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Personalised Care and Support Planning and PHB Quality Framework

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Introductions

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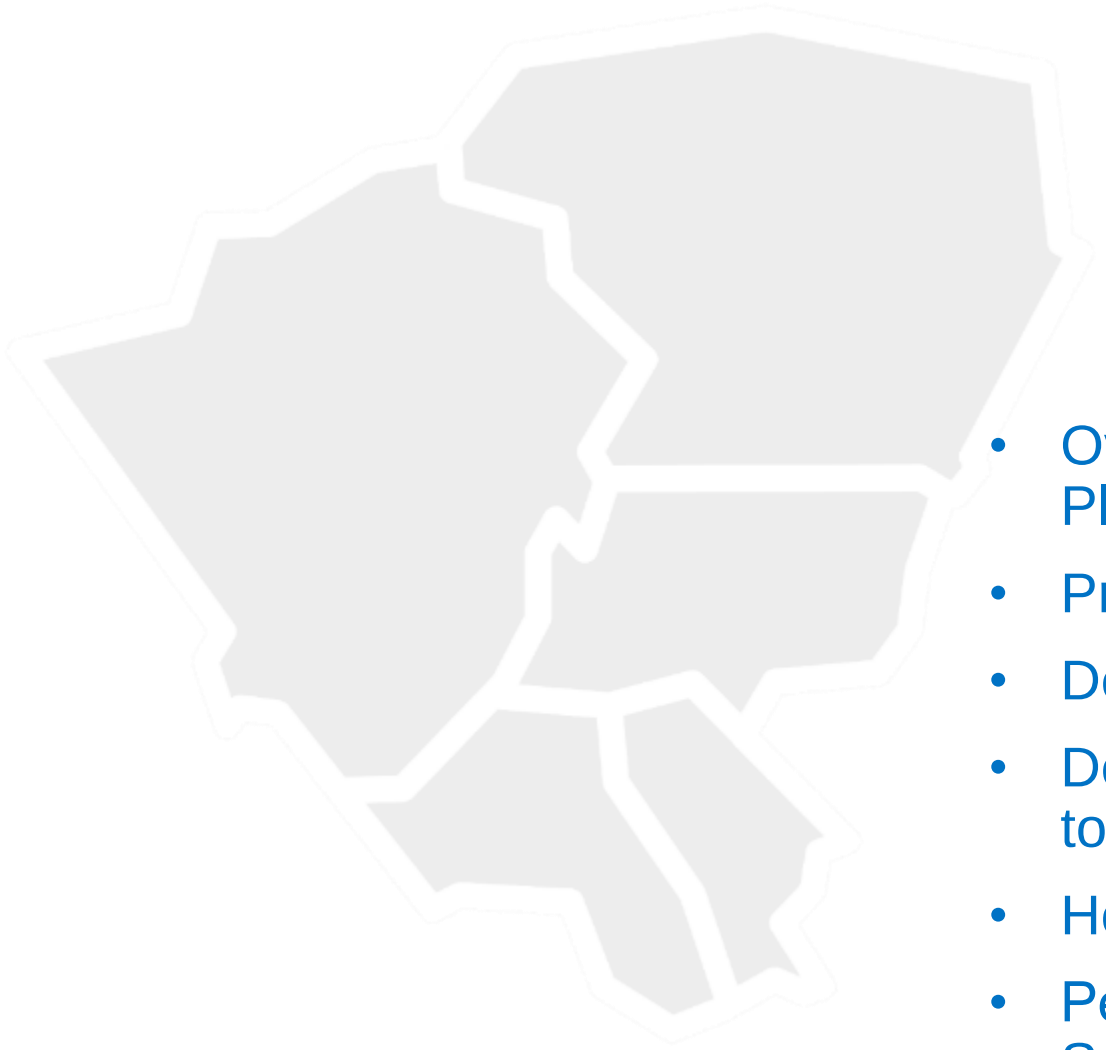
Learning Objectives



- Overview of Personalised Care and Support Planning
- Preparation tools for the conversation
- Developing Person-centred outcomes
- Developing outcomes from Working /Not Working tool
- How will we embed this in our everyday work?
- People’s experience of Personalised Care and Support Planning (PCSP)
- Personal Health Budget Quality Framework

Being comfortable together

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- No such thing as a silly question
- Listen to each other with respect
- Everybody's contribution counts
- Mobiles off or on silent
- Give & Get

