Local Government Association

NHS England

Integrated Personal Commissioning

Personalised care and support planning

Summary guide

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1 Introduction

Integrated Personal Commissioning (IPC) and personal health budgets are part of a wider drive to personalise health, social care and education.

They promote a shift in power and decision-making to enable a changed, more effective relationship between the NHS and the people it serves, aligning to the **Five Year Forward View**.[1]

IPC is a partnership programme between NHS England and the Local Government Association. It supports the improvement, integration and personalisation of services, building on learning from personal budgets in social care and progress with personal health budgets.

This guide provides best practice advice, not statutory guidance. The IPC operating model sets out the essential components of IPC and provides a template for local areas to follow. It provides a best practice approach for implementing personal health budgets.[2]

The model is aimed at IPC areas, but will be of interest more widely. This includes NHS commissioners and others involved in providing health, education and social services, including the independent and voluntary sectors, as well as people interested in personal health budgets or IPC.

1.1 Who is this document for?

This summary guide is aimed at people who are leading local implementation in IPC areas. The content will be relevant also for people implementing personal health budgets across England, leading implementation of the Care Act and of the special educational needs and disability (SEND) reforms. It is also relevant to people with lived experience of care and support and voluntary, community and social enterprise (VCSE) organisations.

The relevant guidance[3] for local authorities and the NHS encourages a joined-up approach. The advice in this guide and the supporting resources sets out the learning so far on how this can be achieved.

The guide details approaches that have been developed for IPC and personal health budgets. As such, this guidance on how best to deliver personalised care and support planning has been considered within the context of supporting people with complex needs. However, the principles and approach of personalised care and support planning can be applied more widely across a number of different models of care. The issues of single, named coordinators and multidisciplinary approaches, workforce development, and single summary plans are of relevance to commissioners and care practitioners regardless of which cohorts they are supporting.

Whether local organisations are seeking guidance on how to deliver IPC, or how to introduce or improve their approach to personalised care and support planning, these products should provide some useful direction and examples to assist in planning local approaches to supporting people with long-term conditions.

1.2 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.

Personalised care and support planning is at the heart of personal health budgets and IPC and results in a personalised care and support plan (or an education, health and care (EHC) plan for children and young people). The Care Act 2014 also states that an individual should have one care and support plan. The Guidance on Direct Payments for Healthcare[5] is clear about what must be included in any care and support plan that includes a personal health budget.

More widely, personalised care and support planning can be beneficial to anyone with ongoing care needs or long-term conditions. It provides an opportunity to discuss what matters to the person, the outcomes they want to achieve, and what support they can access, whether through statutory services or through personal connections and local VCSE services, to help them build their knowledge, skills and confidence to manage their health and wellbeing.

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 to 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.

1.3 Personalised care and support planning: What this looks like for people and families

- People will have a different or better conversation with practitioners which focuses on what matters to them and what is working and not working in their life.
- This will be done in a way that builds on their skills, knowledge and confidence.
- People will experience an integrated process coordinated by a single, named coordinator and a single care and support plan developed in partnership and owned by them.
- People will have the chance to regularly review their care and support plan.
- It's easy to find out what support and services are available.

1.4 Personalised care and support planning: What needs to be in place

- A common framework and integrated, proportionate process for personalised care and support planning (incorporating Patient Activation Measure (PAM) embedded to tailor the planning approach to applicable individuals) (see section 2.1).
- IPC hubs are in place (see section 2.2).
- A single summary care and support plan (see section 2.3).
- Training, mentoring and support for all parties delivering better conversations (see section 2.4).
- Positive approach to choice, risk and decision-making (see section 2.5).

2 Personalised care and support planning: what needs to be in place

2.1 A common framework for personalised care and support planning (incorporating Patient Activation Measure)

2.1.1 What is this?

An overarching six-stage planning framework that supports the implementation at scale of personalised care and support planning for IPC. The six stages are:

1. Context
2. Preparation
3. Conversation
4. Record and agree
5. Make it happen
6. Review

The framework is broken down into three different levels: what needs to be in place from the point of view of people, professionals and system (particularly commissioners and system leaders) and identifies what needs to be in place.

2.1.2 Why do this?

As well as the benefits of personalised care and support planning outlined in section 1.2, care planning is a requirement of both the Care Act 2014 and the Children and Families Act 2014. Where appropriate, Clinical Commissioning Groups (CCGs) should work with local authorities, education and other healthcare providers to ensure that the person has a single care and support plan covering all their needs.

2.1.3 What does this mean in practice?

In order to put personalised care and support planning in place for IPC, sites should use the common planning framework. Planning is offered to everyone in the IPC target population and their carers whose needs are not fully met through a community-based approach. Personalised care and support planning brings together those with lived experience of care and support and those with professional expertise to identify all the issues, develop solutions and initiate actions. Planning builds on the person's assets and resources, ensuring they are in the driving seat of decision-making.

In IPC, personalised care and support planning is intended to be proportionate, tailored and comprehensive so that it includes all the support a person receives. A tailored approach is achieved through use of the Patient Activation Measure (PAM) (more information on PAM is available on the **NHS England** website). This approach can reflect the full spectrum of input, from light touch, technology-enabled support for self-planning, through to more intensive one-to-one support, with simple tools deployed to tailor the approach accordingly. For children and young people with special educational needs and/or disability (SEND), this is aligned with the local EHC planning process – the EHC plan is the IPC single summary care and support plan.

2.1.4 What advice and tools are available?

- **Annex A: Personalised care and support planning framework**.
- **Annex B: IPC hub/MDT approaches and the single, named coordinator**.

2.2 IPC hubs are in place

2.2.1 What is this?

IPC is delivered through enhanced multidisciplinary teams (MDT) within care coordination hubs (IPC hubs). These are the equivalent of multispecialty community provider (MCP) care hubs, providing practical, operational interaction with IPC cohorts. They can include GPs, nurses, social workers and condition or impairment-specific specialists (such as mental health, learning disability or children's nurses). IPC hubs and MDTs specifically include input from the VCSE sector, peers and volunteers.

Everyone in the IPC cohort should have a single, named coordinator who acts as a consistent point of contact for all their care and support. They will provide coordination and information, timely support, and will work exceptionally closely with the person and their family to make sure the person is in control of their support. The single, named coordinator is a key component of IPC hubs and MDTs.

2.2.2 Why do this?

A multidisciplinary approach provides support and resources to people to achieve what is important to them.

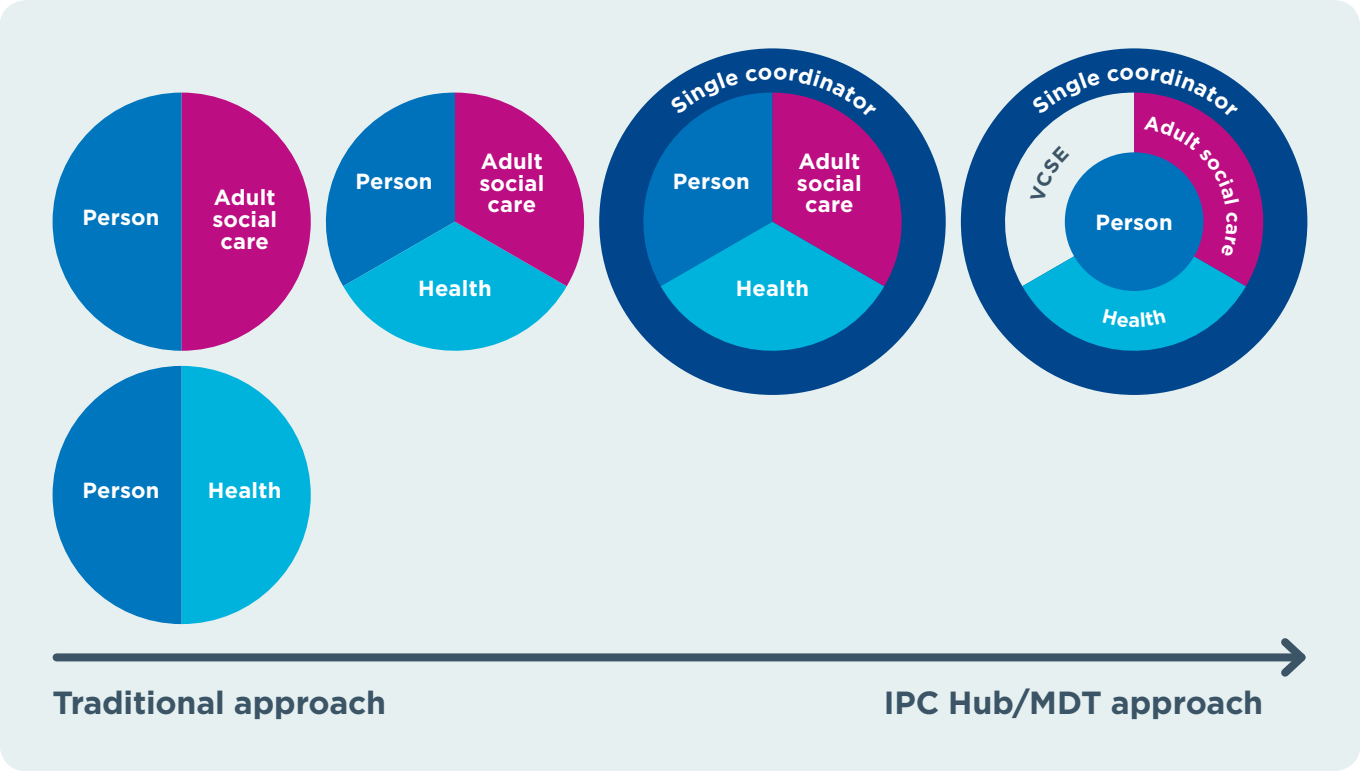
IPC hubs and MDTs can achieve the following:

- ensure that support is person-centred and person-led
- a better experience for people, reducing duplication and preventing people falling between services
- provide a fuller understanding about a person and their situation and therefore their support needs, matching the right practitioner(s) to the person
- improved integrated working
- improved trust between everyone involved in the process
- identification of and use of a wider range of resources
- proactive approach to managing support
- resource-efficient way of meeting reporting requirements.

People with lived experience report that having a single, named coordinator is supportive in finding their way through local health and care systems, and enables them to build a relationship with a single, named coordinator which improves their experience.

2.2.3 What does this mean in practice?

There is a continuum of approaches to IPC hubs and multidisciplinary teams, demonstrated in the diagram below:



Local areas may wish to consider one of the following models:

1. Full IPC hub approach. Integrated multidisciplinary team co-located and linked to GP surgeries.
2. Mixed approach. Integrated teams based on partnership working and cooperation and some co-location.
3. Virtual approach (see also Occasional approach below). Virtual teams where there is a single coordinated care and support plan summary, associated plans and a single coordinator who primarily liaise virtually.
4. Occasional approach (see also Virtual approach above). Bringing multidisciplinary specialists together on a single day at set frequencies so people whose work relates to a specific cohort can see everyone on one day and coordinated plans can be agreed.

See also section 2.1 above.

2.2.4 What advice and tools are available?

- **Annex B: IPC hub/MDT approaches and the single, named coordinator**.

2.3 A single care and support plan

2.3.1 What is this?

Each person should have a single care and support plan that acts as an overview for all other plans. This single care and support plan need not include the detail required in other plans, i.e. condition-specific treatment or care plans. However, it should include the key points and salient information about a person and ensure these other plans (e.g. condition-specific treatment or care plans) are linked up. It must reflect what is important to them and how best to support them. This can then be recorded in a one-page detachable summary.

2.3.2 Why do this?

To provide the best possible support to people it should be known what is important to each person and how they want to be supported. A lot of information is recorded about people, and a single care and support plan and one-page summary is a quick way of understanding who they are as a person. The way that people want to be supported provides information on how anybody supporting them can help and care for them. It means that the person doesn't have to share their story time and time again.

2.3.3 What does this mean in practice?

See section 2.1 above for how to implement this in practice.

2.3.4 What advice and tools are available?

- **Annex C: Single care and support plan and better conversations**.
- **Annex D: Personalised care and support planning for personal health budgets**.

2.4 Training, mentoring and support for all parties delivering better conversations

2.4.1 What is this?

Ensuring the workforce is practically supported through training, mentoring and coaching in order to deliver personalised care and support planning at scale.

