Personalised Care and Support Planning (PCSP) Framework

Defining and implementing quality personalised care and support planning

Enter

January 2023

Contents

Foreword

The NHS Long Term Plan recognises personalised care as one of the five major practical changes to the NHS to ensure we have a service that is fit for the future. This means people will get more control over their health, and more personalised care when they need it, including being fully involved in planning their care, based around their own personal skills and strengths and how they want to live their lives.

Personalised care and support planning, done well, empowers people to take control of their own health and wellbeing, gives them options to improve their own quality of life and encourages them to engage in a plan that they made for themselves, in turn improving their own health care outcomes.

It provides improved opportunities to create a well engaged and motivated workforce who value their own job satisfaction and see improvement in their clinical performance as engaged patients result in fewer urgent, emergency and repeat admissions meaning workforce have more time to spend with the people who need it the most. It shifts responsibility from workforce being seen as fixers to the patient being in control of their own lives and the management of their own conditions being supported by health care professionals.

Over the last few years, we have seen the successful implementation of personalised care and support planning within a number of key national programmes, including cancer, maternity, stroke, primary care and mental health. For more information about the work in these areas see our FuturesNHS platform.

Introduction

Purpose and scope

The personalised care and support planning framework is designed to support Integrated Care Systems (ICSs) to understand and create the conditions for sustainable implementation of personalised care and support planning, in line with the essential delivery of personalised care within systems. It is intended to support those involved in the leadership, design, development and delivery of personalised care and support planning across all sectors.

ICS's play a pivotal role in supporting partners to deliver high quality personalised care, building on best practice, and realising improved outcomes and experience for those using NHS services. This framework supports collaborative working, offering strategic guidance to all partners, and those using their services, on how PCSP is part of the solution to improve outcomes, tackle inequalities and make best use of resources.

Primary Care Transformation and Integrated Approaches

Both the ICS Design Framework and next steps for integrating primary care: Fuller Stocktake report, outline the expectation for ICSs to work at place level, integrating and co-ordinating the delivery of health, social care and public health services around the needs of the population. By using Public Health Management methods to target populations who would benefit from PCSP, ICS can empower staff to offer care and support that is flexible and innovative and refocus resources to their local priority support offers.

It is not intended that National teams will use the framework to assure progress. However, it can be used to self-assess and self-assure the quality and progress of local systems implementation of personalised care and support planning at scale.

It has two sections, the first defines what a good planning process and the resulting plan looks like from both an individual and workforce view, and the second section provides tools and resources for system implementation and quality improvement.

Section 1 – Introducing and defining the 5 criteria.

This section is designed to introduce the 5 technical criteria for personalised care and support planning, defining what best practice looks like for each criteria and indicating what can and can't be counted as a personalised care and support planning for data purposes.

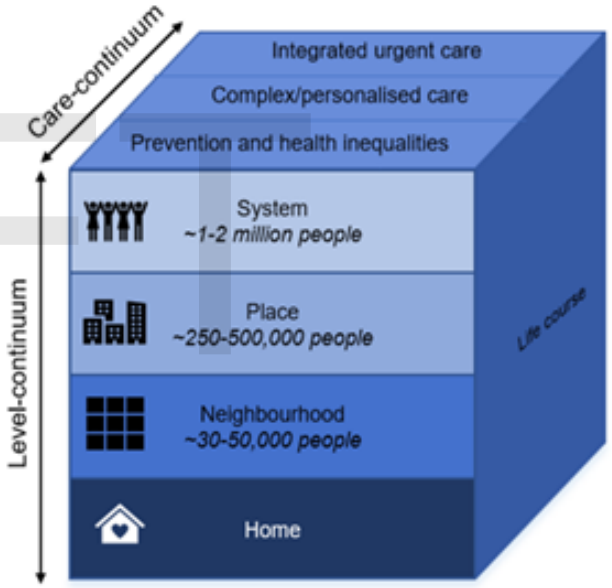
Section 2 - A quality improvement and maturity framework to support the implementation of personalised care and support planning at scale.

