

Personalised Care and Support Planning (PCSP) Checklist

Incorporating:
Guide to counting PCSP

DRAFT

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Guide to Personalised care and support planning

What is Personalised Care and Support Planning?

Great personalised care and support planning is about having a different kind of conversation about health and care, which is focused on what matters to the person as well as their clinical and support needs. This leads to a single plan that is owned by the individual and accessible to those supporting the person.

Getting personalised care and support planning right is essential for people to gain more choice and control over their life and the support they are receiving to manage their health.

The [NHS Long Term Plan](#) (LTP) sets out an ambitious target for the implementation of the Comprehensive Model for Personalised Care. Personalised care and support planning is one of the six components which make up this model. [Universal Personalised Care](#) details how this will be achieved, setting an ambitious but achievable target of 750,000 personalised care and support plans developed by 2023/24.

Overall, Systems have already outperformed against these targets smashing the LTP target by 2021/22. This was, in part, due to the contribution of Maternity services and the work undertaken through Better Births on their data system. Systems are encouraged to now build on this work by spreading PCSP and PCSP approaches across all priority services and pathways.

Personalised care and support planning is a series of facilitated conversations in which the person, or those who know them well, actively participates to explore the management of their health and well-being within the context of their whole life and family situation.

The process recognises the person's skills and strengths, as well as their experiences and the things that matter the most to them. It addresses the things that aren't working in the person's life and identifies outcomes and actions to resolve these.

Introducing and defining the 5 criteria.

NHSE&I have developed a [set of criteria](#) which articulate the definition of a PCSP, and provides strong quality indicators for personalised planning. We did this because it is not possible to develop a national template that would meet the needs of all parts of the system or clinical pathways where PCSP may be embedded.

These criteria have been coproduced with people with lived experience and clinicians and demonstrate what is required from a personalised care and support planning experience rather than seeking to adopt a one size fits all approach.

The five criteria are:

1. People are central in developing and agreeing their personalised care and support plan including deciding who is involved in the process
2. People have proactive, personalised conversations which focus on what matters to them, paying attention to their needs and wider health wellbeing
3. People agree the health and wellbeing outcomes they want to achieve, in partnership with the relevant professionals

4. Each person has a sharable personalised care and support plan which records what matters to them, their outcomes and how they will be achieved
5. People have the opportunity to formally and informally review their care plan.

What do we mean by each of these criteria?

The information below intends to provide clarity on what should be in place for each of these criteria and therefore for the planning process and the resulting plan. The format provides a best practice statement followed by the key elements that should be in place to meet that criteria and a statement as to when systems could not count a PCSP. There are also links to examples of what this looks like in practice.

1. People are central in developing and agreeing their personalised care and support plan including deciding who is involved in the process.
Best Practice Statement: The person owns their plan and was central to creating it. They were involved in its development as an equal partner. They were well prepared, knew what to expect and had information that met their individual information needs. They are regularly involved in reviewing it and they can share it as they need or wish. A range of resources / advocacy / peer support / family / brokerage were made available to the person to support the development of the plan.
Therefore, to count this element as contributing to a PCSP we should see:
<ul style="list-style-type: none"> • The person is well prepared for the planning process, receiving information in a way that meets their information needs, about the purpose of the plan, how the process will take place and who will be involved. • The person has chosen who will be involved in the planning process. The professionals involved in the planning process are prepared and have the right information for the process i.e. test results, information about eligibility etc. • There are a range of resources available to support the person with the development of their plan, including resources that support them to develop the plan themselves, and peer support.
You could not count it as a PCSP if:
<ul style="list-style-type: none"> • The person was not involved in writing the plan, didn't have the opportunity to involve people they wished to be involved and were given no information to prepare them for the planning process.

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2. People have proactive, personalised conversations which focus on what matters to them, paying attention to their needs and wider health and wellbeing
Best Practice Statement: The person feels fully involved and the process is explorative and empowering. It captures what matters to them in the context of their whole life and explores what support will help them stay well and live the life they want.