2.4.2 Why do this?

Personalised care and support planning is a new way of working. At its heart, it is a process to have better or different conversations and ensure that what matters most to people is identified and support is designed and organised to meet the person's outcomes.

Whilst a personalised care and support plan must be recorded in some way, the plan itself is not an outcome. The process is a way for people and practitioners to come together in whatever way works for the person and ensure that the person has as little or as much support as they want and need at all stages of the process. This is a shift for practitioners: no longer are they seen as the expert in a person's care and support; now there is a 'meeting of experts' with the person firmly driving the process and decision-making. This is a partnership: clearly starting with the principle of planning with people and not planning for them.

2.4.3 What does this mean in practice?

See section 2.1 above for how to implement this in practice.

2.4.4 What advice and tools are available?

- Annex E: Supporting the workforce.

2.5 Positive approach to choice, risk and decision-making

2.5.1 What is this?

Successful delivery of personalised care and support requires a balance between enabling individual choice and control and managing risks of all types – clinical, financial, personal and reputational – for the person, for the practitioners and for the organisation and systems. It requires a change from a risk-averse approach to one in which individuals and organisations are able to identify and manage risk in order to improve people's outcomes. A positive approach to enabling people to make different choices and take risks must be balanced with the duty to have proper arrangements in place to protect people and to comply with professional duty of care. It must therefore also sit within a clear governance framework of accountability and responsibility.

2.5.2 Why do this?

The personalised care and support planning framework explicitly includes ensuring there is a personalised approach to risk management and a positive approach to risk enablement. Good conversations about risk and risk enablement also mean that people can develop contingency plans so they have systems in place to get support at an early stage to avoid a crisis.

2.5.3 What does this mean in practice?

A good personalised care and support planning process addresses positive risk enablement, through:

- clear conversations so practitioners know and understand a person's set of circumstances
- comprehensively assessing needs to enable proper identification of risks
- putting in place clear action plans/contingency plans to manage and mitigate risks
- ensuring there is a proportionate approach to signing off personalised care and support plans, including any considerations of risk
- completing timely and in-depth reviews, covering both clinical and financial areas as well as review of the personalised care and support plan.

A good governance framework, encompassing both financial and clinical responsibility and accountability, provides a clear structure within which a positive and empowering approach to risk takes place.

As part of implementing changes to business processes, a privacy impact assessment should be completed before any data is processed. This will ensure that privacy and confidentiality of individuals is respected and Data Protection requirements are met. Further guidance is available in the IPC and personal health budget finance and commissioning handbook.[2]

2.5.4 What advice and tools are available?

- **Annex F: Positive approach to risk, choice and decision-making**.

3 Ensuring equal access

Promoting equality and addressing health inequalities are at the heart of our values. 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 (as cited under the Equality Act 2010) and those who do not share it
- 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 local authorities, the NHS 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. Examples of how personalised care and support planning can work for different groups are available on the NHS England website.

Steps that sites can take to help ensure personal budgets work well for groups with protected characteristics under the Equality Act 2010 include:

- making information about personalised care and support planning available in a range of formats
- working with VCSE organisations and community groups to provide feedback on how well the local approach is working
- ensuring people can choose their single, named coordinator, and ensure a range of options that reflect the local community are available
- undertaking independent care and support plan audits and reviews to understand how well or otherwise care and support planning is working for people with protected characteristics.

IPC also builds in a whole life, whole family approach, which takes into account the needs of carers, including young carers. NHS England has published advice on carer health and wellbeing, setting out the responsibilities of local authorities and the NHS.

4 More information on personalised care and support planning

The Personalised health and care framework provides more detailed advice and practical tools to support local implementation.[2]

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NHS England

5 Annex A: Personalised care and support planning framework

5.1 Introduction

This document provides an overarching, six-stage planning framework that supports the implementation at scale of personalised care and support planning for IPC. It is derived from the Think Local Act Personal (TLAP) personalised care and support planning tool, and also draws on and reflects other key frameworks and published literature (see the framework for details).

The six stages are:

1. Context
2. Preparation
3. Conversation
4. Record and agree
5. Make it happen
6. Review.

The framework is broken down into three different levels: what needs to be in place from the point of view of people, professionals and system (particularly commissioners and system leaders). There is a continuum across each of the stages and across each of the different levels, so the placement of what needs to be in place at a particular stage and level doesn't mean it shouldn't be in place in other parts of the framework. For example, the IPC hub/multidisciplinary team approach is a factor that underpins virtually all of the framework.

The framework identifies what needs to be in place for each of the six stages of what is recognised as good personalised care and support planning. All of these elements can be brought under one of nine key themes:

1. Have an overarching cross-system vision and strategy for personalised care and support planning. [VISION]
2. Workforce [WF]: ensuring the workforce is supported to deliver personalised care and support planning at scale.
3. Single coordinator and IPC hub/MDT approaches [HUB]: how to ensure there is a single point of contact for each person's care and support planning journey, and where they are located.
4. Single care and support plan and better conversations [PLAN]: how to ensure there is one single care and support plan, which other plans feed into, which captures the person and what is important to them.
5. Good, clear communication and information. [INFO]
6. Clear decision-making and accountability. [DM]
7. Clear focus on review. [RVW]
8. A proportionate, tailored approach to personalised care and support planning. [PROP]
9. An enabling approach to risk. [RISK]

The framework also identifies what might particularly hinder good personalised care and support planning. These factors are often the opposite of what helps; in the main, hindering factors that are particular barriers in their own right have been included, rather than simply the opposite of what helps.

In order to put personalised care and support planning in place for IPC, sites must:

- use this common planning framework
- have IPC hub/multidisciplinary teams in place, including a single, named coordinator.

Details on how to do this are contained within this document and separate sections on IPC hub/multidisciplinary teams and single, named coordinators. In each of these much more detail is provided on how to put these themes into place and resources to put these into place.

In addition, there are elements of the personalised care and support planning framework that feed into wider determinants of the local health and care economy – such as peer support, co-production, cohort identification, commissioning and market development, and a cross-system vision and plan. These elements are therefore supported by products from other collaborative development groups.

5.2 Personalised care and support planning framework

	1. Context	2. Preparation	3. Conversation	4. Record and agree	5. Make it happen	6. Review
People: Helps	[PLAN] Telling story once, building on existing plans. [INFO] Provision of clear, accessible information for everyone. [VISION] Possibility of a whole family approach.[6] [INFO] Understanding of rights and what someone can expect from care and support planning. [INFO] The relationship between assessment and care and support planning is clear. [PROP] Tailored and proportionate approach, appropriate to a person's level of knowledge, skills and confidence.	[HUB] Single point of contact who supports the person and acts as coordinator through their journey. [VISION] Thinking both 'whole life' and differently around care and support and so what's possible. [INFO] Tailored, accessible information and support gathered and shared ahead of conversation(s) on what to expect. [PROP] Tailored and proportionate approach, relevant to the person but respecting personal choice. [INFO] Consent and understanding of the process, what information will be shared and who will be involved.	[WF] Create the right environment in which to have the conversation(s). [WF] Right types of people involved in the conversation(s) alongside the person. [WF] Different practical tools available to support conversation(s).	[DM] Know what the process is and who is involved for agreeing a single care and support plan. [PLAN] Single care and support plan and summary. [DM] Know what the right to appeal is if not agreed.	[WF] Knowing responsibilities for implementation: the person's own, other people's and providers'. [HUB] Involving wider circles of support for implementation. [INFO] Understanding what informal, universal, community and statutory resources are available. Support around budgets to enable outcomes to be met.	[RVW] Adapting plans as needed and not just at formal review: viewing the plan as a live document. [RVW] Knowing what to do and who to contact if circumstances change. [RVW] Transparency and no surprises: knowing the purpose of the review and having this communicated. [PROP] Make it proportionate and appropriate: according to planned or requested review, change of circumstance, key life stage, risk, etc. [RVW] Reviewing the actions and outcomes: how is the plan moving forward?

	1. Context	2. Preparation	3. Conversation	4. Record and agree	5. Make it happen	6. Review
People: Hinders	Poor knowledge, skills or confidence (i.e. low activation levels). Preconceived attitudes/beliefs. Not embarking on planning at an appropriate time. Duplication or overlap with other planning instead of integrated approach. Use of jargon.	Unclear communication or engagement not tailored to the person. Lack of consistent approach to (self-) assessment.	Lack of time to build relationships for the full conversation(s). Fixed approach or set questions for conversations. Power imbalance, e.g. not recognising carers as experts, fear of disagreeing with 'professionals'. Not supported to consider future needs, especially at key life stages.	Lack of involvement in recording/agreeing the care and support plan.	Doing 'to' service users. No 'market' to make choices from.	Unclear purpose for review. Lack of flexibility.

	1. Context	2. Preparation	3. Conversation	4. Record and agree	5. Make it happen	6. Review
Practitioners: Helps	The need to meet statutory duties and professional obligations across the whole process (including Care Act, SEND reforms/ EHC planning, Care Programme Approach, care and treatment reviews, etc). [WF] Relationships across health, education and social care. [VISION] Clear end-to-end, continuous pathways for integrated personalised care and support planning. [VISION] Support from managers and leadership. [WF] Ongoing training on personalised approaches across the system, including VCSE sector and providers.	[WF] MDT approach relevant to identified cohort. [PLAN] Gathering and sharing knowledge/ summary of what's known about a person, especially from recent assessments. [HUB] Single point of contact who supports the person and acts as named coordinator through person's journey. [WF] Ongoing training, coaching and mentoring to work in a personalised way.	[WF] Creating dedicated space and time to have personalised conversation(s). [WF] Looking at 'whole life' conversation(s), encouraging aspirational thinking and taking account of all resources available. [WF] Ongoing training, coaching and mentoring practitioners on personalised conversations. [WF] Different practical tools available to support personalised conversation(s). [WF] Using independent facilitation to support personalised conversation(s). [RISK] Personalised approach to risk management.	[INFO] A clear, quick and transparent process: recording goals, plans and actions simply and clearly. [PLAN] Single care and support plan and summary in format chosen by the person, linked to other relevant records and plans, including carers' plans. [DM] Simple, integrated, clear sign-off process as close to the person as possible and involving appropriate people proportionate to need. [DM] Support on how to handle disagreement, integrated agreements/ governance of exclusions. [WF] Being open to failure, not knowing, and creative solutions.	[PLAN] Single care and support plan can be accessed by all relevant parties involved. [INFO] Understanding and information available on what's available locally. [WF] Opportunity for different roles and operational options to make it happen. [WF] Encourage ownership and action – being clear about who will support the care and support plan to move forward. Support individuals to commission/broker services, e.g. direct payment support.	[RVW] Flexibility in when to review – when it is appropriate as opposed to when the system decides, who does it. [WF] Proportionate use of practitioners to contribute meaningfully to reviews.

