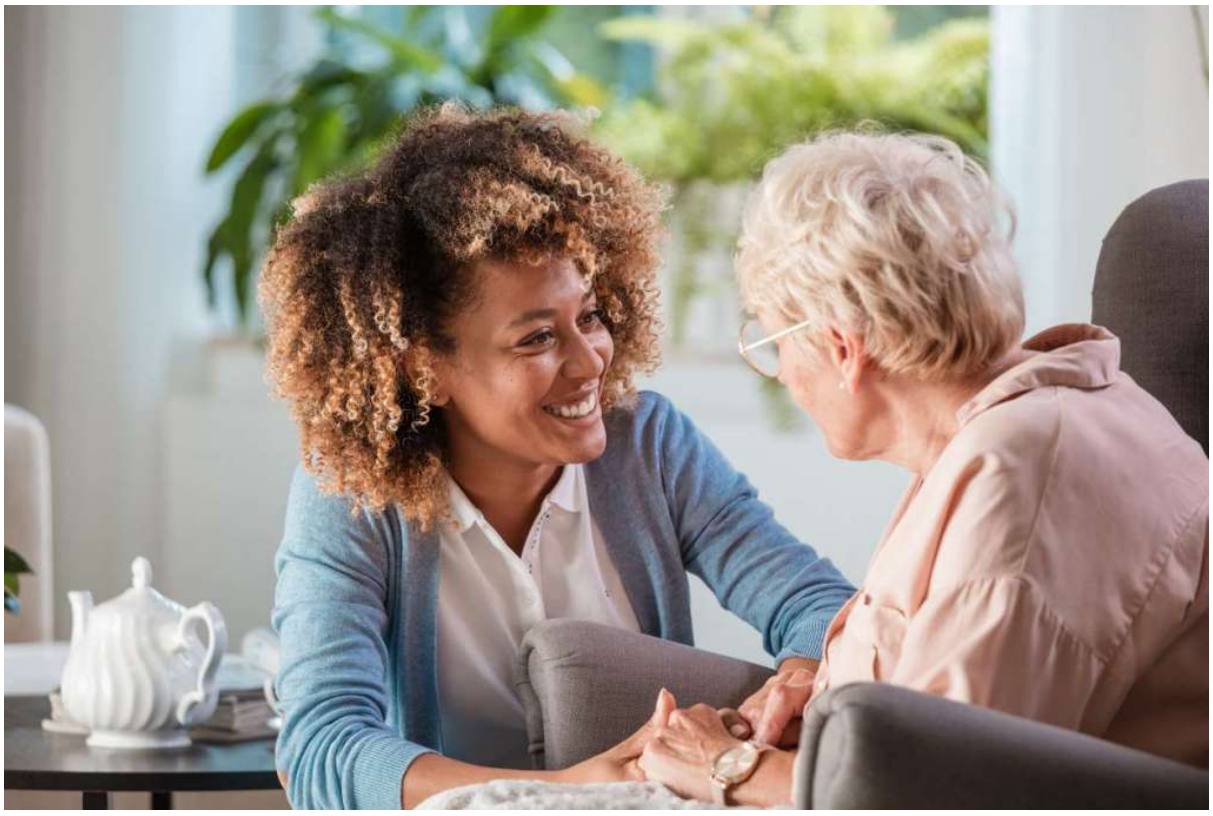
Empowering the Workforce for Personalised Care

Evaluation of the Personalised Care Institute's Training Offer in England



Report prepared by the Self-Care Academic Research Unit (SCARU), Imperial College London School of Public Health

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Executive summary

Background

- Personalised care represents a fundamental shift in health system design from reactive, disease-centred practice to proactive, person-centred care grounded in shared decision-making and co-production.
- The Personalised Care Institute (PCI) was established by NHS England as the national centre for personalised care education.
- This mixed-methods evaluation, conducted by Imperial College London, provides the most comprehensive analysis to date of PCI's impact on workforce knowledge, confidence, motivation and ability to deliver personalised care.