Therefore, to count this element as contributing to a PCSP we should see:
<ul style="list-style-type: none"> • The planning conversation starts with what matters to the person, the things that make life good. This could include information about important people, significant routines & rituals and important possessions. The things which worry them about their condition(s) and how they manage them.
<ul style="list-style-type: none"> • Then the conversation looks at the support the person needs to manage their condition(s). This includes what they do on a day to day basis to manage their condition(s), prevent a deterioration of their condition(s) and what to do and who to speak to, if a deterioration occurs.
<ul style="list-style-type: none"> • During the conversation the person is listened to and understood in a way that builds a trusting and effective relationship taking account of the persons health literacy, skills, knowledge and confidence.
You could not count it as a PCSP if:
<ul style="list-style-type: none"> • The conversation does not include a discussion about what matters to the person and only looks at what is wrong with the person, focusing on their needs but not within the wider context of their whole life. It would also not be counted if the person does not feel listen to or their health literacy skills, knowledge and confidence have not been taken into account.

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3. People agree the health and wellbeing outcomes they want to achieve, in partnership with the relevant professionals
Best Practice Statement
The plan is written by the person themselves, if they wish to (with support if required) in their own words and language. The outcomes are developed in partnership with professionals and address what is important to the person to achieve as well as meeting their clinical needs.
Therefore, to count this element as contributing to a PCSP we should see:
<ul style="list-style-type: none"> • The person develops health and wellbeing outcomes in partnership with the relevant professionals.
<ul style="list-style-type: none"> • The outcomes are based on what the person wants to change, or achieve, not just what professionals think they should achieve.
<ul style="list-style-type: none"> • The whole plan is written from a personal perspective that reflects the person rather than in a language more familiar to the service or system.
<ul style="list-style-type: none"> • The plan evidences a balance between the persons needs in the context of their whole life and the support (clinical or otherwise) needed to manage their condition(s).
You could not count it as a PCSP if:
<ul style="list-style-type: none"> • If the plan is not written from the person's perspective or is written in a way more aligned with the service or system. It would not be counted if the outcomes in the plan did not reflect what the person wanted to achieve and were written by professionals and not in partnership with the person.

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4. Each person has a sharable personalised care and support plan which records what matters to them, their outcomes and how they will be achieved

Best Practice Statement

The plan contains a description of what matters to the person, the support they require, the outcomes they want to achieve and an action plan to achieve them. The plan is available in a variety of formats, based on what the person needs, including digital options and is fully sharable and editable by the person.

Therefore, to count this element as contributing to a PCSP we should see:

- A clear record of what matters to the person e.g. information about important people and how they stay connected to them, significant routines etc.
- A clear record of the support they need to manage their condition, including what they will do for themselves, what family and friends may be able to do and then what other support they require.
- A clear record of the agreed outcomes and actions
- A clear record of contingency plan, risk arrangements and treatment escalation, where these are relevant.
- If the person has a personal health budget or integrated budget, then a budget sheet detailing how the budget will be spent must be included in the plan.
- It must be editable and sharable by the person and relevant others and in a range of formats

You could not count it as a PCSP if:

- There was no clear record of what matters to the person, and the agreed outcomes and actions from the planning conversation. It would not be counted if the plan could not be shared with all those involved in the person's care.

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5. People have the opportunity to formally and informally review their care plan.

Best Practice Statement

The plan is available to view, edit and review when the person wants to, both formally and informally.

Therefore, to count this element as contributing to a PCSP we should see:

- The plan is reviewed on an annual basis, or as required by statutory guidelines.
- The person is able to informally review their plan when they want, with those supporting them and they know how to do this. e.g. how to access electronic versions, contacting their care coordinator, etc.
- The person knows they can request a formal review if their situation changes and how to do this.

You could not count it as a PCSP if:

- The person was not able to review and edit their plan informally when they needed to and did not know how to request a formal review.

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Counting Personalised Care and Support Plans

Personalised care and support planning is one of 30 Long Term Plan Metrics set out in order to support and monitor the achievement of the targets outlined in the Long Term Plan and Universal Personalised Care. Systems are required to count the number of **new** and **reviewed** PCSP, that meet the 5 criteria, on a quarterly basis.

