# Personalised Care and Support Planning (PCSP) Checklist

## Background

This guidance is aimed at supporting systems to understand in more detail the national definition and criteria for Personalised Care and Support Planning, why it is important to focus on the whole of a person's life, and the five quality criteria which must be met for a clearly defined PCSP.

## Introduction

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. This checklist will set out the detail that sits behind each of the criteria.

## What is personalised care and support planning?

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.

The NHS Long Term Plan 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, with an ambitious but achievable target of 750,000 personalised care and support plans developed by 2023/24.

## Personalised Care and Support Planning as a Long Term Plan Metric

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 above. Systems are required to count the number of **new** and **reviewed** PCSP on a quarterly basis.

Below are the five criteria for ensuring that plans meet the definition of a PCSP and provide strong quality indicators for planning. These 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.

All of these criteria need to be present for a local PCSP to align with this definition:

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 checklist below provides clear information on what should be in place for each of these criteria and therefore for the planning process and the resulting plan to meet these indicators. There is a best practice statement, the key elements required to meet that criteria and then an example of what this might look like in a particular area of 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, we should see:** | ✓ |
| 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 | |

**Some examples:**

**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/

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, 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. | |
| 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. | |
| 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. | |

**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.

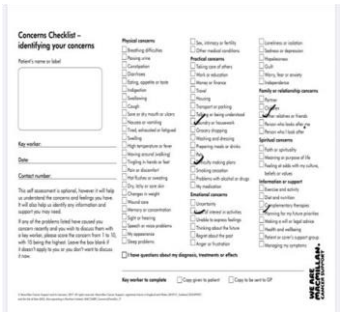
3. **People agree the health and wellbeing outcomes they want to achieve, in partnership with the relevant professionals**

| **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, we should see:** | ✓ |
| The person develops health and wellbeing outcomes in partnership with the relevant professionals. | |
| The outcomes 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). | |

**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:




**Jane's concerns checklist**

**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/

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.**

| **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, 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 | |

**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.

[Link to be put in when guidance has gone through gateway.]

**Professional Records Standards Body (PRSB)**

The Professional Records Standards Body have developed a digital care and support planning standard, so care plans can be effectively shared between patients, carers and all the health and care professionals involved in that person's care. Click the link below to see the standards.

https://theprsb.org/standards/dcsp/

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, 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. | |

**Examples:**

**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/

**Counting Data**

Information about where to find data to count PCSP can be viewed in Annex 3.

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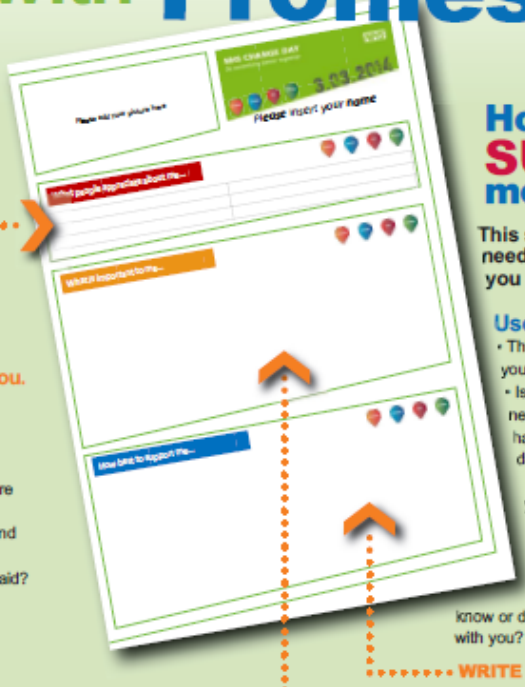
## Annex 1 – One Page Profiles

# Getting started with One Page Profiles



## What people APPRECIATE about me

**This section is a list of your positive quantities**

**WRITE THEM HERE**

A list of your characteristics that people value and appreciate about you.

### Useful Questions:

- What do people thank you for?
- What characteristics do people like and admire about you?
- What would your partner, family and best friend say they love or value about you?
- What is the best compliment you have been paid?
- What do you think your best qualities are?