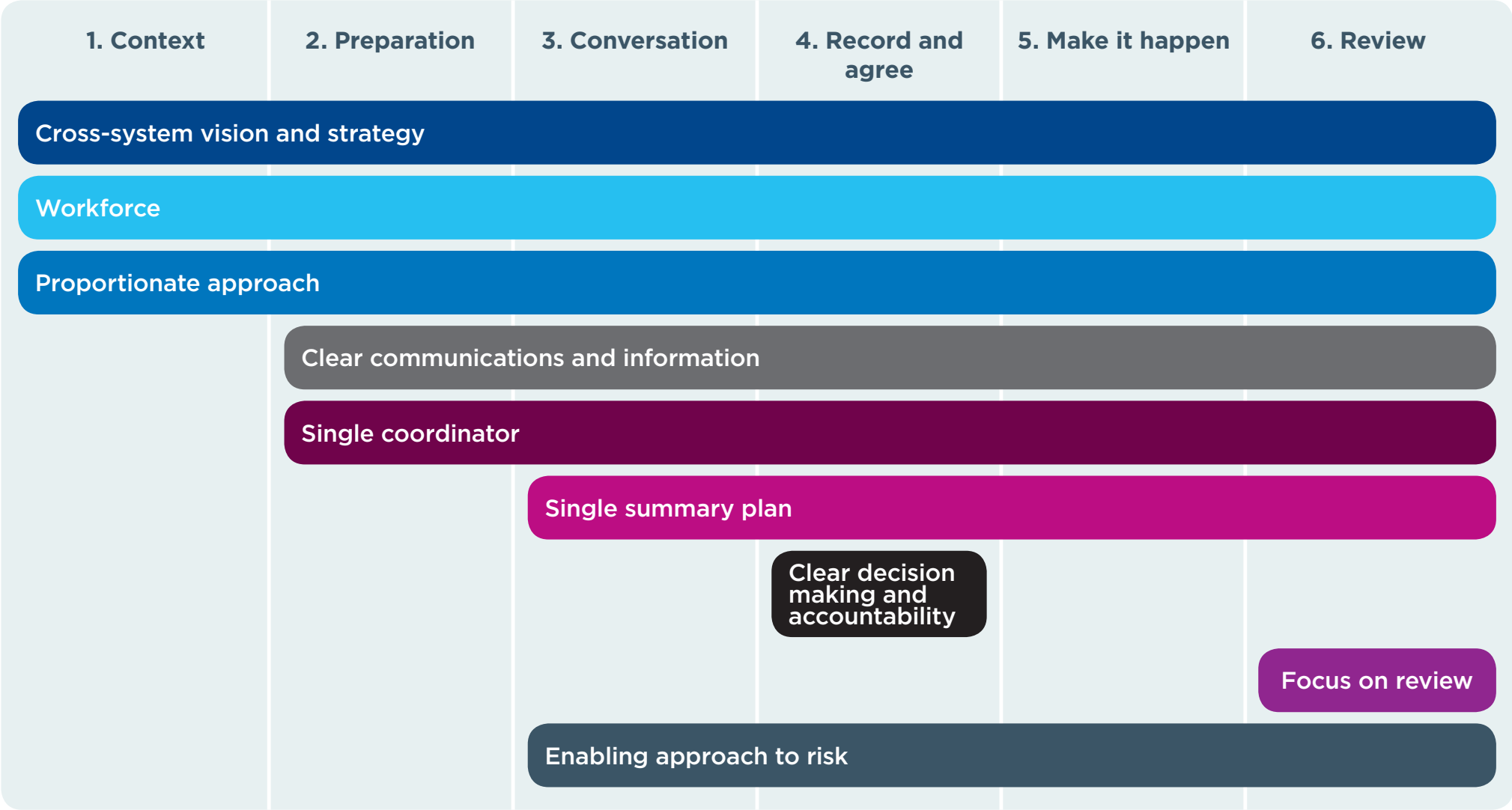
	1. Context	2. Preparation	3. Conversation	4. Record and agree	5. Make it happen	6. Review
Practitioners: Helps	[WF] Action learning opportunities. [WF] Identify ambassadors, champions, early adopters and peer leaders to help influence/unblock personalised approaches.					
Practitioners: Hinders	Professional boundaries: lack of clarity on whose job personalised care and support planning is. Medical or professional model and perceptions of thinking: "We already do it", "We know best".	Uncertainty about how to work and plan in a multidisciplinary way. Lack of up-to-date information. Lack of time to engage. Lack of skills, openness or enabling mindset. "Hiding behind forms/ process."	Time/targets: unrealistic caseloads, task-oriented roles, lack of time. Too much focus on assessed need and access to formal services. Too much focus on risk. 'One size fits all' mindset and fixed services hinder creativity.	Lack of guidance on what is formally required in a care and support plan. Organisational blockers: e.g. silo workers, middle managers. Complex sign-off procedures, including panels. Not being able to 'let go' of a care and support plan, recognising that it is not the property of the practitioner.	Lack of resources for 'key working', distracted by other priorities. Lack of trusting individuals to spend money and who is responsible/ accountable. Lack of knowledge on how to cost completely new offers. Lack of engagement with VCSE sector.	Not seeing review as an integral part of the process. Using time reactively not proactively. A focus on audit and not outcomes at review. Not thinking through future and evolving needs.

	1. Context	2. Preparation	3. Conversation	4. Record and agree	5. Make it happen	6. Review
System: Helps	The need to meet statutory duties and policy imperatives. [VISION] Cross-system strategy agreed between all partners and involving leaders, based on clear understanding of the case for personalised care and support planning for all audiences. Cohort identification: identifying who will benefit from planning in this way. Information sharing requirements have been considered, appropriate governance is in place and risks to personal information is minimised. Engagement and co-production with local population about current quality of planning and services.	[WF] Clear identification of the existing workforce who need to be supported. Strategic workforce development to support future workforce. A clear change management plan, including addressing culture change.	[WF] Identify ambassadors, champions, early adopters and peer leaders to act as change agents. [WF] Incorporate personalised approaches into supervision and objectives. [WF] Having a range of options in addition to the practitioner workforce to support conversation(s).	[VISION] Encouraging system-level view of resources, not just 'social care' or 'health' needs and resources. [DM] Agreeing a proportionate approach to recording and signing off. [DM] Being open to changing rules, policies and customs. [VISION] Onwards referral paths for people who may need individual service design.	Commissioning strategy that enables development of current market to reflect people's preferences. [RISK] Positive approach to risk enablement.	[RVW] Encouraging innovation and flexibility in practitioners. [RVW] Encouraging a focus on improving outcomes. [RVW] Using review as an opportunity to create a broader picture of the current market and gaps to influence commissioning strategy. [RVW] Monitor implementation and measure impact of personalised care and support planning.

	1. Context	2. Preparation	3. Conversation	4. Record and agree	5. Make it happen	6. Review
System: Helps	Commissioning, contracting and payment that encourages personalised approaches. [RISK] Positive approach to risk enablement.					
System: Hinders	Lack of funding. Lack of integrated, joint or partnership working. Condition or policy-specific pathways. Risk-averse culture. Not using available information and data, e.g. Joint Strategic Needs Assessment.	Lack of personalised skills across the workforce. A focus on processes and not people. Inflexible IT and finance systems. Unable to share information and data between agencies.	Performance management used too narrowly to manage and not encourage/ facilitate creativity.	Requirement for multiple plans and silo working. Lack of trust, e.g. relying on panels not social workers for decisions. Lack of knowledge on impact, e.g. poor definition of outcomes and actions.	Duplication and silo working leads to mixed messaging. Lack of clarity on policies: policies can be misinterpreted. Procurement processes potentially stifling creativity.	Rigid review processes can stifle. Seeing review as an opportunity to reduce spending.

5.2.1 Key themes

The nine themes identified in the personalised care and support planning framework form the strands of work any area must undertake in order to deliver and embed personalised care and support planning at scale. The diagram below represents how each of these themes contributes to each stage of the personalised care and support planning process.



5.3 Putting personalised care and support planning into practice at scale

Below is summarised learning on the vital areas that form the basis for any action plan to successfully take forward personalised care and support planning at scale for IPC. This isn't the only way to approach this key shift, and the best way to do it will depend on local circumstances. Areas of work don't necessarily follow one after another, and one action isn't 'finished' before the next one 'starts'. Many strands of this work would run in parallel with each other, and so run throughout the whole process (e.g. working in co-production with people with lived experience of care and support (see point e) and appropriate governance arrangements (see point f)).

- Baseline/mapping and gapping
  - a. Map all the existing assessment, care and support planning, decision-making and review pathways and processes for your identified cohort across all agencies.
  - b. Identify the workforce – including any existing multidisciplinary teams (MDTs), other teams within the NHS or local authority, or individuals located elsewhere (including the VCSE sector) – who are part of the existing pathways and processes for the identified cohort.
  - c. Using the personalised care and support planning framework and associated IPC products ((a) single coordinator and IPC hub/MDT approach, (b) workforce, (c) single summary care and support plan), self-assess your current approach to care and support planning.
  - d. Undertake communications and stakeholder mapping to identify all means of promoting awareness of personalised care and support planning.
- Vision and action plan
  - e. Based on points a to d above, develop a shared system-wide vision (local authority, health, VCSE sector) with people with lived experience of care and support.
  - f. Develop a multi-year action plan for personalised care and support planning to put your shared vision into practice, including actions and responsibilities across each agency (local authority, health, VCSE sector) and with people with lived experience for the identified cohort you are working with. Have a dedicated multi-agency leadership/action team that meets regularly to oversee this vision and multi-year action plan.
  - g. Identify ambassadors, champions or early adopters who are already delivering personalised care and support planning. Support them – through supervision, coaching and mentoring – to build on what they are already doing, and to share their approaches with other individuals and teams who will be impacted.
  - h. Put in place a single, named coordinator and IPC hub/MDT approach (see Annex B).
  - i. Put in place a single summary care and support plan (see Annex C).

j. As part of the IPC communications strategy, identify and share personal stories from people who have had a good experience of personalised care and support planning and the difference it has made. Identify good planning by practitioners and share this as well. Do this on an ongoing basis.

k. Provide a support programme for the development of personalised care and support planning to all relevant frontline staff and managers. Ensure the training is co-delivered with people with lived experience of care and support. Training should include the following elements:

   a. face-to-face training

   b. ongoing online learning and refection

   c. ongoing awareness sessions and webinars

   d. support materials.

l. Put in place a proportionate care and support planning process (see section below).

m. Regularly communicate the approach to personalised care and support planning with all who will be involved through dedicated events, drop-ins to team meetings, and information on websites/intranets.

- Embed

n. Embed personalised care and support planning approach in supervision to encourage reflective practice: include at least 15 minutes in every professional supervision to support reflective practice, identify stories and areas for personal development with regard to planning.

o. Embed personalised care and support planning in team meetings to encourage reflective practice: include at least 15 minutes in every team meetings to share success stories, challenges and opportunity to discuss potential solutions.

p. Ensure ongoing coaching and mentoring and create space for front line and managers is available: action learning, power hours, champions development and networks, supporting decision-makers.

q. Ongoing communications (as above).

r. Count and measure: use IPC evaluation metrics and any local measures to count and measure the difference that personalised care and support planning approaches are making to people locally. Measurement options include: **Adult Social Care Outcomes Framework, EQ-5D**, and Warwick Edinburgh Mental Wellbeing Scale. Continue to identify and share personal stories of the difference personalised care and support planning has made.

5.4 Taking a proportionate approach

Within IPC and personal health budgets, personalised care and support planning is intended to be proportionate, tailored to each person's level of knowledge, skills and confidence, and reflecting the full spectrum of potential input and support from professionals. This proportionality reflects a wide range of circumstances – of people, professionals and systems. It also supports the most effective use of resources within any area.

There are three broad areas to consider when developing a proportionate approach to personalised care and support planning:

- defining a proportionate approach
- applying proportionality
- bringing it all together.

5.4.1 Defining a proportionate approach

Personalised care and support planning is not a 'one size fits all' process. There will be a wide range of approaches that can be taken with various considerations informing the approach, including (but not limited to):

- How much support to plan is provided?
- Is this support in person or virtual?
- How many people will be involved in the decision about signing off the care and support plan?

It may be useful to define proportionate approaches taking into account these and any other local considerations.

5.4.2 Applying proportionality to IPC cohorts

In the same way that there is no single personalised care and support planning process, there are no identical people. Each person will come to the personalised care and support planning process with differences in the complexity of their needs, and their level of knowledge, skills and confidence. The planning process should therefore aim to take account of these differences.

On the level of knowledge, skills and confidence, the Patient Activation Measure (PAM) provides a measure of a person's skills, confidence and knowledge to manage their own health, scored from one to four. Areas using PAM can use this as a way to inform proportionate approaches to personalised care and support planning. Where areas don't formally use PAM, people and professionals can still use the descriptions of the different levels of PAM as part of the personalised care and support planning conversation stage to identify what level of knowledge, skills and confidence a person considers themselves to have.

5.4.3 Bringing it all together

By thinking about proportionate approaches to planning itself, as well as who care and support planning is for, it may be possible to think of a range of proportionate approaches to personalised care and support planning.

5.5 Other key resources

Other work to support personalised care and support planning has been taking place in parallel to the IPC programme. The resources developed or in development are therefore applicable to and recommended for IPC sites, as follows:

- a **CQUIN to support personalised care and support planning** (NHS England Person-centred Care Team)
- a **Getting started on personalised care and support planning guide** (RCGP)
- a **clinician network for personalised care and support planning**
- a module in GP training on personalised care and support planning (RCGP – forthcoming 2017/8)
- **workforce skills development publication** (Health Education England).