Mechanisms for counting personalised care and support plans

Here is some information to support the collection of PCSP metrics

Personalised care and support planning (PCSP)	The number of personalised care and support plans (PCSP) agreed in the reporting period	1187911000000105 Personalised care and support plan agreed (finding)
	The number of patients who have received a review of their Personalised care and support plan in the reporting period	1187921000000104 Review of Personalised care and support plan (procedure)

There are several other data sets that will be used to capture PCSP activity in local systems, they are:

Maternity Services Data Set - A new version of this data set has been in use since April 2019 (MSDSv2). This includes a tick-box for “personalised care plans”, the definition for which is taken from Better Births and which we have assured to be consistent with the key features of PCSP.

Cancer - COSD - The national cancer team have developed a new set of Living With and Beyond Cancer data items to be included in the new COSD version 9 dataset, Which all trusts will be required to submit person-level data for all people with cancer on whether a HNA and a PCSP have been (a) offered (b) completed (c) point-in-pathway (d) profession of person conducting the HNA or PCSP.

Quality and Outcomes Framework (QOF) – The following QOF indicators may be used for counting purposes:

Dementia - DEM004: Percentage of **dementia** patients with a face-to-face reviewed care plan within the last 12 months (face-to-face by GP practice).

Stroke – six-month review (PCSP) (SSNAP database) and annual review in primary care. These reviews take place using the Stroke Association’s review specification.

Mental health – MH002 - care plans.

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Appendix 1 - Best practice examples

Criteria 1: People are central in developing and agreeing their personalised care and support plan including deciding who is involved in the process.

Preparing Olivia

To help Olivia prepare for the different conversation, her family and staff at school helped her to take some photographs of the things that matter to her so that she could share them at her planning meeting.

Olivia and her family wanted to include some of their close friends in planning with Olivia, but they couldn't be there - the person supporting Olivia to plan, wrote down some questions in a short booklet so they could contribute that way.

At school, Olivia's speech and language therapist prepared some social stories about the process of planning and also about the planning meeting that Olivia was going to have so she knew what to expect and everyone thought carefully about how to prepare for the meeting so that it would work best for Olivia.

Think Local Act Personal (TLAP)

Think Local Act Personal have developed a Personalised Care and Support Planning tool, that explores different stages of the personalised care and support planning process, through a number of different personas. Links from these resources will be used throughout this document.

Click the link below to see how Kathy and those around her prepared for her planning conversation.

<https://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/preparation/kathy/>

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Criteria 2 - People have proactive, personalised conversations which focus on what matters to them, paying attention to their needs and wider health and wellbeing

Examples:

Think Local Act Personal (TLAP)

Click the link below to see how Jim had his planning conversation.

<https://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/conversation/jim/>

Cancer Support

Macmillan Cancer Support have embedded six simple questions into the electronic Holistic Needs Assessment, in order to personalise the conversation had with any cancer patient about the support they require. These questions are:

Who are the most important people in your life? How often do you see them and what do you like to do together? (This could be partners, family, friends or even pets!)

What would make a good day for you? (Think about all the elements that would make up a good

day, like who you would be with and what you would do.)

When you are having a bad day what can help to make it better? (think about the things that you or others can do to help you if you are having a bad day)

What are the daily or weekly things you enjoy doing? (Think about the important activities and routines that you have)

What would you never leave home without? (Think about the important possessions you have and always like to have with you)

What do you think the people who know you well would say your best qualities are? (for example, sense of humour, honesty, loyal friend, kind and caring)

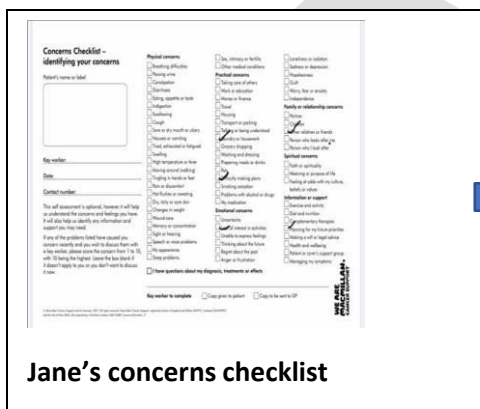
A cancer support service in Yorkshire piloted the questions in the support they offer. The questions, along with a concern's checklist, were sent in advance to the person for them to think about them and then discussed at the first meeting. From there a plan was formulated to provide support & guidance re the issues concerning them. One person described feeling like the session was a friendly chat more than assessment.