## How to SUPPORT me

**This section is what others need to know or do to support you to be at your best**

### Useful Questions:

- Think about what a good day is like for you at work, and a bad day as well
- Is there anything that other people need to know or can do to help you have more good days and less bad days at work (within reason!!)?
- What makes you feel better when you are stressed, unhappy or unwell?
- What can others do to help when you are stressed or unwell?
- If someone was new to your work, what would they need to know or do to be able to get on really well with you?

**WRITE IN HERE**

## What is IMPORTANT to me

**WRITE IN HERE**

**This section describes what really matters to you – the people, places, routines and aspects of your life that reflect who are you, and what is important to you**

- Who are the people who mean the most to you? How often do you see them? When? Where?
- What would you never leave home without?
- What do you always carry around with you in your bag or pocket?
- What would you usually do each week, weekend and miss if you could not e.g. TV programmes, hobbies, interests, people you see, places you go?

### Useful Questions:

**People**
- Who are the people who mean the most to you?
- How often do you see them? When? Where?

**If I could...**
- If you had a whole day to do whatever you wanted – where would you like to go?
- Who would you spend it with?
- What would you do?

**I usually...I always...**
- What does your typical week look like in the evenings?
- What would you usually do each week and would miss if it did not happen? e.g. TV programmes, hobbies, interests, people you see, places you go?

**Favourites**
- What is your favourite way to spend a weekend?

## WHAT NEXT?

### Look back at your first draft

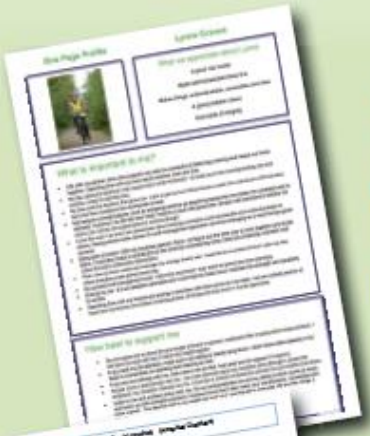
**Now that you have some ideas and notes, start creating a detail one-page profile. Go from one word to detailed bullet points (it cannot be too detailed)**

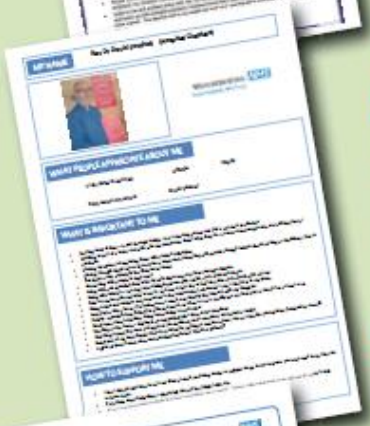
- Instead of just 'family' ***write*** *– my partner Dave, and his daughter Lucy, and grandson Oliver. We have Sunday lunch together each week without fail.*
- Instead of 'Communication' ***write*** *– email works best for me to stay in touch, I check it everyday at 8am*
- Instead of 'holidays' ***write*** *– getting a week in sun every year when I can afford it - usually Spain in August*

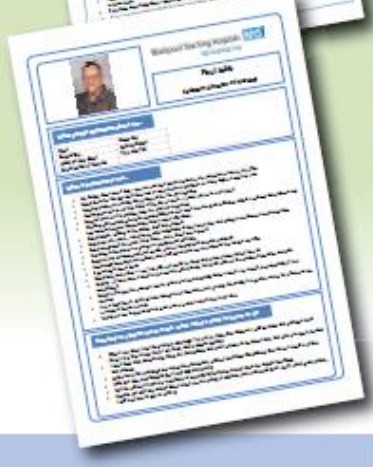
# One Page Profiles

## Getting them right

**A good one-page profile makes you feel like you have met the person, just from reading it. Check your one-page profile is the best it can be.**







### 1 Is it detailed?

Great one-page profiles go beyond one or two words, they explain how often, who with, when and where too.