This section is designed to provide information on the key enablers to embed personalised care and support planning as business as usual across systems and provide a structure for self assessment of local progress.

Roles and responsibilities in supporting the delivery of PCSPs

ICSs and integrated care boards (ICBs) have a broad range of responsibilities that empower them to better join up health, social care and the voluntary sector to improve population health and reduce health inequalities. This includes supporting commissioners and providers collaborating at place level and through multi-disciplinary teams delivering services and working together across neighbourhood footprints. Below we have outlined the broad roles and responsibilities at each level for embedding PCSP.

Designation	Roles and responsibilities
System	ICB/ICS are responsible for driving quality and sustainable implementation of PCSP in clinical pathways and wider programmes
Place	Responsible for embedding PCSP into system design and planning
Neighbourhood	Integrated neighbourhood teams are accountable / responsible for ensuring that PCSP is used as a point of coordination and continuity of care for anyone who would benefit from personalised care. It should be proportional to need and be part of robust operational practices.
Local	Responsible for delivering PCSP at a local level.
People	People are responsible for actively participating in the development and implementation of their plan, within their capability.



The integrated care cube

Personalised care and support planning explained

Good 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, in turn, leads to a single plan that is owned by the individual and accessible to everyone supporting the person.

Many conversations between healthcare professionals and patients are primarily focussed on the person's health needs. The conversations lack a focus on the wider aspects of a person's life and capturing a record of this. In PCSP you start the conversation from a different point, by finding out what matters or is important to the person in their life before discussing, in any detail, their health. This helps to build a picture of how someone wants to live their life and they are seen through the lens of their whole life situation rather than being seen through the lens of their condition. After this you then look at their health issues and the support they may need with them.

This means the plan has a balance of the things that are important to, or matter to them, and the things that are important for them to pay attention to, or do, to stay as healthy and well as possible.

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 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.

What people say

- "I feel heard for the first time"
- "I feel listened to"
- "I feel seen for the first time"
- "It's not just about keeping me warm and clean its about giving me the life I want to live" ***Anna Severwright***
- "As a person with experience of mental health challenges, I am familiar with the frustrations that result from recounting my story to different professionals. For some people it can be upsetting – traumatising even, as disturbing memories are recounted again and again. Precious time is also spent needing to build trust with a new set of professionals". ***Isaac Samuels***
- I had a series of conversations facilitated by my HCP, where all of my health and wellbeing needs were discussed collectively. We talked about what I wanted to be able to do and agreed a package of support for me, as well as for some members of my family which gave control and balance in my life. It helped me to reduce my caring responsibilities and created space and time for me to care form my own needs and wellbeing as well as the people I cared for. I was able to make sure that when I was ill myself that my family were cared for too. ***Dan, a carer***

Section one
Introducing and defining the 5 criteria

NHS England have developed a set of criteria which articulate the definition of a personalised care and support planning and provide strong quality indicators for personalised planning. This has been done 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 personalised care and support planning may be embedded. These criteria have been co-produced with people with lived experience and clinicians, anddemonstrate 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 over the next few pages provides clarity on what should be in place for each of these criteria, and therefore for the planning process, and the resulting plan as a whole.

The format provides a best practice statement including the key elements that should be in place to meet that criteria and a statement as to when systems could not count a personalised care and support planning. There are also links to examples of what this looks like in practice.

Key care act sections have been highlighted which align with each of the criteria.

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 - what we should see:

- The person owns their plan and is central to creating it as an equal partner.
- The person is well prepared for the planning process including understanding the purpose of the plan. They understand how the process will take place and have been given information in a way that meets their information needs.
- The person is able to choose who will be involved in the planning process, including family & friends that know them well.
- The professionals involved in the planning process are prepared and have the right information available for the process i.e. test results, information about eligibility.
- 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 including peer support, where appropriate.

It should not be described or counted as a personalised care and support planning if:

- The person was not involved in writing the plan, didn't have the opportunity to involve people they wished to be involved, and/or were given no information to prepare them for the planning process.