5.6 References and resources

The six-stage planning framework above is derived from **TLAP's personalised care and support planning tool.**

Other planning frameworks that have been drawn on and reflected in the above include:

- **NHS England care planning STP aide-memoire**
- **National Voices Care and Support Planning Guide** and **VCSE sector role discussion paper**
- **Year of Care/House of Care toolkit**
- **EHCP journeys – education, health and care plans for children and young people with special educational needs and disabilities**
- **Transition to adult care: Ready Steady Go**
- **RCGP/Health Foundation, Stepping forward**
- **TLAP Delivering care and support planning guidance**
- **Progress for Providers**

The framework also takes accounts of narratives for person-centred care, including:

- **A general narrative**
- **My life, my support, my choice: for children and young people with complex lives**
- **No Assumptions: a narrative for personalised, coordinated care and support in mental health**

6 Annex B: IPC hub/MDT approaches and the single, named coordinator

6.1 Introduction

This section focuses on how to put in place IPC hub/multidisciplinary team (MDT) approaches and a single, named coordinator for personalised care and support planning.

6.2 IPC hub/multidisciplinary team working

6.2.1 What is an IPC hub/MDT approach and who is in it?

A multidisciplinary approach involves drawing appropriately from multiple disciplines to explore problems outside of normal organisational or professional boundaries and reach solutions based on a new understanding of complex situations.

IPC is delivered through enhanced multidisciplinary teams (MDT) within care coordination hubs – or IPC hubs. These are the equivalent of multispecialty community provider (MCP) care hubs, providing practical, operational interaction with IPC cohorts. They can include GPs, nurses, social workers and condition or impairment-specific specialists (such as mental health, learning disability or children's nurses).

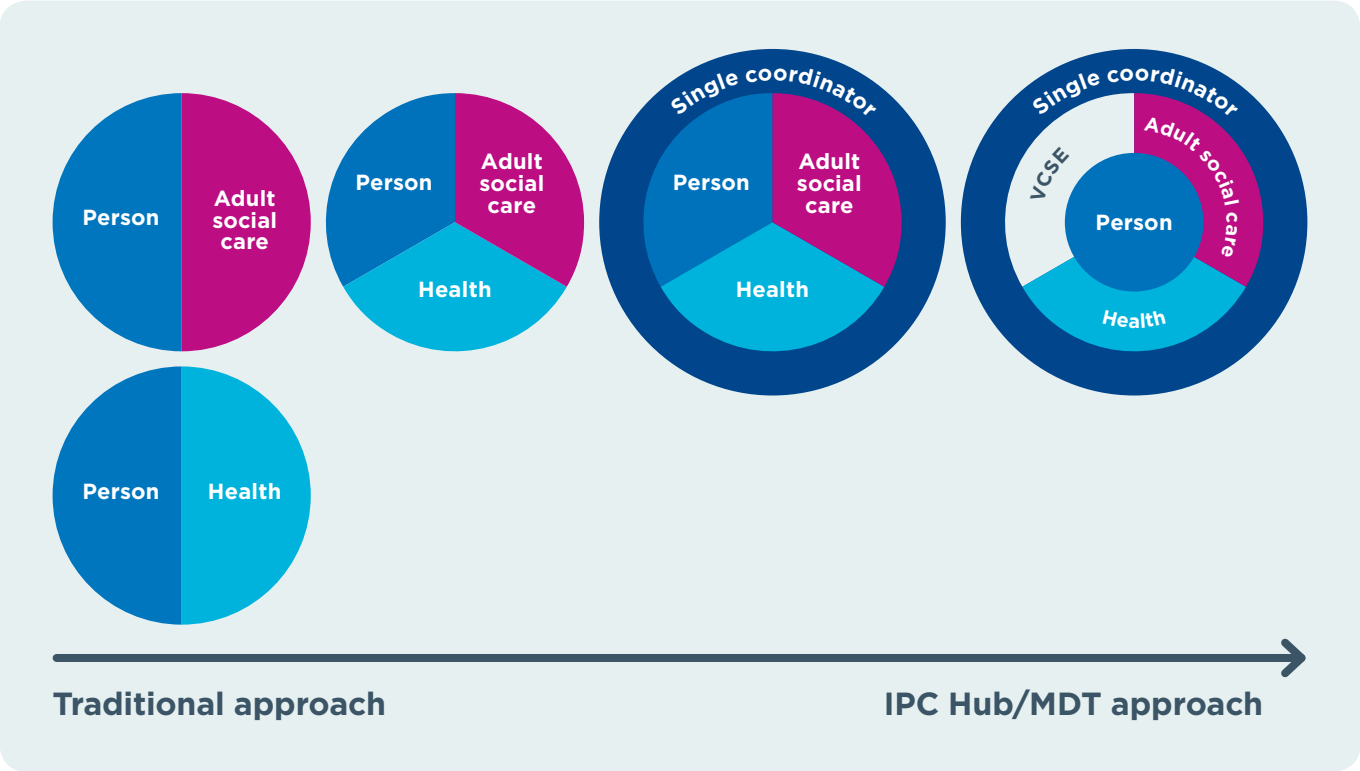
As part of the IPC approach, hubs and MDTs specifically include input from the VCSE sector, peers and volunteers. The potential workforce pool from which the IPC hub/MDT is drawn is detailed at the end of this Annex.

The single, named coordinator (see below) is a key component of the IPC hub/MDT.

The IPC hubs themselves can be located in various locations, including primary care, social care, community or specialist providers, or within the VCSE sector. This will depend on local circumstances and the identified cohort.

6.2.2 Options for structuring IPC hub/MDT approaches

There is a continuum of approaches to multidisciplinary teams, demonstrated in the diagram.



Note: single words in the diagram summarise any of the roles that may be found under that broad heading (see section 6.4 Who is meant by the 'workforce'). For example, 'Person' also includes family and carers and peer support.

Local areas may wish to consider one of the following models:

1. Full IPC hub approach. Integrated multidisciplinary team co-located and linked to GP surgeries.
2. Mixed approach. Integrated teams based on partnership working and cooperation and some co-location.
3. Virtual approach (see also Occasional approach below). Virtual teams where there is a single coordinated care and support plan, associated plans and a single coordinator who primarily liaise virtually.
4. Occasional approach (see also Virtual approach above). Bringing multidisciplinary specialists together on a single day at set frequencies so people whose work relates to a specific cohort can see everyone on one day and coordinated plans can be agreed.

Options 1 and 2 provide the most likely means by which to achieve the intended outcomes of IPC. In areas where there is no, little or unsuccessful history of MDT working, options 3 and 4 provide a practical starting point before fully realising option 1 or 2.

6.2.3 Effective IPC hub/multidisciplinary team development tool

The purpose of this framework is to support the local development of what good looks like for effective IPC hubs/MDTs. The development tool can be used to support the establishment, ongoing development and regular review of IPC hub/MDT effectiveness. Over time, the development tool could be used as a self-assessment tool by IPC hubs/MDTs.

The development tool can be used as the basis of conversations with IPC hub/MDT coordinators or, where this role is not established, facilitated with the IPC hub/MDT which is in place to review current effectiveness and establish a bespoke action plan for development. It will support the identification of development needs for IPC hubs/MDTs at all stages of development, and is not intended as a monitoring or scrutiny mechanism and should not be used for this purpose.

The development tool includes the following indicators of effectiveness:

1. Execution of the task (clarity of purpose, outcomes, process).
2. Structure and membership.
3. Meeting management.
4. Roles and functions.
5. Integrated care processes.
6. Debate and discussion.
7. Trust within the team.
8. Individual/collective agreement.
9. Acceptance of accountability.
10. Attention to results.

This framework has been adapted from Bradford, Airedale, Wharfedale and Craven's Integrated Care for Adults Programme.

'**The principles of workforce integration**' also outlines the key principles for integrated working and shares practical resources to put MDTs into practice.

MDT/IPC hub name	Location	
Indicator	What works well	Development actions
1. Execution of task. • **Are clear on their purpose.** • **Understand the processes in place.** • **State outcomes required.** • **Identify actions to take forward.**		
2. IPC Hub/MDT structure. • **Core membership is agreed on the basis of population need.** • **Associate membership is agreed to support care planning as appropriate.**		
3. Meeting management. • **Frequency of meetings is agreed.** • **Venue is agreed.** • **Time and length of meeting is agreed.**		
4. Roles and functions. The group has established key roles to support effective working such as: • **lead practitioner (see role profile)** • **meeting coordinator** • **meeting chair** • **integrated care coordinator** • **collective leadership of the MDT.**		

MDT/IPC hub name	Location	
Indicator	What works well	Development actions
5. Integrated care processes. • **Valid consent is obtained and recorded from all referred adults, including consent for information sharing.** • **Processes are in place to accommodate patients who may lack capacity – in line with the Mental Capacity Act 2005.** • **Members understand the principles of confidentiality.** • **Processes are in place to enable recording of discussion.** • **Processes are in place to document the single care and support plan.** • **Process is in place to identify a single, named coordinator.** • **Process is in place for timely review.** • **Appropriate information governance approaches are in place.**		

MDT/IPC hub name	Location	
Indicator	What works well	Development actions
6. Healthy debate and discussion. • **Discuss different professional approaches.** • **Deal with disagreements immediately.** • **Challenge the evidence behind ideas.** • **Are interesting and persuasive in their discussions.** • **Ask deeper, probing questions.** • **Discussion results in new approaches to care and support.**		
7. Trust within the team. • **Openness around gaps in knowledge and need for advice or assistance.** • **Comfortable sharing new ideas and challenging old ideas.** • **Have shared purpose and unified goals.** • **Are welcoming to new members/ observers.** • **All members of the MDT are valued as equal partners (health, social care, VCSE sector).**		

MDT/IPC hub name	Location	
Indicator	What works well	Development actions
8. Individual/collective commitment. • **Attend meetings regularly and on time.** • **Pay attention to conversation.** • **Commit to actions agreed and carry them out.** • **Contribute to the process.** • **Feel contributions are valued.** • **Make decisions.** • **Leave the meeting with a plan.**		
9. Acceptance of accountability. • **Identify who is responsible for action.** • **Understand the potential impact of success on the wider health and social care system.** • **Challenge lack of action or avoidance.** • **Deal with poor performance.** • **Don't allow shifting of blame.** • **Admit to/take responsibility for errors.**		

MDT/IPC hub name	Location	
Indicator	What works well	Development actions
10. Attention to results. • **Identify outcomes desired.** • **Understand aims and objectives.** • **Use clear processes to achieve results.** • **Discuss and evidence results.** • **Take credit for positive results.** • **Use creative approaches to obtain outcomes.**		

6.3 Single, named coordinator

Everyone experiencing the IPC care and support journey should have a single, named coordinator who acts as a consistent point of contact for the whole journey. This role will provide coordination and information, timely support, and must work exceptionally closely with the person – who should be in control of their journey and their support – as well as their family/carers. In addition to this coordination role, the single, named coordinator can also support development of a person's personalised care and support plan and coordinate delivery of a wide range of services.

The single, named coordinator is one of the people from the IPC hub/MDT approach (see below for details on what roles are included in an IPC hub/MDT approach) – providing or enabling care and support designated to take a coordinating role. This could be, for example, a social worker, nurse or person working for a VCSE organisation. It could also be a peer supporter, a family member or the person themselves. The person holding the role does not necessarily have to be a qualified professional or practitioner. The key is for a choice to be available for the person being supported of who the single, named coordinator is, rather than it simply defaulting to one professional.

6.3.1 Single, named coordinator characteristics

There is no one list that could ever define the characteristics of single, named coordinators. Some characteristics of single, named coordinators can include, but aren't limited to:

- patience
- empathy
- an open mind
- being assertive when needed
- ability to innovate, be creative and solve problems
- inclusiveness and openness
- building and developing relationships
- flexibility
- tact
- trust.

This results in them being a good listener and an effective advocate, and so having:

- the ability to establish trust and build confidence
- an understanding of the importance of face-to-face contact and keeping in touch
- respect for the full history of each person
- the ability to work well with others
- status and authority, and the ability to make changes
- recognition of the importance of equality and diversity.

6.3.2 What single, named coordinators do

Key aspects of the role of a single, named coordinator include:

- Being an experienced and knowledgeable person, who can communicate, navigate and coordinate within a complex system of care and support.
- Supporting or ensuring the practical arrangements to ensure good personalised care and support conversations can happen.
- Providing timely information and support.
- Offering preventative care and support – understanding and recognising health and care conditions, noticing changes, enabling change and supporting people to balance different options.
- Engaging and involving carers, family and anyone else the person wishes to involve.
- Ensuring the care and support plan is agreed and signed off.
- Working in partnership to ensure the person's care and support plan is delivered – named coordinators must have or form effective working relationships with others in the health and social care system. They must have good knowledge of other services and professionals across health, social care and the VCSE sector, and how to contact them, including specialist care that may be out of the area.
- Sometimes, the named coordinator can also be the lead care and support planner. In this instance, they would develop the single care and support plan and ensure other information from other plans is appropriately linked. On other occasions, it can ensure the person knows the plan for their care and support, signs their agreement and has ownership of the plan, and then making sure other team members are aware of and understand the care and support plan.