Objectives

- The primary objective was to assess the educational effectiveness, practical application and system-level relevance of PCI training across six core e-learning modules.
- The evaluation also sought to identify barriers and enablers influencing implementation to inform future strategic positioning of PCI within national workforce transformation frameworks.

Methods

- A mixed-methods design integrated quantitative and qualitative data. Pre- and post-course surveys were completed by 8,186 participants (4,676 pre; 3,510 post), with 2,473 matched pairs analysed using Wilcoxon signed-rank tests.
- Outcome domains included understanding, confidence, motivation and incorporation into practice.
- Three-month follow-up surveys (n=1,092) explored sustained skill use and behavioural integration.
- Open-text responses (n= >10,000) and stakeholder interviews (n=48) were analysed thematically using Braun and Clarke's reflexive approach.
- The study received a favourable opinion from Imperial College Research Ethics Committee (ICREC #7084703).

Results

- Significant improvements were observed across all domains and modules ($p<0.01$). Effect sizes were largest for **c**onfidence ($r=0.59–0.67$) and understanding ($r=0.48–0.62$).
- Smaller but positive effects were recorded for motivation ($r=0.20–0.29$) and incorporation into practice ($r=0.30–0.40$).
- Follow-up data confirmed sustained impact: 81.7% reported confidence in applying new skills, 69.1% frequently used them in practice and 76.9% intended continued use.
- Learner satisfaction exceeded 4.3/5 across all courses, with completion rates between 58–80%.
- Free-text analyses identified recurrent themes of improved communication, empathy, shared decision-making and patient empowerment.
- Barriers included limited time, organisational constraints and variable leadership support.

- Stakeholders characterised PCI as a trusted national enabler that should not loose visibility despite some funding withdrawal and called for renewed policy alignment and cross-sector engagement.

Consolidated Findings by Value Domain

- **Immediate value.** PCI reached thousands of learners across roles with high completion and satisfaction. Afternoon engagement peaks suggest incorporation within working hours, junior doctor variability mirrors rota realities. The platform's flexible, modular design likely supports scale and accessibility.

- **Intentional value.** Motivation to apply learning was high at baseline and increased post-course in most modules. Learners articulated specific intentions around SDM conversations, agenda setting and goal-oriented PCSP, indicating internalisation of principles as practical method.

- **Applied value.** Three-month responses point to frequent use of skills, improved interaction quality, increased confidence and intent to continue. Barriers, time, team alignment, environmental set-up, were common and should be targets for managerial action.

- **Contextual value.** Stakeholders identified policy withdrawal, the dissolution of NHS England and loss of data visibility as material risks. They called for PCI to function as a strategic convener, reconnecting policy, education and practice through standards, partnerships and metrics.

Discussion

- PCI training demonstrably improves workforce capability for personalised care and yields consistent behavioural intent across roles and regions.
- However, translation into routine practice is constrained by system-level factors, workload, cultural inertia and diminished infrastructure following the loss of national leadership.
- Sustaining PCI's impact requires its continued reintegration into NHS workforce strategy, reinstatement of monitoring dashboards and extension beyond clinical domains to social care, VCSE and public health sectors.
- As measurement is the heart of science, PCI is well positioned to collaborate with academic partners to develop and validate the Personalised Care Outcomes and Readiness Assessment (PERSONA) tool to help quantify the quality, consistency and experience of personalised care across health and social care settings.

Conclusions

- PCI has established a scalable, evidence-based model for personalised care education, producing significant learning gains and sustained behavioural confidence across England's health and care workforce.
- To secure long-term impact, PCI should be positioned as a strategic convener linking education, policy and practice rather than solely a training provider.
- With renewed investment and cross-sector integration, PCI can serve as the anchor institution for person-centred workforce transformation and a global exemplar of best practice whilst at the same time maximising alignment to the NHS Tree Shifts.

