Personalised Care and Support Planning (PCSP) Quality Framework

Implementing quality personalised care and support planning

Enter

DRAFT

Tools and resources to check progress against implementation and the quality of the offer for people, systems and clinical pathways

Contents

DRAFT

Introduction

Purpose and scope

The PCSP quality framework is designed to support ICS to understand and create the conditions for the successful and sustainable implementation of personalised care and support planning (PCSP), in line with the performance expectations for the delivery of personalised care within systems. It has a focus on informing and improving operational delivery to:

- Deliver high quality care,
- Improve the experience of those people who have a personalised care and support plan,
- Develop workforce confidence in the delivery and commissioning of high quality PCSP, ensuring value for money.

This in turn will support the four aims of ICS:

- Improve outcomes in population health and health care,
- Tackle inequalities in outcomes, experience and access,
- Enhance productivity and value for money,
- Help the NHS support broader social and economic development.

It is intended to support those involved in the leadership, design, development and delivery of personalised care and support planning across all sectors.

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 against key NHS Long Term Plan Commitments, and annual operational and planning guidance requirements for personalised care and PCSP.

The framework has two sections:

Section 1 – Introducing and defining the 5 criteria.

This section is designed to introduce the 5 technical criteria for PCSP, defining what best practice looks like for each criteria and indicating what can and can't be counted as a PCSP 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 PCSP as business as usual across systems and provide a structure for self assessment of local progress.

DRAFT

Personalised Care and Support Planning explained

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

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.

DRAFT

Section one
Introducing and defining the 5 criteria

DRAFT

NHSE have developed a set of criteria which articulate the definition of a PCSP 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 PCSP 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 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 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

Care Act 2014 section 1(3)(a-f), Section 9(5)(c), section 25(3) and (4), section 27(2)(b) refers

DRAFT

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.

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

- The person is well prepared for the planning process including the purpose of the plan, how the process will take place and who will be involved, receiving information in a way that meets their information needs.
- 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 including peer support, where appropriate.

You could not count it as a PCSP 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.

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

Care Act 2014 section 1(3)(a-f) refers

DRAFT

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.

To count this element as contributing to a PCSP 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 things which worry them about their condition(s) and how they manage them.
- The conversation only 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.

You could not count it 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.

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

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) refers

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 (goals) are developed in partnership with professionals and address what is important to the person to achieve, as well as meeting their clinical needs.

DRAFT

To count this element as contributing to a PCSP 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 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:

- 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.

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

Care Act 2014 section 3(1)(a-c), section 25(9)(a-c), 10(a-c) refers

Best Practice Statement:

- The plan contains a description of what matters to the person, the support they require, the outcomes (goals) 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

DRAFT

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, 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

You could not count it 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.

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

Care Act 2014 section 27(1)(a-b) refers

Best Practice Statement:

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

DRAFT

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.

Section two
A quality improvement tool and maturity framework to support the implementation of Personalised Care and Support Planning at scale

DRAFT

Implementing PCSP in Systems, Services or Clinical Pathways

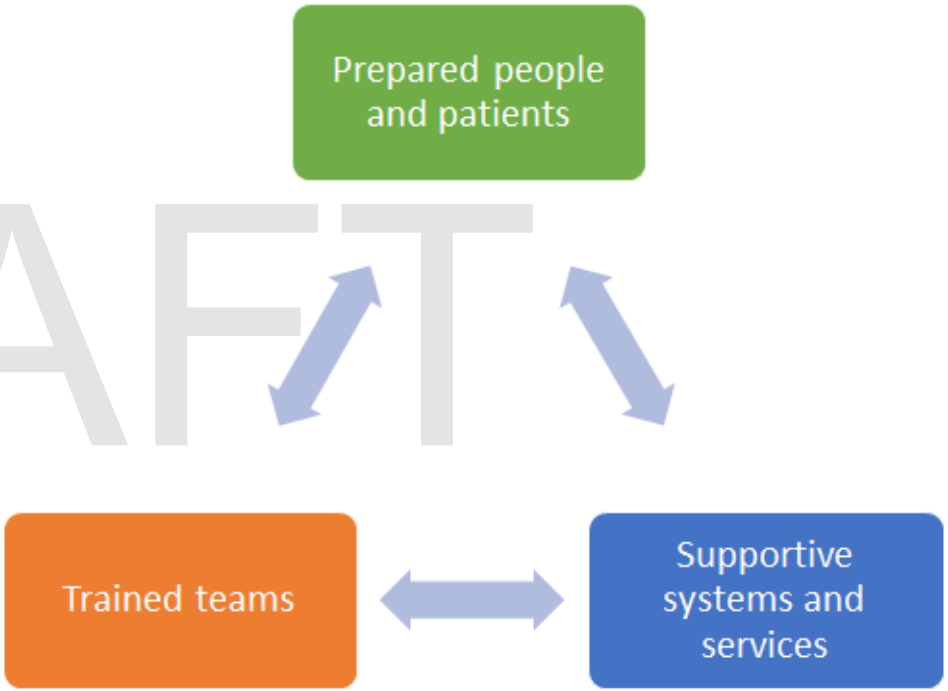
To successfully implement personalised care and support planning as business as usual, and at scale, there needs be a systematic approach to ensuring the culture, processes and workforce activity, of the organisation, effectively support embedding PCSP. This should sit within the wider implementation of personalised care - all the components of personalised care are complementary and interlink.

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 PCSP specifically. It is not intended to be part of any formal assurance activity by national teams.

The foundations

We have based this guide on these foundations which are drawn from the learning from the MAGIC programme (making good decisions in collaboration) funded by the Health Foundation in 2013 and have featured in NHSEI resources for the interlinked component of Shared Decision Making since then.

The foundations cover the fundamental areas within system design to ensure optimal implementation of personalised care.
We have adopted these foundations for PCSP approaches and implementation, for consistency.



DRAFT

How this framework can be used

Each of the foundations is explored in detail over pages 16- 21. For each foundation we have set out:

- What this means for people in the form of a set of 'I' statements.
- 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 ICS, systems or clinical pathways can use, that gives an opportunity to assess their view of the baseline in relation to implementing the PCSP 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.
- Links (link to resources page) to additional information and useful resources for each foundation.

	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

DRAFT

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 PCSP with people to ensure that it continues to be relevant
- Feedback from PREMS and PCSP 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 PCSP have been covered and recorded
- We have clear strategies, policies and agreed metrics which focus on preparation for planning conversations across all pathways

DRAFT

Quality Improvement / self assessment against the key enablers

Prepared People and Patients

Prepared People and Patients	Enablers for improvement – to successfully implement this element we would expect to see:		Maturity			
			1	2	3	4
	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.				

DRAFT

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

DRAFT

Quality Improvement / self assessment against the key enablers

Supportive Systems and Processes

Supportive systems and processes	Enablers for improvement – to successfully implement this element we would expect to see:		Maturity			
			1	2	3	4
	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.				

DRAFT

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, PCSP 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 can balance the persons 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.

DRAFT

Quality Improvement / self assessment against the key enablers

Trained Teams

Trained teams		Enablers for improvement – to successfully implement this element we would expect to see:	Maturity			
			1	2	3	4
	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.				

DRAFT

Contact us

For any further information on this guidance and personliased 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 PCSP.

DRAFT