6.3.3 How to put a single, named coordinator into place

Below are key resources that will enable you to put in place a single, named coordinator:

- **NICE guidance on what the role of a single, named coordinator should be**
- **A wide range of examples and case studies of single, named coordinator/navigator roles, including job descriptions, from London Health Programmes**
- **There are different options for how you can fund a single, named coordinator, or indeed a dedicated single, named coordinator/navigator function. These are outlined in detail, with some indicative costs, in Appendix 1 of TLAP's Delivering Care and Support Planning report**
- **Key worker approaches for children and young people**

6.4 Personalised care and support planning: who is meant by the 'workforce'?

Below is an outline of the roles that are typically associated with personalised care and support planning. There are some roles that could do personalised care and support planning irrespective of the cohort. These can include (but aren't limited to):

- care navigators
- brokers
- qualified support planners
- local area coordinators
- provider staff
- GPs or practice-based nurses
- community matrons
- the person themselves, with/without support
- family member/carer
- peer support/people with lived experience of care and support.

Care navigators, brokers, support planners and local area coordinators could be located in the local authority the NHS or in the VCSE sector (including user-led organisations).

In addition to the above possibilities, there are also some roles that could do personalised care and support planning for specific cohorts. A non-exhaustive list of these is given below.

- Children and young people:
  - children's social workers
  - children's nurses
  - paediatricians
  - occupational therapists
  - physiotherapists
  - child and adolescent mental health (CAMH) teams
  - speech and language therapists
  - teachers, teaching assistants
  - special educational needs coordinator (SENCO)
  - specific VCSE partners.
- Adult social care (which could cover physical or sensory impairments (PSI), older people (OP), people with a learning disability (LD), depending on local arrangements):
  - social workers
  - occupational therapists
  - specific VCSE partners.

- Health (including NHS Continuing Healthcare (NHS CHC)):
  - doctors/consultants/specialists
  - nurses (including specialist nurses, depending on condition, e.g. cardiac nurses)
  - occupational therapists
  - physiotherapists
  - speech and language therapists
  - psychologists
  - psychiatrists
  - other health clinicians and health and care support workers
  - specific VCSE partners.
- Mental health:
  - (mental health) social workers
  - mental health nurses
  - community psychiatric nurses
  - care coordinators (all of the above)
  - occupational therapists
  - mental health providers
  - specific VCSE partners.
- Learning disabilities:
  - (learning disability) social workers
  - learning disability nurses
  - occupational therapists
  - doctors, including GPs
  - advocates
  - care navigators, brokers
  - VCSE sector partners
  - learning disability providers.

It is vital that once the local cohort(s) for IPC have been identified the teams who work with these cohorts are also identified. This will immediately identify the teams and professionals to prioritise to support with personalised care and support planning.

A useful overview of the role of specialists and generalists/community-based supporters in care and support planning is provided by the Year of Care Partnership.

7 Annex C: Single care and support plan and better conversations

7.1 Introduction

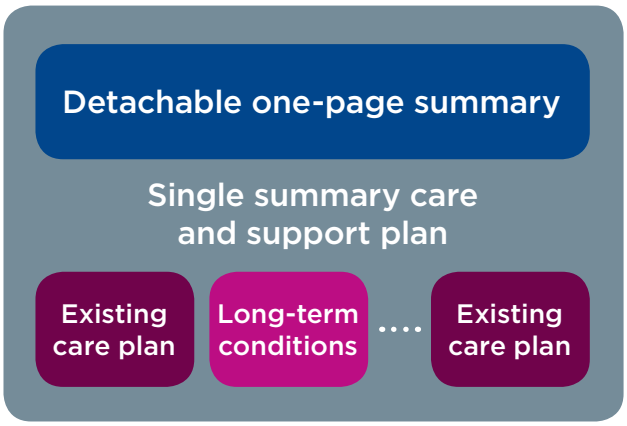
This section develops key principles and options on how areas can put care and support planning into practice at scale and share good practice, focusing in particular on how to produce a single care and support plan and support better conversations.

7.2 Developing single care and support plans

Each individual should have a single care and support plan as an overview for all other plans.

This need not include the detail required in other plans, i.e. condition-specific care or treatment plans. However, it should include the key points and salient information about a person, include details common to all other plans, and ensure these other plans (e.g. condition-specific treatment or care plans) are linked up. It must reflect what is important to them and how best to support them. This can then be recorded in a one-page detachable summary. The single care and support plan should also then explicitly link to the detailed plans a person may have, and must include a summary of other information from the 'what matters to you' conversation, including:

- aspirations
- outcomes
- action plan
- risk management
- contingency planning
- budget sheet (where applicable)
- self management



The various plans therefore sit together as per the diagram.

Some important points:

- The single care and support plan must meet the requirements of all agencies involved.
- A good care and support plan will signpost to other relevant assessment and planning information, rather than including it and making it a vast plan.
- There needs to be a visible thread between assessment, personalised outcomes and implementation actions.
- The care and support plan needs to serve a purpose, is driven by the person who knows they have ownership, whilst working in partnership with others.

In addition, developing single care and support plans through IPC is an opportunity to take a whole family approach, and so create single plans for whole families. A whole family approach is one which takes a holistic view of a person's needs to identify how their needs for care and support impact on family members or others in their support network.

7.2.1 Focusing on outcomes

Outcomes are changes in, or sustainment of, physical behaviours, health conditions or mental states or emotions. Therefore, outcomes may relate to both health and wellbeing.

Outcomes should describe the things that the person wants to change or achieve – they are not services, treatments, therapies or items. People may need help to identify their outcomes and to ensure they are as specific and individually relevant as possible. The personalised care and support plan must clearly describe what is being aimed for, and in specific terms, what will be working better, be maintained or be avoided. This can include what is hoped for when someone has a degenerative condition or as their health deteriorates and they approach the end of life.

Outcomes must be recognised and owned by the person. A good outcome changes something that isn't working and builds on/maintains something that is working. It should be specific and personal to the person and be something the person or those around them have some influence or control over. If this isn't the case, then something has gone wrong with the conversation and there needs to be further dialogue to agree joint priorities between the person and the healthcare practitioner, including a discussion on risk and contingency planning.

7.2.2 Developing the first draft of a one-page summary

- What is a one-page summary?

A one-page summary is a starting point to summarise what matters to a person (what is important to them) and how to support them well. The expert on the content of a one-page summary is the person themselves and people who love and care about them. It also shares what others appreciate about the person. The one-page summary could be the first page of a personalised care and support plan, which is also detachable from the rest of the plan so it can be used in lots of different ways.

- Why have them?

To provide the best possible support to people, it should be known what is important to each person and how they want to be supported. A lot of information is recorded about people, and a one-page summary is a quick way of understanding who they are as a person. The way that people want to be supported informs how anybody supporting them can help and care for them. It also means that the person doesn't have to share their story time and time again.

- How do they relate to a person's NHS Summary Care Record?

The one-page summary should not be confused with a person's NHS Summary Care Record (SCR). This is an electronic record of important medical information, created from a person's GP records. It is held on a central database and includes information such as medication, allergies and adverse reactions. It is made available, with the person's permission, to authorised healthcare professionals, e.g. paramedics or staff in accident and emergency. It ensures they have faster access to key information needed to treat people.

- What should be in them?

There are four suggested sections of a one-page summary:

1. What people appreciate about me.
   - What this section is: What is good about the person? What do others value about them? What are the positive contributions that they make?
   - What this section isn't: A list of accomplishments or awards – instead it is a summary of their positive characteristics.
2. What is important to me.
   - What this section is: A summary of what really matters to the person. This tells people what is really important to them, which they must pay attention to. What their hobbies, passions and interests are. Who is important to them, and what makes a 'good day' for them.
   - What this section isn't: Simply a list of things that they like – instead it is a summary of what really matters to them.
3. How best to support me.
   - What this section is: The specific information that would be useful for other people to know and do if they are supporting the person in the best way possible.
   - What this section isn't: A list of very general hints – instead it is the specific information that would be useful for other people to know about the person to make sure they feel supported.
4. Brief health summary.
   - What this section is: This is a brief description of the person's key health conditions.
   - What this section isn't: Detailed and specific information about a person's health condition.
   - How to develop a one-page summary

Developing a one-page summary is more like being a detective than doing a questionnaire. It is not just about finding out the answer to the question, but trying to establish how important it is to the person, or what this tells us about the help and support they need with their health.

The first answer gives us a clue about what may be important to the person but your follow-up questions need to help you understand whether this is simply a like or dislike, or something that is important enough to go on their one-page summary.

The question never to ask is "Why?" However gently asked, it is a request to justify and explain; it is better to say things like: "Tell me more about that."

The key is to start a conversation, to learn about what matters to the person from their perspective. The goal is learning deeply, not getting through as many questions as possible. It is important to note that for some people it can take time for them to think about the things that are important to them and to trust somebody enough to tell them.

Here are some good questions to use: you do not have to use them all. You will find the ones that you are most comfortable with and get you the best results. They are just being offered as guidance and help and are not meant to massively increase the planning process.

You could weave them into your regular planning process as you go through the more formal questions you have to ask or you could ask them all together and then make notes to develop the one-page profile. As you gain more confidence you may be able to develop the one-page profile directly as you are having the conversation.

1. What people appreciate about me (for the first section of the one-page summary)
   - What would your family say they like and love about you?
   - What would your best friend say that they liked about you?
   - What is the best compliment anyone has ever paid you?
2. What is important to me (for the second section of the one-page summary)
   - About people
     - Who are the most important people in your life?
     - How do you stay connected to them? What do you do together? Where, when and how often do you do things?
   - About things the person likes to do
     - In a typical week what do you do with your time?
     - What do you always do when you first get up in the morning?
     - What do you always do before you go to bed?
     - In a typical week what would you do with your time?
     - What is the best and worst day of the week for you? What happens then and who are you with?
     - What is the best and worst time of the day for you? What happens then and who are you with?
     - 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?
     - What makes you feel better when you are unhappy or upset?
     - What is your favourite TV programme or film?

- About important possessions
  - What are your most important possessions?
  - What would you never leave home without?
  - What do you always keep in your pockets or bag?

3. About supporting the person (for the third section of the one-page summary)
   - Staying healthy
     - What helps you stay as healthy as possible?
     - What hinders you from staying as healthy as possible?
     - Is there anything that really embarrasses you?
     - In the past, what has brought you comfort when you have been distressed?
   - About decision-making
     - If you need information, how would you like it presented it to you?
     - How can you be supported to understand the information given to you?
     - What are the best and worst times to ask you to make a decision?
4. Top tips
   - Ask
     - Ask the question and then follow up by saying: "Tell me more." Think of it as a conversation rather than interview.
   - Guess
     - What does this tell you about the person?
     - Does their answer tell you that something is important to the person?
     - Does it suggest an area that the person would benefit from help or support in?
     - Does it tell us about a characteristic that others appreciate and value in the person?
   - Check
     - Check with the person you are talking with whether your guess is right.
   - Add
     - Add information to one of the following three areas on the one-page summary:
       - Like and admire
       - Important to the person
       - How to support the person.

More information on developing one-page profiles and summaries is available from Helen Sanderson Associates.