Operating Model for Personalised Care

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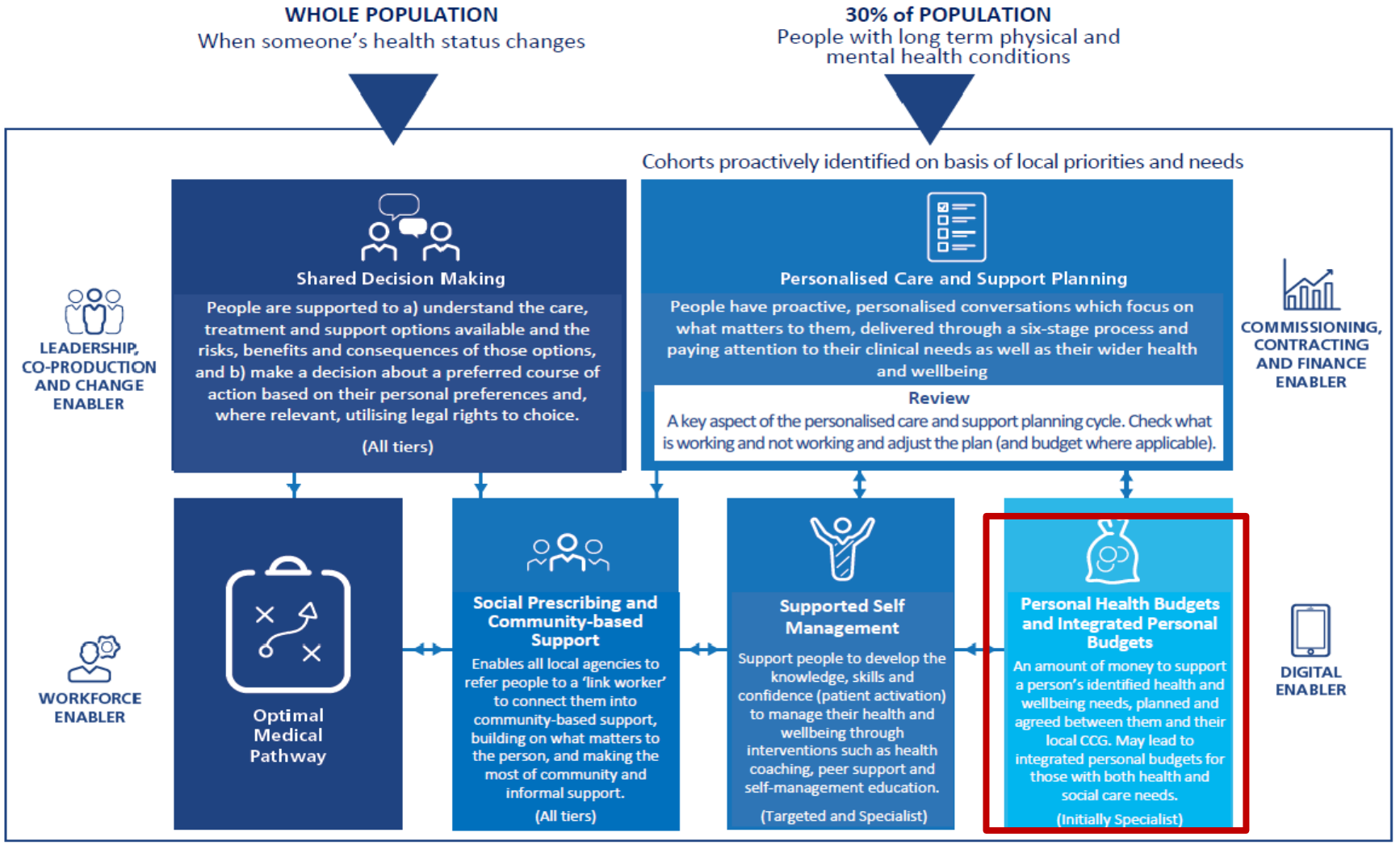