1. Introduction

Background
Personalised care is a system ambition and a professional practice. It reorients care from a narrow biomedical model to a biopsychosocial approach in which individuals co-produce goals and plans that reflect their values, preferences and social context. It relies on capabilities such as shared decision-making (SDM), personalised care and support planning (PCSP), health coaching and effective communication and it assumes organisational conditions that enable protected time, managerial endorsement and digitally inclusive access to learning.

In England, the Personalised Care Institute (PCI) was established as a national centre of excellence to standardise, scale and assure training quality for these capabilities across the workforce.

This report consolidates an independent mixed-methods evaluation of the PCI learning offer conducted by researchers at Imperial College London School of Public Health. It synthesises quantitative outcomes from pre- and post-course surveys for six e-learning modules with analysis of three-month follow-up responses, thematic review of free-text reflections and stakeholder interviews and focus groups with national actors.

The report is written for PCI, NHS England and academic readers who require a rigorous account of educational impact, workforce relevance, system value and actionable next steps. It excludes important non-cardinal findings by design as these are published elsewhere (the main evaluation report and technical annex).

Aims and Evaluation Framework
The primary aim was to assess the impact of PCI training on health and care professionals' (HCP) understanding, confidence, motivation and readiness to incorporate personalised care in practice.

Specifically, the evaluation sought to:

(i) Examine reach and engagement
(ii) Describe enablers and barriers to application, and
(iii) Derive improvement opportunities for curriculum, accreditation and strategic positioning.

The evaluation lens draws on four linked value domains: (i) Immediate (reach and engagement), (ii) Intentional (motivation and intent to change), (iii) Applied (early practice use), and (iv) Contextual/System (conditions shaping sustained implementation).

2. Methods

Design and setting
Mixed-methods design with a quantitative core, enriched by qualitative data. The evaluation covered six PCI modules delivered on Moodle between 1 August 2024 and 15 March 2025: Core Skills; Shared Decision Making; Personalised Care & Support Planning; Remote Consultations; Leading Personalised Care as a Junior Doctor; and Maternity, Personalised Care & Support Planning.

Data sources and participants
A total of 8,186 surveys were completed: 4,676 pre-course and 3,510 post-course. After cleaning and matching by unique user ID, 2,473 participants had paired pre- and post-course data for inferential analysis. Course-specific denominators varied by module (e.g., SDM pre n=1,615; post n=1,265). Three-month follow-up forms yielded 1,092 responses overall. However, due to missing course identifiers, a smaller subset (n=264) with identifiable course linkage informed course-level follow-up analyses. Semi-structured interviews were held with four external stakeholders to surface assumptions regarding how PCI may have impacted personalised care in the NHS. Contextual data was analysed using thematic analysis to highlight salient themes.

Measures
The four outcome domains were captured via Likert-type items scored 1-3 (Understanding, Confidence, Motivation, Incorporation into Practice). Post-course surveys also included the Intentional Value Scale. The follow-up survey assessed confidence, frequency of skill use, perceived effects on patient/carer interaction, work satisfaction, perceived effectiveness, work environment and intent to continue using skills.

Statistical analysis
Difference distributions (post–pre) were tested for normality (Shapiro–Wilk). Given non-normality in the differences for the four domains, Wilcoxon signed-rank tests assessed paired change by course and domain, with effect sizes reported as r. Where distributions were normal for specific Junior Doctor items, non-parametric testing was retained for consistency across domains. Engagement timing was analysed descriptively.

Qualitative analysis
Open-text reflections from pre- and post-course surveys (over 10,000 entries across questions for two key questions) were thematically categorised using structured prompts. Due to volume, a proportion were machine-assisted to cluster responses by recurrent concepts (e.g., patient-centredness, SDM, communication skills, application to practice). Stakeholder insights were derived from semi-structured interviews (n=4 participants) and analysed using reflexive thematic analysis.

Ethics
The study received a favourable opinion from Imperial College Research Ethics Committee (ICREC #7084703). All survey and interview data were anonymised; storage and processing complied with GDPR.