7.3 Single care and support plan: Challenges, lessons learnt and resources for better conversations

The Care Act 2014 states that an individual should have one care and support plan. A number of challenges present themselves when trying to achieve this, as there are a number of plans a person could potentially have (e.g. a condition-specific treatment plan). To help address these challenges, there are a number of overall principles to keep in mind:

- Preparation – think about who you are going to be engaging with and ensure you are prepared for the next meeting, the next conversation, the next review; there are a number of tools which can help you to support the individual, their families and other professionals to think about what is important and what they want to say. Often it takes time for the person to build a relationship with the person leading the preparation stage and this needs to be factored in when planning the time it will take.
- Current information and data – ensure you have reports and assessments that are up to date and request new ones if necessary; this will form part of your preparation. Establish ways of working so that data can be shared appropriately, such as developing information sharing agreements between relevant partner organisations.
- Training – agree with all stakeholders, including the VCSE sector, the training and development that is required so that everyone is delivering the same message, and how this will be delivered. This ensures a consistent approach for the person and ways of working which are embedded into everyday practice. This will also ensure any challenges from professionals, around changes in cultures, can be addressed.
- Clear sign-off process and risks – develop cross-system strategies to achieve a seamless process for signing off the care and support plan and any risks, which will engender a positive approach to risks.
- Communication – have a communication protocol which includes how to plan with people who do not use words: this should include considered selection of people from the relationship circle, a well-defined communication plan which captures the ways the person does communicate and what these things mean, and briefing the facilitator prior to the meeting. It could also include the use of advocacy. If new ways of communicating and supporting the person emerge from the different conversation, these need to be recorded and included in future personalised care and support plans.
- Focused outcomes – writing focused outcomes for the person which will require good training and development, good preparation and a positive approach to risk.
- EHC and other plans – establish whether the person has other plans (such as condition-specific or treatment plans) which need to be integrated. Carry out local mapping exercises to plot both processes and how they can become one.
- Contingency – identify what will prevent a care and support plan from proceeding and develop contingency strategies, ensuring a positive approach to risk is upheld; this can then form part of the final care and support plan.

- Managing risk – identify risks and implement positive risk-taking practices; these should be included in the training and development processes.
- Sign-up of professionals – develop strategies to encourage professionals to sign up to the single care and support plan and one-page summaries. Different areas will require different methods of engagement using best practice, case studies and evidence.

In addition to these principles there are lots of practical steps that can be taken to overcome the challenges of personalised care and support planning. In the table below lots of detail is provided on how this can be done, including examples, possible solutions and a wide range of practical resources and templates you can use for better conversations.

There are also considerable resources identified in the last part of the overarching personalised care and support planning framework section.

Learning/challenges?	Suggestions/solutions	Examples/resources
1. The need to ask the right questions to get information about what is important to people.	• Standardise the training for those who will be visiting the person. • Be prepared before visiting the person for the first time. • Prepare the person and their family about the tools that will be used. • Find out about existing information/assessments. • Find out all other professionals involved already. • Know who will be the single point of contact for person.	
2. Challenge to embed into professional practice.	• Training and workforce development. • Start small and gradually increase both numbers of people and different care groups. • Encourage professional groups to incorporate in their standards, e.g. Royal College of General Practitioners.	See: Co-production for personal health budgets and Integrated Personal Commissioning: Summary guide

Learning/challenges?	Suggestions/solutions	Examples/resources
3. To establish a clear sign-off process for both health and social care.	• Liaise with IPC Senior Responsible Officers to ensure this is on the agenda for all relevant meetings.	See: Personal budgets, integrated personal budgets and personal health budgets: Summary guide
4. Have a communication protocol which includes how to plan with people who do not use words.	• Consider use of advocates. • Complete a relationship circle which identifies those who know the person well. • Person coordinating plan to brief the facilitator in detail about how to communicate with person. • Agree how to record the care and support plan to make it as accessible as possible to the person. • Agree with those in the relationship circle who the best person is to have the different conversation with the person.	
5. Writing focused outcomes for the person.	• Ensure good preparation stage. • Workforce development on how to write good outcomes.	
6. Need a practical guide on how to do this process with EHC and family plans.	• Establishing whether the person has an EHC plan and any other existing plans. • Local mapping exercises to plot both processes and how they can integrate.	Co-production for personal health budgets and Integrated Personal Commissioning: Summary guide
7. Challenge to change perceptions of the staff and the person.	• Workforce development. • See details for Challenge 3, above.	Co-production for personal health budgets and Integrated Personal Commissioning: Summary guide

Learning/challenges?	Suggestions/solutions	Examples/resources
8. Identify what will prevent a care and support plan from proceeding.	• Develop contingency plans for the 'What ifs' and communicate this to all.	See section on Choice, risk and decision-making.
9. Managing risk.	• Identifying risks. • Implementing positive risk-taking practices. • Rolling out training to the workforce.	See section on Choice, risk and decision-making.

7.4 Assessments (statutory, condition-specific and locally developed)

There is a key principle to ensure the person only tells their story once. The guidance below supports this.

- Inevitably there is overlap between the assessment and care and support planning stages, so attention has to be paid to ensuring questions that are asked at assessment that give information relevant to care planning are not repeatedly asked at care planning stage. Good practice is for the single, named coordinator to be present and part of the assessment, if the person wants.
- Assessments have to be shared with those developing care and support plans, so they can follow the thread between identified needs and outcomes. The appropriate consents will need to be in place for sharing to happen.
- Working in an integrated way means accepting and working with the professional opinions of your colleague in a MDT so ensuring repeated assessments are not required.
- Before preparation stage, any statutory, condition-specific or locally-developed assessments will need to have been completed and if there are additional specialist needs identified, these should also be completed prior to the conversation stage.
- Ensure there is a process for identifying carers and signposting to appropriate services for assessment.

8 Annex D: Personalised care and support planning for personal health budgets

8.1 Introduction

Whilst there are many similarities between the approach to personalised care and support planning in both IPC and personal health budgets, this section describes in more specific detail what personalised care and support planning should look like to support delivery of personal health budgets. It should be read in conjunction with Guidance on Direct Payments for Healthcare: Understanding the Regulations.[5]

8.2 About personalised care and support planning for personal health budgets

8.2.1 Importance of the process

The personal health budget personalised care and support planning process does not just involve writing a document or completing a template – it is an active, ongoing relationship and dialogue, with changes of role for people, healthcare practitioners and commissioners.

Personalised care and support plans can include all the services and support provided, whether traditionally commissioned or through notional or third party budgets, as well as direct payments.

In some circumstances, it may be appropriate for personalised care and support plans, and the process to develop them, to be proportionate to the size of the person's personal health budget. For example, personalised care and support planning for a small personal health budget intended to purchase a piece of equipment may not be as comprehensive as personalised care and support planning for someone in receipt of NHS CHC living in their own home, where the budget covers more of the person's assessed health and social care needs.

8.2.2 Local context and principles

Applying the common personalised care and support planning framework (see Annex A) to personal health budgets generates important local context and principles – sometimes called the 'local offer' – for personalised care and support planning as follows:

- Clarity on who is eligible to receive a personal health budget.
- Clarity on the purpose and principles of personal health budgets for each group of people who is eligible to receive one.
- Good information, advice and support, to enable people to find out more about personal health budgets and whether or not a personal health budget is available or right for them.
- Clarity about all aspects of the money, including how the budget is set, and the scope and flexibility of budget spend.
- An agreed local approach to choice, safeguarding and risk-enablement (see Annex F).
- Agreed criteria for personalised care and support plan authorisation or sign-off.
- An agreed process for appeals.
- Agreement about how personalised care and support plans and outcomes will be monitored and reviewed.

8.2.3 Who provides support

It is vital people are supported throughout the planning process. Within IPC the role of the single, named coordinator is key (see section 6.3). This is also sometimes the role that provides independent support for personal health budgets.

In an area delivering solely personal health budgets, the role of the single, named coordinator is sometimes split between two different roles: 'care coordinators' and 'brokers' who provide independent support.

A care coordinator must be named by the CCG when someone is in receipt of a direct payment, and this must be recorded in the personalised care and support plan. The care coordinator is responsible for managing the assessment, ensuring the person (or their representative) and the CCG have agreed the personalised care and support plan, ensuring monitoring and review, and ongoing liaison.

Brokers or independent support can provide a wide range of functions, including:

- providing information
- giving technical advice, for example, relating to recruitment and employment of personal assistants
- coordinating support and resources
- assisting the person to manage their obligations and responsibilities in relation to their budget
- enabling things to happen
- obtaining clinical support where necessary.

There will be overlap between the roles of all those involved in the process and it is particularly important to understand the discrete role each person has to play, and that crucially the process is about planning together, not planning for the person.

8.3 The stages of the personalised care and support planning process

The stages of the personalised care and support planning process for personal health budgets are as set out in the common planning framework – preparation, conversation, agree and record, making it happen and review. The framework describes what each stage is (see Annex A above).

Below are specific details of each stage relevant only to personal health budgets.

8.3.1 Preparation

For professionals, preparation may include:

- Gathering up-to-date information about the person from relevant health, social care or education assessments and interventions.
- Reviewing case notes and existing plans.
- Obtaining an indicative budget to plan with, and understanding how this has been calculated.
- Understanding roles and responsibilities of various other people who may be involved in the delivery of personal health budgets locally.
- Understanding the local context and principles for personal health budgets.
- Making contact with the person, providing information in advance of the first meeting to guide on what to expect from the personalised care and support planning process and addressing any initial queries or concerns.
- Managing the practicalities of setting up the personalised care and support planning conversation based on the person's preferences (e.g. date and time, location, etc.).

For the person, their nominee or representative, this may include:

- Reviewing information received in advance of the personalised care and support planning process to understand what is involved, how long the process may take and what to expect at each stage of the process.
- Thinking about, and discussing with family members, friends and carers, what's important to them, what might be possible, and beginning to think about the outcomes they may like to achieve with support from their personal health budget.
- Making arrangements to involve other family members, friends and carers in the personalised care and support planning process.

8.3.2 Conversation

The personalised care and support planning framework incorporates all the components that make for effective conversation in the planning process. For personal health budgets, there are some specific requirements that must result from the conversation.

What to include in a personalised care and support plan

To enable the personal health budget to be authorised, those responsible for agreeing the final budget must be able to see and agree a personalised care and support plan that meets clear criteria.

For personal health budgets requiring a direct payment, the regulations set out that a personalised care and support plan must include:

- The health needs of the individual and desired outcomes to be achieved through purchase of services in the personalised care and support plan.
- What the direct payment will be used to purchase.
- The size of the direct payment, and how often it will be paid.
- The name of the care coordinator responsible for managing the personalised care and support plan.
- Who will be responsible for monitoring the health condition of the person receiving care.
- The anticipated date of the first review, and how it will be carried out.
- Where necessary, an agreed procedure for discussing and managing any significant potential risks.
- Where people lack capacity or are more vulnerable, the plan should consider safeguarding, promoting liberty, and where appropriate, set out any restraint procedures.
- The period of notice required if the CCG decides to reduce the amount of the direct payment.

Although the regulations apply only to direct payments, these are useful criteria to support personalised care and support planning for all types of personal health budgets. In addition, it is best practice to include the following information:

- All of the information noted in the single care and support plan (see Annex C).
- If the person lacks capacity to make their own decisions, the plan should show how decisions were reached and who is acting on the person's behalf.
- The budget available to the person to meet their assessed health and wellbeing needs.
- Where the budget will be held and managed.
- How the personalised care and support plan will be put into action.
- Any training required by care workers/personal assistants supporting the person.
- A contingency plan for the provision of care and support in emergency situations.

Personalised care and support plans should describe the outcomes that a person wants to change or achieve. More detail on how to do this can be found in Annex C.

Discussing the money

Understanding how the budget has been set will help with the personalised care and support planning process, particularly with discussions about how outcomes will be met. CCGs can take different approaches to setting budgets, but regardless of the approach taken, there should be a clear link between the indicative budget and the person's assessed needs. The professional who is supporting the person to develop their personalised care and support plan should be able to explain the approach taken to setting their budget. This will enable the dialogue around personalised care and support planning, developing outcomes and planning budget spend to take place in a more transparent way.

People will need to know what their budget can be spent on and what is excluded. Personal health budgets cannot be used for:

- gambling
- debt repayment
- tobacco
- alcohol
- anything illegal or unlawful.

Personal health budgets will not be appropriate for all aspects of NHS care a person may need. There are also a number of services which cannot be purchased using a direct payment or third party budget:

- primary medical services provided by GPs
- public health services, such as vaccination or immunisation, screening etc.
- urgent or emergency treatment services
- surgical procedures
- NHS charges, such as prescription or dental charges.

Apart from these exclusions, personal health budgets can be used for a broad range of services, agreed as part of a personalised care and support plan, that are likely to meet the person's health and wellbeing outcomes. CCGs should be careful not to exclude unusual requests without examining the proposal on a case-by-case basis; these may have significant benefits for people's health and wellbeing. When the personal health budget is delivered through a direct payment, the CCG must make arrangements for the person, their representative or nominee to obtain information, advice or support in connection with this. The person receiving the direct payment (whether it is the individual requiring support, their nominee or a representative) is responsible for ensuring that it is only used as specified in the personalised care and support plan.