**Instead of this – "cycling"**

**It is better to write this - "My bike and the freedom it gives me. I aim to get out on it three times a week for a minimum of at least 20 minutes but a full hour of cycling is best."**

### 2 Is it specific?

Look out for the word 'regularly' – it could mean daily, weekly, monthly or annually.

**Instead of this – "blogging and tweeting regularly"**

**It is better to write this - "Sharing through blogs two or three times a week and connecting with people through twitter about nursing or chaplaincy, four or five times a day, especially with @wenurses"**

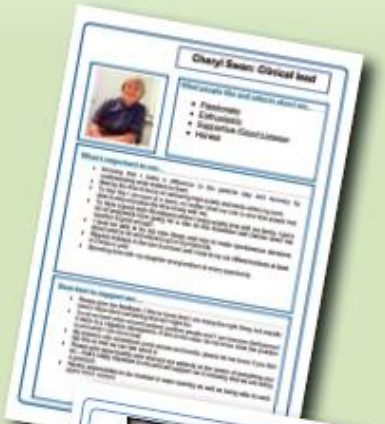
### 3 Could you use it?

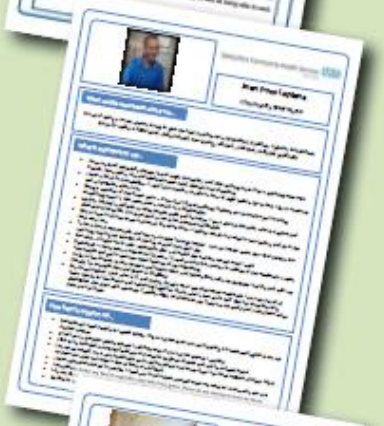
The 'how to support me' section should give you good specific detailed information, so that if you had to support that person, or be part of their team, you would know exactly how to do this well.

**"Update me with key points about what you are doing to achieve your outcomes (but I don't need great detail – I will trust you to get on with it)."**

**"My passion can sometimes come across as forceful, please let me know if you feel like this so we can talk about it."**

**"I do not like wasting time – if you are going to be late, please let me know."**





## Now check...

**You know you have a great one-page profile, when you could take the name and photo off the profile and people would still recognise the person from the information on it. Try it out and see for yourself!**

## Annex 2 – Personalised Wellbeing Plan Template

### Personalised Well-being Plan

| | | | |
|---|---|---|---|
| **My Name:** | | **I like to be known as:** | |
| NHS Number: | Phone number: | | Email Address: |
| Address: | | | Post Code: |
| Are you an unpaid carer for/regularly support anyone else? | YES / NO / Not applicable | | |
| Some of my own care and support is given by an unpaid carer/family member/friend | YES / NO / Not applicable | They have given permission to be contacted by NHS representatives. YES / NO / Not applicable | |
| Their contact details are: | | | |
| **Things you need to know about me and my health** | | | |
| **What matters to me most:** | | | |
| **My health condition(s):** | | | |
| **This is what I already do to keep myself well:** | | | |
| **These are the changes to my health I need to look out for, and this is what I will do if they happen:** (tell us what the change is including your symptoms and who will help you) | | | |
| **My medicine:** (include where it is kept and how you take it) | | | |
| **What I am worried about at the moment:** | | | |
| **What support I will need to stay as well as possible** | | | |
| **What I will do to help myself:** | | | |
| **What my family, friends and neighbours will do:** | | | |
| **Other help I will need:** | | | |
| **Where I can get help now:** | | | |
| **If you need to contact my GP or designated contact, here are the details you will need:** | | | |
| **My GP is** | **My emergency contact is** | Relationship to me | Other e.g. social worker, housing association, care worker |
| Telephone number: | Telephone number/Contact details: | | Telephone number: |

## Annex 3 - Mechanisms for counting personalised care and support plans

Here is some further information to support the collection of PCSP metrics

**SNOMED –** There are two new codes for personalised care and support planning that were introduced into the SNOMED-CT directory on 1 April 2020.

| | | |
|---|---|---|
| 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. 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. The COSD v9 implementation guidance refers to the PCSP standard set out in section 3 of this document.

**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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