3. Results

Reach and engagement
Across seven and a half months, PCI training achieved substantial reach across roles and regions. Course registrations and completions were highest for SDM and PCSP; completion rates ranged from about 58% (Maternity PCSP) to 80% (PCSP), with high learner satisfaction across modules (average=4.3/5; high-satisfaction responses=76-82%). Engagement was predominantly within working hours, with mean completion times clustered between 13:40 and 14:10 and median times between 13:36 and 14:11; junior doctors showed the widest spread, consistent with variable schedules.

Professional groups most represented across courses included Care Coordinators, First Contact/Physiotherapists, Physiotherapists, Social Prescribers and midwifery staff for the maternity curriculum. This mix reflects both ARRS roles and clinical teams engaged in integrated primary care.

Change in learning outcomes (paired analysis)
Across the six modules and four domains, 28 of 30 pre to post comparisons increased (26 significantly; 2 nonsignificantly). One comparison, Motivation in the Junior Doctor module, decreased slightly and nonsignificantly. Effect sizes were largest for Confidence (r often ≥0.6) and Understanding (r usually ≥0.5), with smaller but positive effects for Incorporation and Motivation.

1. **Core Skills (n=830 paired for domains):** Understanding r=0.61; Confidence r=0.67; Motivation r=0.25; Incorporation r=0.31; all increases significant.
2. **Shared Decision Making (n=1,204):** Understanding r=0.57; Confidence r=0.63; Motivation r=0.28; Incorporation r=0.34; all increases significant.
3. **Personalised Care & Support Planning (n=1,016):** Understanding r=0.62; Confidence r=0.66; Motivation r=0.20; Incorporation r=0.33; all increases significant.
4. **Remote Consultations (n=149):** Understanding r=0.49; Confidence r=0.59; Motivation r=0.29; Incorporation r=0.19; all increases significant.
5. **Leading Personalised Care as a Junior Doctor (n=25):** Understanding r=0.58 (↑, significant); Confidence r=0.63 (↑, significant); Motivation r= –0.09 (↓, non-significant); Incorporation r=0.40 (↑, non-significant). Supplementary normality testing showed mixed distributions; the small, non-significant negative change in Motivation likely reflects random variation in a small sample.
6. **Maternity, PCSP (n=61):** Understanding r=0.61; Confidence r=0.63; Incorporation r=0.35; all ↑ significant; Motivation ↑ small and non-significant.

These findings show that PCI modules delivered large, consistent gains in knowledge and self efficacy (Understanding and Confidence). Reported readiness to translate learning into practice (Incorporation) and Motivation also improved, though with smaller effect sizes, suggesting contextual constraints on immediate behaviour change.

Three-month follow-up (applied value)
Among follow-up respondents, 81.7% agreed or strongly agreed they felt confident in their skills; 69.1% reported frequent use of course learning; 71.6% perceived improved patient/carer interaction; 61.4% perceived improved work satisfaction; 67-72% indicated improved effectiveness or environment for practice; and 76.9% were sure they would continue

using their skills. Due to missing identifiers, only a subsample could be linked to specific courses and no respondent-level linkage to pre/post was possible. These constraints limit causal inference but align with early application and sustained intent.

Su**mmary of changes across key domains**

- **Immediate value:** PCI achieved broad national reach and high engagement. Over 8,000 professionals completed courses, with satisfaction averaging 4.3/5 and completion rates up to 80%. Learners valued concise, relevant modules that fit within work hours, showing strong accessibility and relevance.
- **Intentional value:** Motivation and intent to apply learning increased significantly. Around two-thirds of learners reported high intent to change practice, particularly through shared decision-making, goal setting, and patient-centred communication. PCI reinforced professional values and provided tools such as BRAN to support implementation.
- **Realised value:** At three-month follow-up, most participants reported sustained confidence (82%), regular skill use (70%), and improved patient interaction and satisfaction. Learners described tangible changes in communication and teamwork despite time and system pressures. These outcomes demonstrate that PCI training produced measurable, durable behaviour change across the workforce.