Examples in practice

Click here to see examples of how this criteria is implemented in practice, including how Olivia was prepared for her meeting in school. You can also explore how the Think Local Act Personal personalised care and support planning tool approaches preparation.

This criteria aligns with the Care Act 2014 section 1 (3)(a-f), section 9 (5)(c), section 25 (3) and (4), section 27 (2)(b)

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 - what we should see:

- 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 conversation should also include the things which worry them about their condition(s) and how they manage them.
- The conversation then 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), what to do, and who to speak to if a deterioration occurs.
- 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.

It should not be described or counted as a PCSP if:

- 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 not be counted if the person does not feel listened to or their health literacy, skills, knowledge and confidence have not been taken into account.

Examples in practice:

Click here to see examples of how this criteria is implemented in practice, including how Macmillan Cancer Support have embedded six simple questions into their electronic Holistic Needs Assessment, in order to personalise the conversation had with any cancer patient about the support they require.

This criteria aligns with the Care Act 2014 section 1 (3)(a-f)

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

Best Practice Statement - what we should see:

- The person develops health and wellbeing outcomes (goals) in partnership with the relevant professionals.
- The outcomes (goals) are based on what the person wants to change, or achieve, not just what professionals think they should achieve.
- 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.
- The plan reflects 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).

It should not be described or counted as a PCSP 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 (goals) in the plan did not reflect what the person wanted to achieve and were written by professionals and not in partnership with the person.

Examples in practice

Click here to see examples of how this criteria is implemented in practice, including how outcomes can be developed from concern's outlined in a holistic needs assessment and addressed through the planning conversation.

This criteria aligns with the Care Act 2014 section 1 (2)(d-i), section 9 (4)(a-c), (6)(a), section 24 (1)(a-c), section 25 (5), section 27 (5)

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 - what we should see:

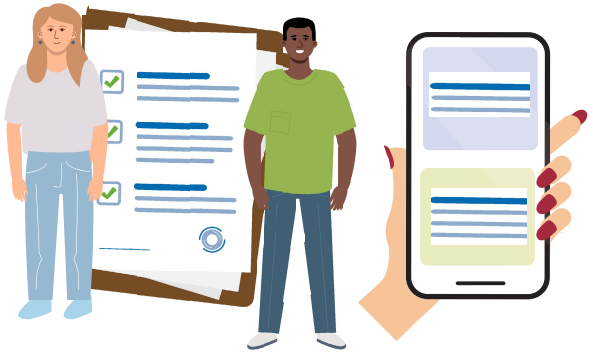
- A clear record of what matters to the person e.g. information about important people and how they stay connected to them, significant routines etc.
- A clear record of the support they need to manage their condition, including what they will do for themselves, what family and friends may be able to do, followed by what other support they require.
- A clear record of the agreed outcomes (goals) 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 available in a range of formats

It should not be described or counted as a PCSP if:

- There was no clear record of what matters to the person, and the agreed outcomes (goals) 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.

Examples in practice

Click here to see examples of how this criteria is implemented in practice, including information about the DAPB 4022 Personalised Care and Support Planning Information Standard that supports the development of digital personalised care and support plans.



This criteria aligns with the Care Act 2014 section 3 (1)(a-c), section 25 (9)(a-c), 10(a-c)

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

Best Practice Statement - what 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.

It should not be described or counted 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.

Examples in practice

Click here to see examples of how this criteria is implemented in practice, including how the Think Local Act Personal Personalised Care and Support Planning Tool suggests reviewing plans should be approached.

This criteria aligns with the Care Act 2014 section 3 (1)(a-c), section 25 (9)(a-c), 10(a-c)

Personalised Wellbeing Plan

A personalised wellbeing plan is a ‘lite’ version of a personalised care and support plan. You can find the resources on our [FuturesNHS platform.]