8.3.3 Signing off the personalised care and support plan and appeals

For sign-off processes to be simple and sustainable, criteria for a good plan should have been made explicit to people themselves, and staff signing off personalised care and support plans need to have sufficient training and feel confident and trusted to ensure these criteria have been met.

Plans may be written in many different styles, but when agreeing the personalised care and support plan, the CCG needs to be satisfied that:

- The health needs of the patient can be met through the purchase of services in the personalised care and support plan.
- The amount of money available will be sufficient to cover the full cost of each of the specific services in the personalised care and support plan.
- The personalised care and support plan will be reviewed as required.
- Any significant potential risks have been discussed with the person, their representative or nominee and appropriate procedures to eliminate, reduce or manage these risks have been included in the personalised care and support plan.
- Where people lack capacity or are more vulnerable, procedures such as safeguarding, promoting liberty and if required, necessary restraint procedures have been included appropriately in the personalised care and support plan.

The individual or their representative must also agree that:

- The person's care needs will be met by the services agreed in the personalised care and support plan.
- The amount of any direct payment is sufficient to cover the full cost of the personalised care and support plan.
- The personalised care and support plan will be reviewed and their needs may be reassessed as part of that review.
- Their information can be shared with relevant bodies to support delivery.

It is necessary for all parties to know what will happen if there is disagreement about signing off a personalised care and support plan, and to have in place a clear process of appeal. Where the CCG is unable to authorise a personalised care and support plan, reasons for this should be communicated clearly and in a timely way to the person, their representative or nominee. Alternative options to meet the person's assessed health needs and outcomes should be identified, and a solution agreed. If any dispute cannot be resolved, the CCG should refer the person to the NHS complaints procedure.

8.3.4 Making it happen

The action planning section of the personalised care and support plan must specify clearly who will do what, and when, in order to reassure the CCG that the health needs and outcomes can be met. It should show who is taking responsibility for each task and how they will do it.

If a person is intending to employ their own personal assistants to undertake specific health tasks, the plan will identify:

- who is accountable for the decision to delegate the task
- how relevant training will be provided
- the process for competency sign-off
- how competency will be reviewed
- ongoing support available for personal assistants carrying out the health tasks.

The ideas about actions to take in order to achieve outcomes will draw together the person's own solutions, which they are committed and motivated to do, with the healthcare practitioner's expertise about local agreed processes, what might have proved useful for others and what research evidence suggests. The actions in the personalised care and support plan should be specific and linked to the outcomes.

8.3.5 Review

It is essential to check at suitable intervals how the personalised care and support plan is working, the health needs of the person, and whether the plan is meeting these needs and achieving their agreed outcomes.

For direct payments, as a minimum, all personalised care and support plans must be reviewed formally within three months of the person first receiving the direct payment. Following this, reviews should be at appropriate intervals, but at least yearly.

Personalised care and support plan and budget review should be proportionate to the person's circumstances, and the process through which they are undertaken should be clearly explained to the person, their nominee or representative.

Sufficient time will be required by the person when preparing for the review to:

- gather together any relevant documentation
- reflect on previously agreed outcomes and the extent to which these have been achieved
- think about what they would like to change or achieve in the future.

People with personal health budgets should be fully aware that they do not have to wait for a scheduled review if their circumstances or health condition have significantly changed, but can call for a review as necessary.

The person responsible for completing the review should be the care coordinator or the healthcare practitioner that knows and understands the person's health needs and their situation. Where possible, the review process should be integrated with other planned clinical reviews, or reviews carried out by a local authority or other statutory services.

A review should consider:

- the person's health needs and any changes that may need to be incorporated into the personalised care and support plan
- whether intended outcomes have been achieved
- how the budget has been used
- any new risks or changes to risks previously identified, including a review of how these are mitigated against
- whether all obligations associated with using a direct payment have been fulfilled, for example, the purchase of insurance, training for personal assistants, employer responsibilities, registration of providers delivering regulated activities
- whether the budget is sufficient to cover the full cost of each of the services identified in the personalised care and support plan.

Having established how the personal health budget is helping the person to meet their outcomes and how the budget has been spent, the review should also include a discussion with the person about their priorities for the coming year and longer term. There may be opportunities to build on the things achieved through the original outcomes, or areas identified that need to change in the short or longer term. The person may just want to maintain their current situation if things are working well.

9 Annex E: Supporting the workforce

9.1 Introduction

This section focuses on how to ensure the workforce is practically supported – including training, mentoring and coaching – to deliver personalised care and support planning at scale. It translates the workforce elements of each stage of the personalised care and support planning framework above into what this requires in practice. Alongside detailing what working in a personalised way requires, there are also links to resources that support putting this into practice in a local area.

It can be used in a number of different ways:

- It can be used for workforce leads to explore strategically the gaps in the workforce's knowledge or skills.
- It can be used at a team level to consider where there may be gaps across a team, IPC hub or MDT.
- It could also be used as a resource within supervision or continuing professional development (CPD), to evaluate progress and development.
- It can also be used by individuals to support their own understanding of the personalised care and support planning process, help them to identify whether the support they are being offered with personalised care and support planning is in line with the principles and highlight some questions to ask.
- In organisations with dedicated personalisation teams, relevant managers may also want to use this resource to benchmark the work of their personalised care and support planning team and action plan areas for development.
- Finally (and more strategically) it can be used as a means to co-produce a contribution to local workforce development plans.

Note: the list details who is meant by the 'workforce' or 'professionals'. This also explicitly includes colleagues who work in the VCSE sector.

9.2 The practicalities of supporting the personalised care and support planning workforce

Personalised care and support planning framework stage and detail	Key practical resources
Context	
• Professionals can answer questions about the role and time for formal personalised care and support planning within IPC with confidence and can signpost people who are clearly not eligible to appropriate alternative support in the Local Offer.	**Recruiting for values and behaviours in social care** **Power hours in team meetings** Practical guidance on the Care Act and whole-family approaches: **practical guidance** **Understanding your staff's current practice: a framework** **Supporting managers to support staff** **Effective supervision**
• Professionals are skilled at explaining the personalised care and support planning process to people and families in ways that work for them as individuals – this includes knowledge of available resources in different formats and paying close attention to individual access needs.	
• Professionals demonstrate in their day-to-day work, through their behaviours, their belief that people are in charge of their own lives and tailor their support accordingly.	
• Professionals understand the integrated approach that IPC demands and work coherently in the different processes, building strong relationships across health, education and social care.	
• Professionals understand and engage with whole family approaches and can apply this within the context of IPC.	
• Those professionals involved in IPC receive ongoing learning, including action learning opportunities.	
• Personalised approaches are consistently considered and explored in supervision and appraisal.	
• Personalised care and support planning ambassadors, champions and early adopters have been identified in all relevant teams and different levels to promote and support planning. They can provide peer leaders to help influence/unblock personalised approaches.	

Personalised care and support planning framework stage and detail	Key practical resources
Preparation	
• Professionals can gather and identify information from a range of sources and from this can support people to identify what is and isn't working.	Tools for thinking about what people want from their life, including: • One-page summaries • Relationship circles • Life story/history • Good day bad day • My places **www.thinkaboutyourlife.org/tools** **Learning from practice on shared decision making** (See also the tools and approaches for personalised conversations below.) **Decision-making agreements** **Understanding Communication Passports**
• Professionals always ensure that the support they offer people to prepare is bespoke to the person and is received in a way which is suitable to their needs: this includes the preparation being carried out in a timely manner.	
• Professionals are well trained and confident in the use of a wide range of person-centred thinking tools to help with preparation.	
• Professionals always support people as individuals to consider their priorities for change in regard to both their health and wellbeing needs.	
• Professionals use person-centred thinking tools to ensure that decision-making remains as close to the person as possible, e.g. decision-making profiles and communication charts.	
• Professionals ensure that they share information with everyone involved in the person's support network about how the person prefers to receive information and model this well.	

Personalised care and support planning framework stage and detail	Key practical resources
Conversation	
• Professionals ensure that people present at the conversation are those the person wanted and that everyone involved in the conversation is clear about the purpose and format of the session. There is no assumption that the conversation has to be a formal meeting.	A wide range of tools and approaches for personalised conversations. The PATH process: **www.inclusive-solutions.com/person-centred-planning/path** and **www.helensandersonassociates.co.uk/person-centred-practice/paths** The MAPS process: **www.inclusive-solutions.com/person-centred-planning/maps** and **www.helensandersonassociates.co.uk/person-centred-practice/maps** **Conversation cards** **Planning Live** **Council for Disabled Children (CDC) resources for professionals working with children and young people on EHC plans** **CDC Outcomes Pyramid** **Skills around the person – implementing asset-based approaches**
• Professionals are skilled in a range of ways to facilitate the conversation. This includes using a range of resources. They are highly skilled in ensuring that the person is always at the centre and are supported to have a conversation that works for them in every way.	
• Professionals are able to confidently use a range of person-centred thinking practices to support the person to explore what is important to and for them and what good support will look like at the making it happen stage.	
• Professionals are skilled in supporting people to develop person-centred outcomes, can explain this to others and know what a good action plan looks like.	
• Professionals understand and promote an asset-based approach and always offer people opportunities to learn what is positive and possible from peer supporters.	
• Professionals understand how to enable people to take positive risks and support the person in the development of robust contingency plans that pay attention to what matters to them.	
• Professionals are clear about the systems in place across agencies to enable person-centred risk enablement.	

Personalised care and support planning framework stage and detail	Key practical resources
• Professionals encourage people to be creative and aspirational and explore things they haven't tried before.	
• Professionals always demonstrate their belief that the person is the expert in their own life, and model this to others. This applies in all aspects of personalised care and support planning, including how the conversation takes place, how outcomes are developed and in action planning.	
• Professionals support people to cost any solutions that require funding, are clear about any rules relating to spending and can clearly explain the process for sign-off. They are knowledgeable around direct payment guidelines and clear about local and national policy around spending. They can answer the person's questions with confidence.	
• Professionals are highly skilled in supporting family members or advocates to be the partner in the conversation if this works best for the person, for whatever reason.	
• Professionals ensure that the conversation takes place in the setting and at the time that works best for the person. They use person-centred thinking tools to explore this.	
• Professionals look at whole life conversations and encourage aspirational thinking, taking account of all resources available.	

Personalised care and support planning framework stage and detail	Key practical resources
Record and agree	
• Professionals make sure that personalised care and support plans are recorded in ways that work for the person, in whatever format they prefer.	**Decision-making agreement** **When we don't agree: facing conflicts** **Understanding Communication Passports** Examples of completed plans: **www.learningcommunity.us/sample_plans.htm** **www.councilfordisabledchildren.org.uk/help-resources/resources/education-health-and-care-plans-examples-good-practice**
• Single, named coordinators are named on the care and support plan.	
• If a person also has other plans, these are brought together as part of the single care and support plan (see Single care and support plan section).	
• Professionals ensure that selected information can be extracted from personalised care and support plans for the person to use to assist in their day-to-day support, for example, one-page profiles or decision-making profiles and have dated action plans.	

Personalised care and support planning framework stage and detail	Key practical resources
Making it happen	
• Professionals encourage the person's ownership of their personalised care and support plan and encourage them to move it forward in ways which work best for them.	
• Professionals are clear about who is coordinating the person's support and the coordinator is clear about the roles and responsibilities of everyone involved in making the person's care and support plan happen.	
• Coordinators are clear about when and why a reassessment is required and when adjustments can be made without further conversation, and ensures that the person has information about this in a way which is chosen by them.	
• Coordinators are the point of contact for the person and everyone involved in their support to provide clarity and offer support in finding solutions.	
Review	
• Coordinators make sure that reviews and their timings are proportionate and offer the opportunity for them to take place in a variety of ways, not just face-to-face. This may include self review and within peer support programmes.	
• Coordinators ensure that reviews are outcome-focused, include priorities for change and offer opportunities for reflection on what has been learnt.	
• Coordinators are skilled in the proportionate involvement of professionals and families and peers to contribute meaningfully to reviews.	

10 Annex F: Positive approach to risk, choice and decision-making

In the context of this document, reference to decisions, decision-making and decision-makers does not relate to decisions about a person's eligibility for a particular service.