Free-text reflections (pre and post)

Across 6,606 responses on “what personalised care means” and 3,786 on “key learnings,” themes were coherent with course aims:

- Definitions (Q06): Patient centredness and equity, SDM and capability framing dominated, with course specific emphases (e.g., digital modalities in Remote Consultations; perinatal context in Maternity).
- Anticipated/actual learning (Q12): Skill acquisition was primary, especially active listening, structured conversations, Benefits, Risks, Alternatives, doing Nothing (BRAN), agenda setting and goal-oriented planning. Application to routine work featured strongly, alongside requests for more interactivity and role specific examples.

Postc ourse reflections described shifts in professional practice (adaptability, role clarity), communication (listening, asking better questions) and patient engagement (respecting preferences, SDM). Reported barriers included time pressure, uneven team buy in and occasional platform friction (e.g., sliders). Learners valued bite sized modules, flexible access and real-world case content.

Stakeholder interviews and focus groups

Four stakeholders (a Personalised Care Champion, a Personalised Care Lead (NHSE), an independent Consultant in Public Health & Social Prescribing, and a Clinical Pharmacist) described PCI as a trusted national enabler with a standardised curriculum and strong user satisfaction. They also noted systemic headwinds including policy churn, the imminent dissolution of NHS England and dashboards, diminished CPD budgets and the risk that PCI appears overly clinical to social care and VCSE audiences. Stakeholders advocated for PCI to act as a strategic convener, whilst looking at ways extend cross sector pathways and reestablish even higher visibility through metrics, partnerships and targeted content (e.g. digital health, trauma informed care, work and health).

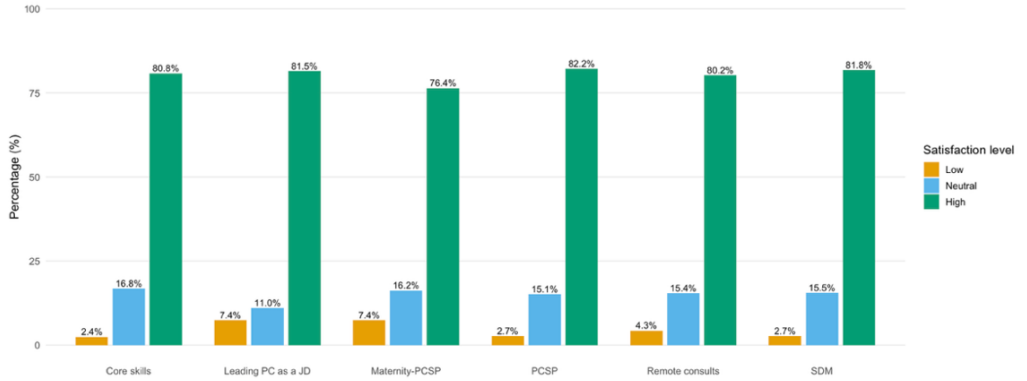

Figure 1: Satisfaction distribution by course (proxy for Immediate value)