- It can be used:
  - As a starting point for building a PCSP, or
  - As a standalone plan where a full PCSP may not be a proportionate response

- It can be completed:
  - By the person (with or without support)
  - With clinicians, ACPs, ARRS roles, dedicated other PCN/Acute staff

- It is a template, with guidance, initially developed in response to COVID and supporting the isolating public and has since been further developed for supporting
  - Discharge,
  - Elective waiting lists,
  - Workforce.

- It contains:
  - Information in line with PRSB PCSP standards
  - An action plan
  - Other useful information

- Like PCSP, it means that up to date information about what matters to a person, their skills and preferences, which has been developed and agreed by the person is available to everyone that is involved in their care. This means that the person only needs to tell their story once.

Section two
A quality improvement tool and maturity framework to support the implementation of personalised care and support planning at scale

Implementing personalised care and support planning in Systems, Services or Clinical Pathways

To successfully implement personalised care and support planning as business as usual, and at scale, there needs to be a systematic approach to ensuring that the culture, processes and workforce activity of the organisation, support this. When PCSP has been successfully implemented we know it can bring the following benefits to your system, service or pathway.

- **More time** with the people who need care – PCSP done well results in fewer emergency and repeat admissions to Urgent and Acute care because people are more engaged and active in their own care. This means people are getting the right support at the right time, in the right way for them.
- **Improved clinical performance** – PCSP results in fewer repeat appointments in Primary Care freeing up clinical time to focus on urgent daily episodic care needs of their population.
- Patients who are **engaged in their own health** and care are more likely to continue to improve their conditions or manage them better using supported self management practices and peer support more effectively.
- **Job satisfaction** – workforce report an enhanced sense of achievement in giving what is right and meaningful for patients
- Workforce who are engaging in developing PCSP report feeling better **engaged in their work and more motivated to do their jobs well.**
- **Workforce report being less stressed** reducing the feeling of being responsible for constantly solving people's problems as patients take accountability for their own health and wellbeing actions and activities.
- PCSP shifts the responsibility from clinicians as fixers, **to the person being in control** of their own lives and conditions supported in partnership by clinicians and their wider care teams.
- Workforce feel they have more time to **prioritise** the people who need support the most as frequent attenders reduce.

How this framework is designed

This guide has been developed to share information and provide systems, services & clinical pathways with the opportunity for self-assessment of their progress in relation to implementation of personalised care and support planning specifically. It is not intended to be part of any formal assurance activity by national teams.

The framework is based around 3 core foundations* which are essential in embedding and sustaining improvement actions in complex system change.

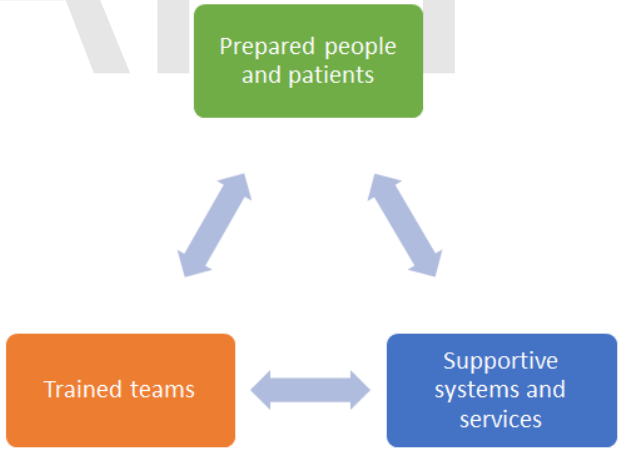
Each of the core foundations is explored in detail over pages 16-22. For each foundation we have set out:

- What this means for people, workforce, and ICBs in the form of a set of 'i' and 'we' statements which have been co-produced with people, workforce, and systems.

- Some key enablers that are significant in supporting the embedding of personalised care and support planning as business as usual within a system or as part of a clinical pathway.

- A maturity matrix which ICBs, systems or clinical pathways can use, that gives an opportunity to assess their view of the baseline in relation to implementing the personalised care and support planning key enablers. This assessment can be used to plan actions for quality improvement and assess progress against the plan - the table to the right of this page explains the levels of maturity we would suggest.