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Criteria 3 - People agree the health and wellbeing outcomes they want to achieve, in partnership with the relevant professionals

Examples:

Within cancer services a personalised care and support plan is developed based on completing a Holistic Needs Assessment (HNA) with the person. The HNA process includes finding out what matters to the person and completing the concerns checklist. This checklist is then used to guide the conversation and subsequent plan, to identify the things that are concerning the person and what they might want to change or achieve in relation to that. From this, clear outcomes and actions can be developed. See the example below to illustrate this:



The image shows a 'Concerns Checklist - Identifying your concerns' form. It includes a header with the title and a sub-header 'Identifying your concerns'. Below this is a large empty box for 'Person's name or label'. There are sections for 'Age range', 'Date', and 'Contact number'. The main body of the form is divided into several columns of checkboxes, including 'Physical concerns', 'Mental concerns', 'Social concerns', 'Information concerns', 'Practical concerns', 'Spiritual concerns', 'Religious concerns', 'Cultural concerns', 'Language concerns', 'Communication concerns', 'Transport concerns', 'Financial concerns', 'Work concerns', 'Housing concerns', 'Travel concerns', 'Food concerns', 'Clothing concerns', 'Personal care concerns', 'Medicine concerns', 'Treatment concerns', 'Side effects concerns', 'Pain concerns', 'Symptoms concerns', 'Diagnosis concerns', 'Prognosis concerns', 'Future concerns', 'Support concerns', 'Information concerns', 'Practical concerns', 'Spiritual concerns', 'Religious concerns', 'Cultural concerns', 'Language concerns', 'Communication concerns', 'Transport concerns', 'Financial concerns', 'Work concerns', 'Housing concerns', 'Travel concerns', 'Food concerns', 'Clothing concerns', 'Personal care concerns', 'Medicine concerns', 'Treatment concerns', 'Side effects concerns', 'Pain concerns', 'Symptoms concerns', 'Diagnosis concerns', 'Prognosis concerns', 'Future concerns', 'Support concerns'. At the bottom, there are checkboxes for 'Have questions about my diagnosis, treatment or other', 'Need further samples', 'Check your contact', and 'Check the service'. The form is titled 'Jane's concerns checklist' at the bottom left.

What is not working/what is the specific concern

Pretending that nothing is wrong - ignoring the cancer altogether.

Offering 'vague' help - when I am at the point when I need the help I won't ask.

Keeping me involved in what's going on, still invite me to things – don't make decisions on my behalf.

Outcome

To feel comfortable asking for specific help when I need it and to not feel I am a burden to people. For example, help with food shopping or cleaning the house.

Actions

Jane to be more specific about the help that she needs and when she needs it.

Jane to ask her friends to be more specific about what help they can offer and when

Think Local Act Personal (TLAP)

Click the link below to see the outcomes Alex discussed as part of her planning conversation:

<https://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/conversation/alex/>

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Criteria 4 - Each person has a personalised care and support plan which records what matters to them, their outcomes and how they will be achieved – in a digital format where possible.

Examples:

One Page profiles

One way of capturing the information about what matters to the person is a one page profile. A one page profile isn't a full PCSP because it doesn't include outcomes and actions, but it makes a great front page for a PCSP and can be detached and shared by the person, so they do not have to keep sharing their story. See annex 1 for information about one page profiles and click on the link below to see examples:

<https://onepageprofiles.wordpress.com/>

Personalised Wellbeing Plan

A personalised wellbeing plan is an example of a PCSP template with a specific format and developed for a specific reason. In this case it was developed to support those shielding due to COVID-19 and/or waiting for elective treatment. For those who are no longer shielding but may still need support, a plan that looks at the whole of a person's life would need to be developed. See annex 2 for the personalised wellbeing plan template and click on the link below for the guidance to developing the plan.

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Criteria 5 - People have the opportunity to formally and informally review their care plan.

Think Local Act Personal (TLAP)

Click below to see how Jim and Millie reviewed their personalised care and support plans:

<https://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/review/jim/>

<https://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/review/millie/>

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