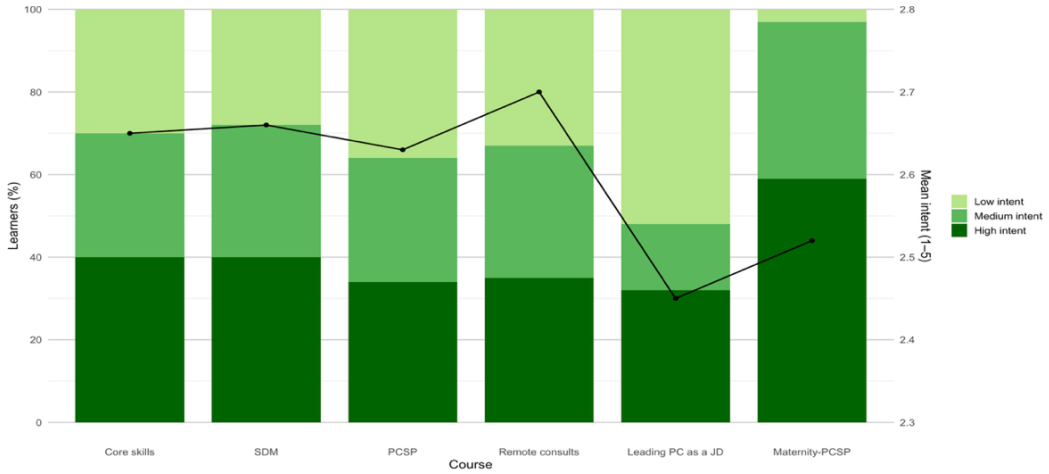

Figure 2: Intentional value (intent to change) distribution by course

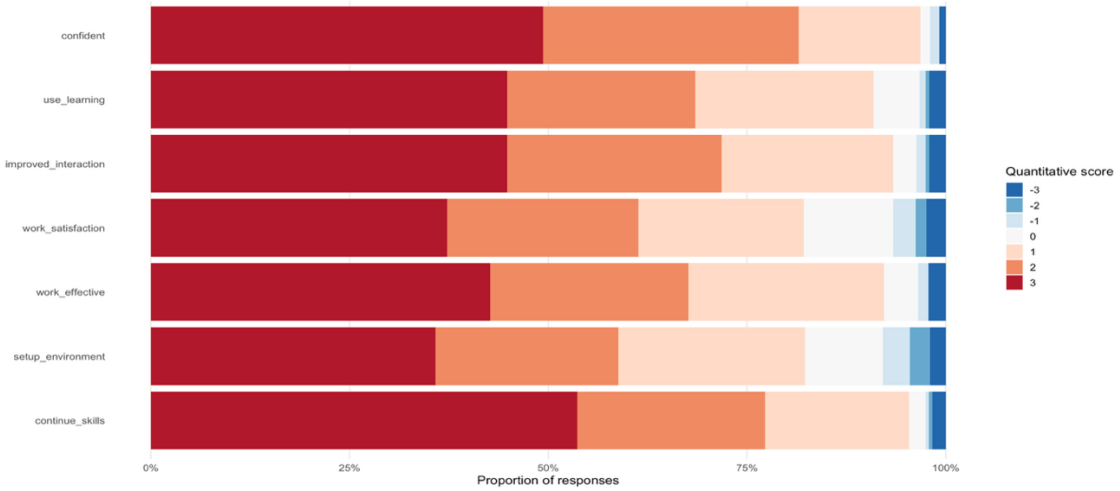

Figure 9: Applied values related to attending the courses collectively (from responses to: 'Did practitioners apply their learning in practice?)

4. Discussion

Summary of principal findings

This objective national evaluation by a third-party academic partner shows that PCI training is effective in strengthening the capabilities needed for personalised care. Large and significant gains in Understanding and Confidence across all modules indicate robust educational value. Positive movement in Motivation and Incorporation confirms intent and early translational behaviours, tempered by the realities of clinical workload, team culture and organisational readiness. Follow up findings support sustained confidence and use in practice. The results align with evidence that structured education improves SDM competence and person-centred communication but also echo a recurrent finding in implementation research: training alone is insufficient without system support. The qualitative corpus emphasises time, managerial endorsement and whole team adoption as preconditions for behaviour change at scale. Stakeholder testimony further highlights post 2024 disinvestment, the removal of regional leadership and lost performance visibility as risks to momentum.

Three cross-cutting insights emerge:

1. **Four dimensions of value are present and interdependent.** Immediate reach, intent to change, early application and enabling context must be advanced together. PCI demonstrably delivers the first three; system actors must underwrite the fourth.
2. **Digital first delivery works for scale and equity** but requires continued attention to interactivity, accessibility and job specific relevance. Learners request more simulation, lived experience inputs and sector tailored scenarios.
3. **The personalised care narrative must extend beyond the NHS clinical frame.** Social care, public health, education, housing and VCSE roles share responsibility for person-centred support. PCI can anchor a shared competency language across sectors.

