as well as elements to consider before implementing the PAM.

https://www.england.nhs.uk/publication/module-1-patient-activation-measure-implementation-quick-guide/

Health coaching

Better conversation: better health

A set of ‘better conversation’ resources for clinicians and health and care leaders which includes a short video, infographics and a resource guide which contains case studies, evidence and tips on how to introduce a health coaching approach to improve the quality of conversation and help people change behaviour.

https://www.betterconversation.co.uk/images/A_Better_Conversation_Resource_Guide.pdf

NHS England and Improvement Health Coaching Implementation and Quality Summary Guide

A health coaching implementation and quality guide which covers two distinct approaches to using health coaching: health coaching as a new stand-alone service and health coaching skills - training health and social care staff and voluntary sector representatives or carers to use health coaching skills as part of their consultations or conversations

https://www.england.nhs.uk/personalisedcare/supported-self-management/supporting-tools/

Self-management education

Quality Institute for Self-Management Education and Training

The national body for quality assurance of self-management education interventions.

http://qismet.org.uk/certification/

Diabetes self-management education: a healthcare profession resource

A quick guide that details eight steps commissioners can take to improve the provision and uptake of diabetes self-management education.

https://diabetes-resources-production.s3-eu-west-1.amazonaws.com/diabetes-storage/migration/pdf/Diabetes%2520self%2520management%2520education%2520%28November%25202015%29.pdf

Peer support

Community capacity and peer support

This guide includes a common framework for developing formal and informal peer support options and how to put them into practice.

https://www.england.nhs.uk/publication/community-capacity-and-peer-support/

National Voices Peer Support Hub

National Voices has launched a Peer Support Hub – an online bank of high quality resources for people looking to measure, evaluate, sustain and grow different types of peer support.

https://www.nationalvoices.org.uk/peer-support-hub

Annex A: How does supported self-management fit with other approaches?

Shared decision making (SDM)

SDM means people are supported to:

- understand the care, treatment and support options available and the risks, benefits and consequences of those options
- make a decision about a preferred course of action, based on evidence-based, good quality information and their personal preferences.

It is, therefore, a process in which clinicians and individuals work together to select tests, treatments, management or support packages, based on evidence and the individual's informed preferences.[23]

Most health and care staff will need to receive accredited training to confidently take part in SDM conversations. The skills required involve training in motivational/health coaching approaches, alongside specific training in risk communication and in working with people at low levels of health literacy.

Personalised care and support planning

People have proactive, personalised conversations which focus on what matters to them, delivered through a six-stage process and paying attention to their clinical needs as well as their wider health and wellbeing.[24]

[23] NICE / NHS England (2016), Shared Decision Making: a consensus statement. Available online: https://www.nice.org.uk/Media/Default/About/what-we-do/SDM-consensus-statement.pdf (accessed 23 October 2018)
[24] NHS England (2017), Personalised care and support planning. Available online: https://www.england.nhs.uk/wp-content/uploads/2017/06/516 Personalised-careand-support-planning_S7.pdf (accessed 21 June 2018).

The goals and actions identified in the personalised care and support plan will often focus on self-management strategies and any additional support they might need.

Social prescribing

Social prescribing enables all local agencies to refer people to a link worker. Link workers give people time and focus on what matters to the person as identified through shared decision making or personalised care and support planning. They connect people to community groups and agencies for practical and emotional support.

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