10.1 Introduction

Successful delivery of personal budgets, integrated personal budgets and personal health budgets requires a balance between enabling individual choice and control and managing risk and associated decision-making. It requires a change from a risk-averse approach to one in which individuals and organisations are able to identify and manage risk in order to improve people's outcomes. It must also sit within a clear governance framework of accountability and responsibility.

This section supports staff engaged in delivering IPC and personal health budgets and aims to:

- increase understanding of issues of risk and choice in order to improve outcomes
- assist staff to think through the management of risk and choice in personal budgets, integrated personal budgets and personal health budgets
- provide practical examples of systems and processes that support positive risk management and decision-making.

10.2 Defining risk

Risk, in relation to personal budgets, integrated personal budgets and personal health budgets, can be broadly categorised into three areas:

1. Clinical risks: related to the health and wellbeing of the person or their carers, and satisfactorily meeting outcomes.
2. Financial risks: related to value for money and sustainability for the NHS and local authorities, appropriate use of resources, and people's ability to manage accounts.
3. Reputational risks: related to the potential for budget spend to affect the reputation of the CCG or local authority.

It is important to have systems in place to manage these risks. However, CCGs and local authorities should not become so focused on managing all the risks that they lose sight of what they are trying to achieve – enabling greater choice, control and flexibility over care and support.

10.3 Duty of care and statutory considerations

A duty of care is established in common law in relation to all services. Personal health budgets or integrated personal budgets increase the level of choice and control that people have; they do not change the statutory duty of care of the NHS and social care to all individuals in their care. NHS decision-makers should consider who may owe a duty of care to the person in circumstances where health services have been outsourced to a third party. Further information regarding duty of care can be found in **Safeguarding Adults: The Role of Health Service Practitioners (2011)**.

The statutory guidance for local authorities and the NHS with regard to risk is also relevant – see Chapter 14 of the Care and support statutory guidance,[4] section 5.5 of Guidance on Direct Payments for Healthcare,[5] and section 9 of the Special educational needs and disability code of practice.[3]

10.4 Opportunities for managing risk

IPC and personal health budget processes support positive risk enablement through:

- clear conversations, so professionals know and understand a person's current situation, care provision, and can provide information and advice about personal budgets, integrated personal budgets and personal health budgets
- comprehensively assessing needs, to enable proper identification of risks and ensure appropriate interim care and support arrangements are in place if required
- setting indicative budgets as accurately as possible, so that assessed needs are sufficiently budgeted for and can be appropriately supported
- putting in place clear action plans/contingency plans to manage and mitigate risks
- ensuring there is a proportionate approach to signing off personalised care and support plans, including any considerations of risk
- completing timely and in-depth reviews, covering both clinical and financial areas as well as review of the personalised care and support plan.

For guidance on managing risk, recording decisions and when to carry out reviews, see the Guidance on Direct Payments for Healthcare.[5]

10.4.1 Understanding health and wellbeing needs

The personalised care and support planning framework is clear that people are experts in their own lives, and provides a person-centred, outcome-focused mechanism for determining the issues facing them. The early stages of gathering information and assessment provide an opportunity to explore any existing or potential risks and discuss how these can be managed positively. This allows the person to reflect on risks and how well they are able to stay safe from harm.

If there is any doubt as to the person's capacity to make relevant decisions, an assessment of mental capacity should be carried out and the principles of the Mental Capacity Act 2005[7] should be followed. Issues of capacity should be fully explored and decisions made about the level of assistance required. This could include supported decision-making, advocacy, specialist communication, or appointing a suitable person to make decisions on their behalf using the best interests guidance in the Mental Capacity Act 2005.

10.4.2 Personalised care and support planning

Personalised care and support planning is central to personal health budgets and IPC. Risk management should be part of the care and support planning process, and as much agreement as possible sought at an early stage. It is vital that people and their families have the information and support they need to make informed decisions, including a discussion of the evidence available on possible choices and risks.

In enabling a person to develop their care and support plan, the risks and benefits are identified and discussed, and consideration is given to what level of risk a person wants to take in their life, and what is acceptable for the organisation to support. The person's awareness of the associated risks is raised, and consideration is given to any approaches that might help eliminate, reduce or manage these risks while still achieving the outcomes they want.

In care and support planning with people who lack mental capacity, it is important that the person is encouraged and permitted to have the fullest possible input into decisions affecting them. It may be that they lack capacity to consent to a direct payment, but they may have capacity to make decisions in other areas of their life. All practical steps to help the person make decisions about their care and support should be taken before any decision is made on their behalf. In all instances, the principles of best interests should apply, which are set out in the Mental Capacity Act 2005. For further guidance on care planning and decision-making for people who lack capacity (including advance decisions and lasting powers of attorney) see the Guidance on Direct Payments for Healthcare.[5]

10.4.3 Proportionate approach to signing off personalised care and support plans

Having considered the health and care needs, the outcomes to be achieved, and how to use the money in the personal budget, integrated personal budget and personal health budget to achieve those outcomes, the proposed care and support plan needs to be agreed and signed off by the relevant professional(s).

Reflecting the personalised approach to care and support, people may choose to meet their needs in ways very different from those traditionally on offer. The care and support plan should therefore show appropriate and proportionate consideration of risk and how it will be managed. Decisions about risk should be taken as close to the person as possible, supported by a local governance framework.

In signing off care and support plans, local authorities and CCGs should endeavour to:

- focus on understanding the health and care needs of the person, not just focus on money
- remain clear on the overall aim of the personal budget, integrated personal budget or personal health budget for the person, their outcomes and what they want to achieve
- think about the impact on the individual as decisions are made, considering middle ground if possible
- consider everything until it can be reasonably excluded and explained, without defaulting to the same approach for all decisions about particular risks
- seek a good balance between enabling the person to achieve their outcomes and managing risk in a way that is acceptable to the organisations involved and to the person.

10.4.4 Risk enablement panels and decision-making

Where appropriate, risk enablement panels can be helpful to support staff with more difficult decision-making and can help to develop a culture of shared decision-making. Personal health budgets and integrated personal budgets are still relatively new, and no one person will have all the answers. Risk enablement panels allow groups of professionals to come together and make decisions, sharing expertise and experience, and offering a supportive place to discuss issues which cannot be resolved through normal processes. They provide a forum for staff to learn together and develop local principles, building resilience within the team and bringing confidence to the process.

Principles describe what the local offer looks like – they are unique to each area and to a specific group of people. These principles describe how integrated personal budgets and personal health budgets work for people as well as how they work for the health and social care organisations involved. The process of developing principles is cyclical – as local decisions are made time and time again, they evolve into or shape local principles, and decision-makers will need to continually test new decisions against these principles to ensure consistency, fairness and sustainability.

Consistency and transparency in decision-making is key, as is having a clear timeline for the process.

Decisions should be recorded and shared across health and care teams. There should also be clarity about how decisions will be shared with people and families – aiming for as much openness and transparency as possible about who was involved in decision-making and the information that was gathered and considered. People have a right to appeal decisions and provision of information about such matters can support effective resolution of any issues.

Poor decision-making can have a wider ripple effect. Therefore it is important to invest in the process which will provide strong foundations on which to build future decisions.

In summary, risk enablement panels equip front-line staff and clinicians with answers, growing knowledge, confidence, expertise and decision-making ability. Over time, this will help to make decisions closer to the person, and manage people's expectations about how budgets can be used.

Risk enablement panels should be used only where needed, to support people with more difficult decision-making, rather than as a default approach to all decision-making and management of risk.

10.4.5 Monitoring and review

It is important to check at appropriate intervals whether the personalised care and support plan is achieving the agreed outcomes for both the person and their carers. Reviews that focus on outcomes rather than processes can be the most effective way of identifying what works well and what doesn't work well for the person.

Reviews are also an ideal time to consider and update considerations of risk. They are a crucial part of personal budgets, integrated personal budgets and personal health budgets and safeguarding, and need to be carried out effectively.

Some people will need more frequent monitoring and review than others – for example, if they are particularly isolated, have a degenerative or fluctuating condition or lack mental capacity, or where other particular risks are identified during personalised care and support planning that need regular monitoring. The ultimate aim of review is to strengthen the person's ability to achieve the outcomes they want.

Information about personalised reviews is available in **Chapter 13 of the Care Act 2014 code of practice, and from Think Local Act Personal**.

10.5 Governance of risk

Personal budgets, personal health budgets and integrated personal budgets require a level of sign-off or accountability in terms of financial or clinical governance, or both, at every stage of the process.

Ideally, decisions should be made as close to the person as possible. However, this may not always be possible, depending on the issue in question or the level of confidence/experience of staff.

A good governance framework sets out responsibility in a hierarchical way and provides a clear management structure for accountability. Good governance should include:

- clear roles and responsibilities for all staff
- a commitment to good quality supervision which includes professional development
- agreed policies and procedures for delivering the service which everyone uses, including responses to crisis
- agreed documentation for the needs assessment, care and support planning, risk assessment, monitoring and review
- a timely process for resolving complex issues (i.e. a panel with senior decision-maker)
- processes for managing complex cases and conflict resolution.

Having a supportive governance structure in place can help with:

- timely decision-making, as staff know who to go to for support with decisions and risk management
- consistency, through having a clear process for sign-off and consistent personnel involved
- transparency, through having agreed decision-makers, whose involvement can be explained to people and families
- support in times of challenge – through having a system of delegated authority which can help to maintain relationships between front-line staff and people/families.

An example governance framework for personal health budgets is given below, which illustrates one practical application of this approach to managing risk and decision-making. NHS and local authority services can be commissioned in a variety of ways, so areas will need to work out an approach that best suits local arrangements.

	Governance framework							
	Clinical	**Financial**	**Clinical**	**Clinical and Financial**	**Clinical and Financial**	**Clinical**	**Clinical and Financial**	**Financial**
	Assessment of need	**Indicative budget authorisation Care plan sign-off**	**Final budget authorisation**	**Agreeing flexible budget spend**	**Care plan review**	**Budget review**	**Financial audit**	
Level 1 Decision-making close to the person	Nurse assessor Case manager		Nurse assessor Case manager		Nurse assessor Case manager	Nurse assessor Case manager	Nurse assessor Case manager	Nurse assessor Case manager
Level 2 Decision making within the CHC team	Peer review CHC service manager	CHC service manager	Peer review CHC service manager	CHC Service manager	Peer review CHC Service manager	Peer review	CHC service manager	CHC service manager
Level 3 Higher level organisational accountability	Specialist HCP Clinical director		Specialist HCP Clinical director		Specialist HCP Clinical director	Specialist HCP Clinical director		(Direct payments team)
Level 4 Higher level organisational accountability		CHC Commissioner		CHC commissioner	CHC commissioner		CHC commissioner	CHC commissioner
Organisational commitment to delivering personal health budgets (CCG board level)								

Good governance sits within a strategy and policy framework that is typically created through the following documents as a minimum:

- corporate risk strategy
- risk enablement policy
- risk register
- risk matrix/governance framework
- person-centred risk assessments (included in personalised care and support planning)
- information governance and information risk policy.

For further guidance on the assessment and management of risk, see the Guidance on Direct Payments for Healthcare.[5]

10.6 Other resources and references

There are a number of other resources that are of use when considering risk in the context of personalised care and support, which are highlighted below:

- **Think Local Act Personal: A Positive Approach to Risk and Personalisation – A Framework**
- **Social Care Institute for Excellence: Enabling risk, ensuring safety – Self-directed support and personal budgets**
- **Skills for Care: Learning to live with risk – An introduction for service providers**
- **Skills for Care: Keeping risk person-centred.**

1. **NHS Five Year Forward View**, NHS England, October 2015.
   Next steps on the NHS Five Year Forward View, NHS England March 2017.
2. The IPC Operating Model and wider framework documents can be found on the **personalised health and care section of the NHS England** website
3. **Special educational needs and disability code of practice: 0 to 25 years**.
   DfE, 2015: Chapter 3.
4. **Care and support statutory guidance: Issued under the Care Act 2014**.
   DH, 2016: Chapter 15.
5. Guidance on Direct Payments for Healthcare: Understanding the Regulations.
   NHS England 2014.
6. A whole-family approach is one which takes a holistic view of a person's needs and to identify how their needs for care and support impact on family members or others in their support network.
7. **Mental Capacity Act code of practice, Office of the Public Guardian 2013**.

Personalised care and support planning
Summary guide

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The information provided in this framework can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request.
Please contact **0300 311 22 33** or email england.contactus@nhs.net

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