Consolidated Findings by Value Domain

- **Immediate value.** PCI reached thousands of learners across roles with high completion and satisfaction. Afternoon engagement peaks suggest incorporation within working hours, whereas junior doctor variability mirrors rota realities. The platform's flexible, modular design likely supports scale and accessibility.

- **Intentional value.** Motivation to apply learning was high at baseline and increased post course in most modules. Learners articulated specific intentions around SDM conversations, agenda setting and goal oriented PCSP, indicating internalisation of principles as practical method.

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Implications for Policy and Practice

- **Reembed personalised care in workforce policy.** Integrate PCI recognised competencies within the NHS Long Term Workforce Plan and ICS workforce strategies; link to appraisal, revalidation, induction and CPD funding. Without policy signals, training uptake and application will remain uneven.
- **Restore monitoring and accountability.** Re-establish a national dashboard for personalised care education and practice (e.g., training completions, SDM/PCSP activity, downstream experience metrics). Require ICB reporting and align indicators with contracts and quality frameworks to incentivise adoption.
- **Back whole team capability.** Commission team based reflective practice, supervision for ARRS roles and protected learning time. Embed personalised care prompts and fields in EPRs to make personc entred work visible.
- **Extend beyond clinical audiences.** Develop PCI pathways for social care, VCSE, public health and education; partner with Skills for Care, local government and OHID. Tailor content and language to non-clinical contexts and community assets.

Actionable insights for the consideration of PCI commissioners

Several actionable insights are proposed for the consideration of commissioners to help scale the PCI offer by 2030 and beyond.

Domain	Recommendation
Curriculum and delivery	• **Codesign new strands** on digital personalisation, trauma informed care, mental health pathways, multimorbidity/polypharmacy and work and health. • **Build sector specific tracks** for social care, VCSE/community roles, public health, education and pharmacy, each with relevant cases and scenarios. • **Increase interactivity** via simulations, microlearning refreshers and lived experience video banks to reinforce application and retention. • **Modular certification** to help learners assemble role aligned portfolios mapped to national capability frameworks.
Data and evaluation	• **Reinstate a national dashboard** linking learning analytics to proxy outcomes (e.g., patient/carer experience measures where available). • **Embed fields in clinical systems** to flag SDM/PCSP interactions, enabling visibility and feedback loops for teams. • **Plan longitudinal evaluation** at 6–12 months with 360-feedback and, where feasible, linkage to service and experience indicators.
Partnerships and positioning	• **Act as a strategic convener.** Lead an annual national learning summit on personalised care; curate cross sector dialogue and share practice. • **Strengthen cross platform signposting** with NHS Learn, Skills for Care and ICS hubs to raise visibility among non-NHS roles. • **Explore international affiliates** to adapt the PCI model for other systems while sustaining core UK access.

Strengths and Limitations

This is the most comprehensive evaluation of PCI learner impact using a large national dataset with 2,473 matched pre post responses across six modules. The research was ethically

approved and employed a consistent analytic approach including triangulation across surveys, free text reflections and stakeholder interviews, and realworld settings and roles to enhance external validity.

The principal limitation of this evaluation is that all outcomes were self reported. Other limitations are that (i) the three-month data lacked unique identifiers for respondent level linkage and had partial course attribution; (ii) the small n in junior doctor analyses introduces imprecision, and (iii) there was no direct linkage to patient level outcomes. These constraints temper causal claims about sustained practice change and downstream impacts but do not change the main finding that the PCI has demonstrably delivered measurable, system relevant educational value at scale.

Future Research and Development

- **Develop the Personalised Care Outcomes and Readiness Assessment (PERSONA)** tool to help quantify the quality, consistency and experience of personalised care across health, social care and community settings, focusing on key dimensions such as shared decision-making, care planning, activation and system responsiveness
- **Sustainability of practice change.** Track behavioural indicators at 6-12 months with team-based observation or 360-feedback, focusing on SDM quality and care-planning behaviours.
- **Patient level impact.** Where feasible, relate training exposure to patient/carer experience metrics pertinent to SDM and PCSP.
- **Cross sector comparators.** Compare uptake and effect across clinical, social care, VCSE and public health settings to optimise tailoring.
- **Digital-first contexts.** Evaluate skills use in remote/asynchronous care and the influence of digital inclusion on personalised care delivery.

