Principles of Person Led Care and Support Planning

*"*Personalised care and support planning is a systematic process based around "better conversations" between the person and their health and social care practitioners" – Think Local Act Personal 2015)

Person led care and support, or similar terms, feature in both the statutory framework and professional standards for both health and social care practitioners (see references for more information). The South West Integrated Personalised Commissioning collaborative has found a wide variety of information on how person led care and support is interpreted and implemented across health, social care and the voluntary sector.

This paper draws on professional standards, policy documents and person led care and support practice to identify key principles to underpin planning, commissioning, delivery and review.

Where 'person' is used below, this also includes anyone who supports the individual, including parents, relatives and carers.

These key principles describe good practice and should be used to review current practice:

1. The person with ongoing health and/or social care needs is an active and equal partner in developing and owning their person led care and support plan (Care Act 2014, Five Year Forward View). The person led care and support plan should focus on the person staying well, living well and may also include dying well

2. The person and all services involved in their care and support collaborate to complete one assessment and to develop one joint plan, agreed by all. It is acknowledged that this plan will be underpinned by practitioners' records and care plans (Care Act 2014)

3. The information in the plan must be meaningful, relevant and accessible to the person in their required format (Accessible Information standard 2015)

4. Person led care and support plans are designed to be portable (Care Act 2014) and should be shared electronically, wherever possible, with whomever the person wishes and consents to share their plan with

5. The person should be enabled to choose who supports them to develop their person led care and support plan, including the right to advocacy and peer support

6. One key worker should be identified to coordinate the process across services

7. A person led care and support plan sets out:
    - health and wellbeing outcomes
    - an action plan specifying clearly who will do what and when
    - risk assessment
    - contingency/emergency plans
    - plans for major life events
    - informal support from friends, family
    - local community 'free or low cost resources'
    - resource statement or indicative budgets where applicable

8. An efficient timely process is required to sign off care and support plans, especially where there is a more than one agency involved

9. It should be simple and easy for the person to revise and change their plan, in partnership and agreement with health and/or social care practitioners

10. Regular reviews of outcomes will contribute to the long term success of the person's plan

11. Appeals process: It is necessary for all parties to know what will happen if there is disagreement about signing off a plan, and to have in place a clear process of appeal. If a plan cannot be signed off, then clear guidance for how it needs to be amended should be given

12. The care and support planning process should be completed in a reasonable time frame, and where possible agreed with all parties at the beginning

13. Audit and review processes should be proportionate

National Voices – Principles of Care and Support Planning

In 2013/14, National Voices, a coalition of health and social care charities worked in collaboration with a wide range of partners and people who use services to develop a common understanding about what is meant by care and support planning. They highlight the four main steps of the care and support planning process and have identified a number of principles to help ensure that the process is truly person-centred. These principles should be at the heart of any changes in process, systems, skills, behaviours and attitudes. Further detail is available from: https://www.england.nhs.uk/wp-content/uploads/2015/01/pers-care-guid-core-guid.pdf

1. Prepare

• Starts from the point of view of the person

• Gathers necessary information and makes it available upfront

• Builds in time to reflect and consider options

2. Discuss

• Takes a partnership approach

• Focuses on staying well and living well (and for some, it will also mean dying well)

• Identifies the actions that a person can take

• Identifies what care and/or support might be needed from others

3. Document

• The main points from discussions are written up, included as part of the person's health and/or social care records, and owned by the person and shared, with explicit consent.

4. Review

• Considers options for follow up and sets a date for review

Reference List

Care Quality Commission website: www.cqc.org.uk

Department of Health 2013, *A mandate from the Government to NHS England: April 2014 to March 2015*, London, The Stationary Office

Department of Health 2014, *Care and support statutory guidance,* online resource, available from: www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation retrieved on 16.01.15

NHS England 2013), *Everyone Counts*: *Planning for Patients 2014/15-2018/19*, online resource, available from: https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf retrieved on 19.11.15

NHS England 2015 *NHS Constitution for England Guidance,* online resource, available from: https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england, retrieved on 19.11.15

NHS England 2015, *Accessible Information Standard*, online resource, available from: https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/#standard, retrieved on 12.11.15

NHS England and Coalition for Collaborative Care 2015, *Personalised care and support planning handbook: The journey to person-centered care,* online resource, available from: https://www.england.nhs.uk/wp-content/uploads/2015/01/pers-care-guid-supp-pract-del.pdf retrieved on 16.11.15

Royal College of General Practitioners 2011, *Care Planning: Improving the Lives of People with Long Term Conditions,* online resource, available from: www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Cancer/Improving%20the%20Lives%20of%20people%20with%20LTC%20-%202012%2005%2009.ashx retrieved on 16.11.15

Think Local Act Personal 2015, *Personalised care and support planning tool,* online resource, available from: http://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/ retrieved on 16.11.15

Bibliography

The **NHS Constitution for England – Guidance 2015** identifies seven key principles which guide the NHS in all it does, with the fourth principle being particularly relevant.

"The NHS aspires to put patients at the heart of everything it does". It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. Patients, with their families and carers where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services."

More information is available from: https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

Care Quality Commission website: www.cqc.org.uk

"You must have care or treatment that is tailored to you and meets your needs and preferences" - one of the five key questions asked of a provider by CQC when it inspects is "are they responsive to people's needs?"

"The intention of this regulation (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9) is to make sure that people using a service have care or treatment that is personalised specifically for them. This regulation describes the action that providers must take to make sure that each person receives appropriate person-centered care and treatment that is based on an assessment of their needs and preferences.

Providers must work in partnership with the person, make any reasonable adjustments and provide support to help them understand and make informed decisions about their care and treatment options, including the extent to which they may wish to manage these options themselves." Also see Key Lines of Enquiry used in inspections which are available from the website.

Department of Health 2013, *A mandate from the Government to NHS England: April 2014 to March 2015*, London, The Stationary Office

The Mandate includes a commitment that by April 2015 "everyone with long-term conditions, including people with mental health problems, will be offered a personalised care plan that reflects their preferences and agreed decision. More information is available from: www.gov.uk/government/publications/nhs-mandate-2014-to-2015

Department of Health 2014, *Care and support statutory guidance,* more information available from: www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

The Care Act 2014 states that "Local authorities should not develop plans in isolation from other plans... and should have regard to all of the person's needs and outcomes when developing a plan, rather than just their care and support needs. The local authority should attempt to establish where other plans are present, or are being conducted and seek to combine plans, if appropriate. This should be considered early on in the planning process (at the same time as considering the person's needs and how they can be met in a holistic way) to ensure that the package of care and support is developed in a way that fits with what support is already being received or developed." It also says "Particular consideration should be given to ensuring that health and care planning process are aligned, coherent and streamlined, to avoid confusing the person with two different systems."