	Level of maturity	Description of maturity
1	Emerging	This element of PCSP implementation is patchy and not currently a priority to develop further across the system.
2	Developing	This element of PCSP implementation is under discussion but not yet in active development.
3	Maturing	This element of PCSP implementation is in active development and in the process of being implemented
4	Embedded	This element of PCSP implementation is fully embedded and will be sustained even in the event of a change of operational or strategic leadership



* This model has been adapted from the outcomes of the MAGIC programme: 'making good decisions in collaboration' developed by the Health Foundation in 2103. This version brings together and consolidates Supportive Systems and Commissioned Services

How you can use this framework

We would suggest engaging with people using your services, and staff at different levels of the workforce, will help get the most useful information from this framework, which in turn can be used to inform quality improvement activity. Here are some ideas that might be useful:

- Single surveys and/or questionnaires for staff and/or people who use the service based on the "I" and/or "we" statements and the key elements of each foundation.
- Mirrored surveys and/or questionnaires based on the "I" and/or "we" statements and the key elements of each foundation:
    - Staff and patients receive the same questionnaire/survey at the same time and the results are compared. This looks for matches and mismatches and identifies whether and where staff and patients have a differing experience.
- Encourage the workforce to identify specific people who use the service to be advocates/experts or ask patient participation and involvement groups to either:
    - undertake questionnaires/surveys.
    - or work with people and/or workforce on specific areas e.g. focus on one or two of the “I” and “we” statements or foundation areas.
- Operate check-in days:
    - Ask every person who uses a service a particular question based on the “I” and/or “we” statements and record the results.
    - Consider using an adapted version of the 15 steps approach [The Fifteen Steps Challenge.]

Prepared People and Patients

What this means for people, ICBs and workforce

People

- I feel that I understand the planning process and what is expected of me, and am happy to engage in it as much as I want.
- I have all the information I need to be able to talk to my clinician about what matters to me to help me live my best life.
- I know what my test results are and understand what they mean,
- I am able to use the information I am given to prepare for my appointment and ask questions about it.
- I can ask for the information in a format that I can use and understand easily.
- I know who else can support me such as peer support groups or local interest groups.
- I know who to approach to get help and advice or where I can find leaflets and posters to help me.

ICBs and workforce

- We see people who are well prepared for the planning process, and they have chosen who to involve in their planning conversation.
- We know how to help people to prepare and can explain the tools/ resources to them in a way they understand, meeting their information needs.
- We regularly update and review personalised care and support planning with people to ensure that it continues to be relevant.
- Feedback from Patient Reported Experience Measures (PREMS) and personalised care and support planning reviews are used in our 1-2-1s and supervision to improve the way we work with people.
- We have policy, processes and resources which support workforce to ensure all elements of a personalised care and support planning have been covered and recorded.
- We have clear strategies, policies and agreed metrics which focus on preparation for planning conversations across all pathways.

Quality Improvement / self assessment against the key enablers

Prepared People and Patients	Enablers for improvement – to successfully implement this element we would expect to see:		Maturity 1	2	3	4	Notes:
	a.	There is a systematic approach to preparing people for their PCSP process. embedded into all systems & pathways, including ensuring that people know and understand the results of tests & assessments before they begin planning.					
	b.	There is a range of services that a person can choose from to get support with the preparation and development of their PCSP. This includes peer support services and services within different settings like primary care and the third sector.					
	c.	There are a range of health literate resources to help people prepare for planning, including digital tools, information letters & leaflets and short films.					

Supportive Systems and Processes

What this means for people, ICBs and workforce

People

- I was fully involved in planning my care.
- I chose who to be involved in my planning.
- I know what I am being asked to do and what my plan will mean to me.
- I had conversations which were about me and what is important to me about my whole life and not just about my health condition.
- I have a plan which includes what is important to me, my goals and wishes, and all of the people involved in my care have access to, and understand, these too.
- My care is planned around what is important to me.
- I was shown my plan and have access to a copy of it that I can change and add to when I think I need to.
- I am invited to give my view about services that are important to me.