Practical Actions for Commissioners and Systems

- **Commission whole team PCI training** for services implementing SDM and PCSP, paired with protected time and supervisory structures for ARRS roles.
- **Mandate PCI recognised competencies** within ICS workforce plans, local induction and provider appraisal cycles; align CPD funds to these competencies.
- **Rebuild monitoring** via a light touch national dashboard and ICB returns; include indicators for training uptake and practice enactment.
- **Embed personalised care fields** in EPRs and templates to make SDM and PCSP visible and auditable.
- **Fund sector specific content** for social care, public health, VCSE and education, recognising cross system responsibility for person centred support.

Looking to the future

The strategic and policy implications arising from this evaluation make clear that while PCI has delivered measurable educational value, unlocking its full system potential depends on sustained investment, governance reform, and alignment with the NHS Long Term Plan's Three Shifts (from hospital to community, from analogue to digital, and from illness to prevention).

By 2035, PCI is well positioned to serve as the anchor institution for person-centred workforce transformation, bridging the health, social care and community sectors. It I recommended to repositioning PCI within the Three Shifts through workforce capability building, digital learning innovation and population-level empowerment.

SHIFT 1: From hospital to community: building community capability and multidisciplinary cohesion

The NHS's renewed commitment to move care closer to home reinforces the need for a workforce trained in person-centred, preventive and relational approaches. PCI can act as the convenor of this transition by equipping professionals across settings (e.g primary care, social care, public health & VCSE) with the skills to support personalised care and self-management in the community. Future PCI curricula should integrate modules on community-based personalised care, social prescribing and collaborative neighbourhood working, aligned with ICS place-based priorities. By embedding personalised care capabilities within community teams, PCI can directly contribute to the shift away from hospital dependency and towards population wellbeing.

SHIFT 2: From analogue to digital: enabling workforce readiness for a hybrid health system

Digital transformation is central to the 10-year NHS plan. PCI's digital-first training infrastructure provides a ready vehicle to upskill the workforce for the next generation of care delivery spanning telehealth, remote monitoring and AI-enabled shared decision-making tools. Future learning pathways should explicitly support digital inclusion, data literacy and safe digital communication, ensuring that professionals can engage patients confidently in technology-mediated care. PCI can partner with the NHS Digital Academy, Skills for Care and ICS digital leads to co-develop "Digital Personalisation" modules, preparing staff for a world where compassionate, person-centred care is increasingly hybrid.

SHIFT 3: From illness to prevention: reframing personalised care as population health

The NHS plan calls for a fundamental reorientation towards prevention, underpinned by self-care, health literacy and early intervention. PCI's educational mission aligns with this ambition by embedding preventive mindsets and health-coaching competencies into everyday practice. By 2035, PCI should expand its focus to include behavioural science, lifestyle medicine, and motivational interviewing as core components of personalised care education. These disciplines reinforce self-efficacy, autonomy and community empowerment which are key to shifting the workforce from reactive treatment to proactive health creation.

5. Conclusion

PCI has delivered measurable, system relevant educational value at scale. Across six modules and thousands of matched observations, learners reported significant gains in understanding and confidence and meaningful improvements in motivation and readiness to apply personalised care. Three-month follow-up findings indicate continued confidence and frequent use of skills. The platform's modular, digital first model enables reach and its standardised curriculum provides a coherent foundation for workforce transformation.

Sustained impact depends on system conditions. To move from individual capability to routine practice, commissioners and leaders should reinscribe personalised care into workforce policy, restore monitoring infrastructure, support whole team application, extend learning beyond the NHS clinical frame to widen provision while safeguarding quality. PCI can then operate not only as a provider of training, but as a strategic convener of cross sector competence, standards and data, an anchor for the cultural and operational shift toward personalised, preventive, relationship-based care.