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Personalised care and support planning: a brief summary guide

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Introduction

This brief summary guide supports integrated care systems (ICSs) to understand and create the conditions for sustainable implementation of personalised care and support planning (PCSP) 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 guide 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 the best use of resources.

This guide provides best practice advice, not statutory guidance. However, it can be used to self-assess and self-assure the quality of local systems implementation of personalised care and support planning.

Who this document is for

This summary guide is aimed at people who are leading local implementation of personalised care and support planning within ICSs.

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 multidisciplinary teams delivering services and working together across neighbourhood footprints.

Where local organisations are seeking guidance on how to introduce, deliver or improve their approach to personalised care and support planning, this guide should provide some useful direction and examples to assist in planning local approaches.

It is also relevant to people with lived experience of care and support, and voluntary, community and social enterprise organisations.

What is personalised care and support planning?

Personalised care and support planning aims to ensure a better or different conversation between a person and their health and social care practitioner to create a more equal relationship. The overall aim is to identify what is most important to the person for them to achieve a good life and ensure that the support they receive is designed and coordinated around their desired outcomes.

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 personalised care and support planning you start the conversation from a different point, by finding out what matters or is important to the person in their life before discussing their health in any detail. 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.

The complexity of a person's needs, the number of conditions they manage, the breadth of services they are currently accessing, and their preferences, will influence the type of support they might receive and the level of choice and control they have over managing their health and care. This ranges from being signposted to support for self-care, to people having control over their care

package using a personal health budget or integrated personal budget. At the heart of these different levels of support is a personalised conversation about what matters to them.

Personalised care and support planning: what this looks like for people, families, and systems

NHS England has developed a set of criteria to define 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 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 information under each criteria provides clarity on what the process and resulting plan should look like for people, families and systems. 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 plan.

The five criteria are:

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 and friends who 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 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 including peer support, where appropriate.

It should not be described or counted as a personalised care and support plan 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.

Criteria 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 and 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 personalised care and support plan 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.

Criteria 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 personalised care and support plan 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.

Criteria 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, for example, 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 personalised care and support plan if:

- There is 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 it could not be shared with all those involved in the person's care.

Criteria 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, for example, 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 personalised care and support plan 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.

Ensuring equal access

Promoting equality and addressing health inequalities are at the heart of the values of personalised care. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations

between people who share a relevant protected characteristic and those who do not share it (Equality Act 2010)
- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Personalised care and support planning is an important tool in helping the NHS, local authorities, and partners to meet the needs of all sections of the population, including people who have been poorly served by conventional health and social care services.

More information on personalised care and support planning

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. More detailed information about implementing PCSP can be found on the Personalised care and support planning FutureNHS platform page (https://future.nhs.uk/connect.ti/PCCN/view?objectId=14302832) (login required).

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