ICBs and workforce

- We can manage our services with enough flexibility to spend time developing personalised care and support planning with the people we care for.
- We feel empowered to support people through personalised care and support planning conversations with the patients we are caring for.
- We have enough preparation time to review a persons personalised care and support planning before the appointment.
- Our data systems tell us when someone already has a personalised care and support planning.
- As commissioners we understand what personalised care and support planning and personalised care and support planning approaches are and can demonstrate how we include it in local incentives, pathway redesign etc.
- We see a clear action plan supporting implementation of personalised care and support planning approaches along with agreed deliverables lead by a board level Senior Responsible Officer (SRO) in each Trust and Primary Care Network (PCN).
- Personalised care is a standing agenda item at board level meetings, and operational meetings which include lived experience representatives.
- We have adopted Data Alliance Partnership Board (DAPB 4022) standards in our digital improvement policy and practice.

Quality Improvement / self assessment against the key enablers

Supportive systems and processes	Enablers for improvement – to successfully implement this element we would expect to see:		Maturity 1	2	3	4	Notes:
	a	There is a clear strategy, and action plan for the implementation of PCSP across the system, part of the system or clinical pathway. There is board level leadership driving the strategy and there is a commitment to coproduction.					
	b	There is a vision for Integrated planning that supports the idea of one plan shared across all health and care settings, so the person only has to say something once.					
	c	There is a simple process for agreeing plans, where this is required.					
	e	There is a clear feedback loop to collect information from the development and implementation of PCSPs to co-produce system change.					
	f	There is a personalised approach to reviewing PCSPs.					
	g	There are robust PCSP processes that meet national criteria, embedded in all appropriate clinical pathways & operational models, and PCSP is included in relevant incentive schemes.					
	h	There is an action plan in place to ensure Digital Transformation includes PRSB and DAPB standards.					

Trained Teams

What this means for people, ICBs and workforce

People

- I felt confident that the person who helped me plan my care listened to me and took the time to understand about me and my life.
- Everyone I spoke to uses the same words and language which I can easily understand.
- My health care professional talked about what my choices meant to me and how I manage my condition(s) and wellbeing.
- My health care professional has a 'can do' attitude: If something is important to me they do their best to acknowledge it and make it happen. I understand why, when they are not able to provide exactly what I want and explain clearly to me what I need.
- My health care worker is available to me when I need to change something or if I do not understand my plan.

ICBs and workforce

- We are given time and space to complete Personalised care, personalised care and support planning and conversational skills training
- We are confident and skilled to help people write personal outcomes (goals)
- We listen to understand what is important to the person
- We work with the person and understand how to balance their needs, in the context of their whole life, against their clinical needs, planning solutions around both.
- We provide the environment and opportunities for Trust and PCN staff to engage in personalised care training through co-produced policies
- We support our workforce, through training, to help patients balance what is important to them against what is important for them to manage their health condition optimally.

Quality Improvement / self assessment against the key enablers

	Enablers for improvement – to successfully implement this element we would expect to see:		Maturity				Notes:
			1	2	3	4	
Trained teams	a.	There is a clear workforce strategy based on training staff in the right values, philosophies and skills.					
	b.	Those directly planning with people are trained in how to have a 'what matters to you' conversation, to develop personalised outcomes (goals) and recognise the value of a person's assets, strengths, abilities & networks.					
	c.	There is a person centred approach to risk management that staff are trained in.					
	d.	There is a network of PCSP work based coaches, championing and promoting PCSP approaches within the workplace.					

Contact us

For any further information on this guidance and personalised care and support planning please contact: england.pcsp@nhs.net

Our FuturesNHS platform is a collaboration platform for healthcare colleagues to work effectively and is a safe and secure place to save, access and share resources and content. It has the latest updates and a range of tools and resources to implement personalised care and support planning.