Personal Health Budget Process

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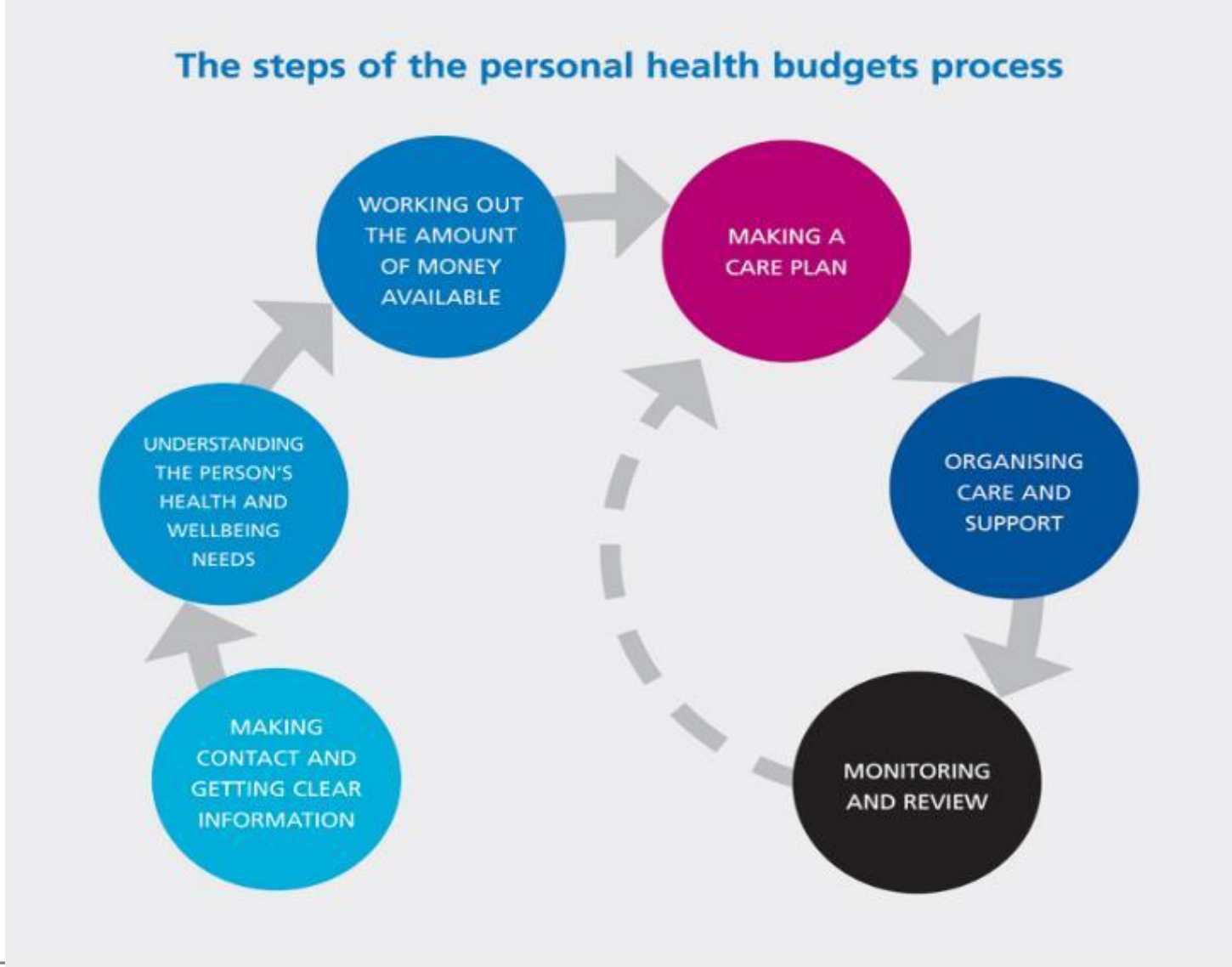

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Overview of Personalised Care and Support Planning

Mark’s story

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Mark's story

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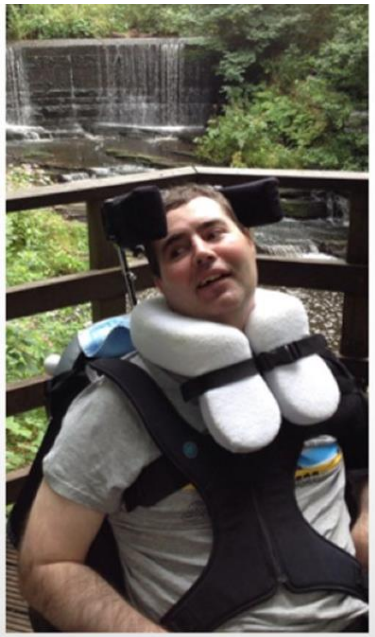
Night out with family

Enjoying football with his PA



Enjoying the summer outdoors

First Christmas with his family

Enjoying his Birthday Party with friends and PA's

https://youtu.be/sSaeO9QMPU8

Mark's Story

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1) From Mark's story, what do you think makes a good care and support plan?

2) What are your concerns or fears about delivering care and support planning?

What personalised care means to me

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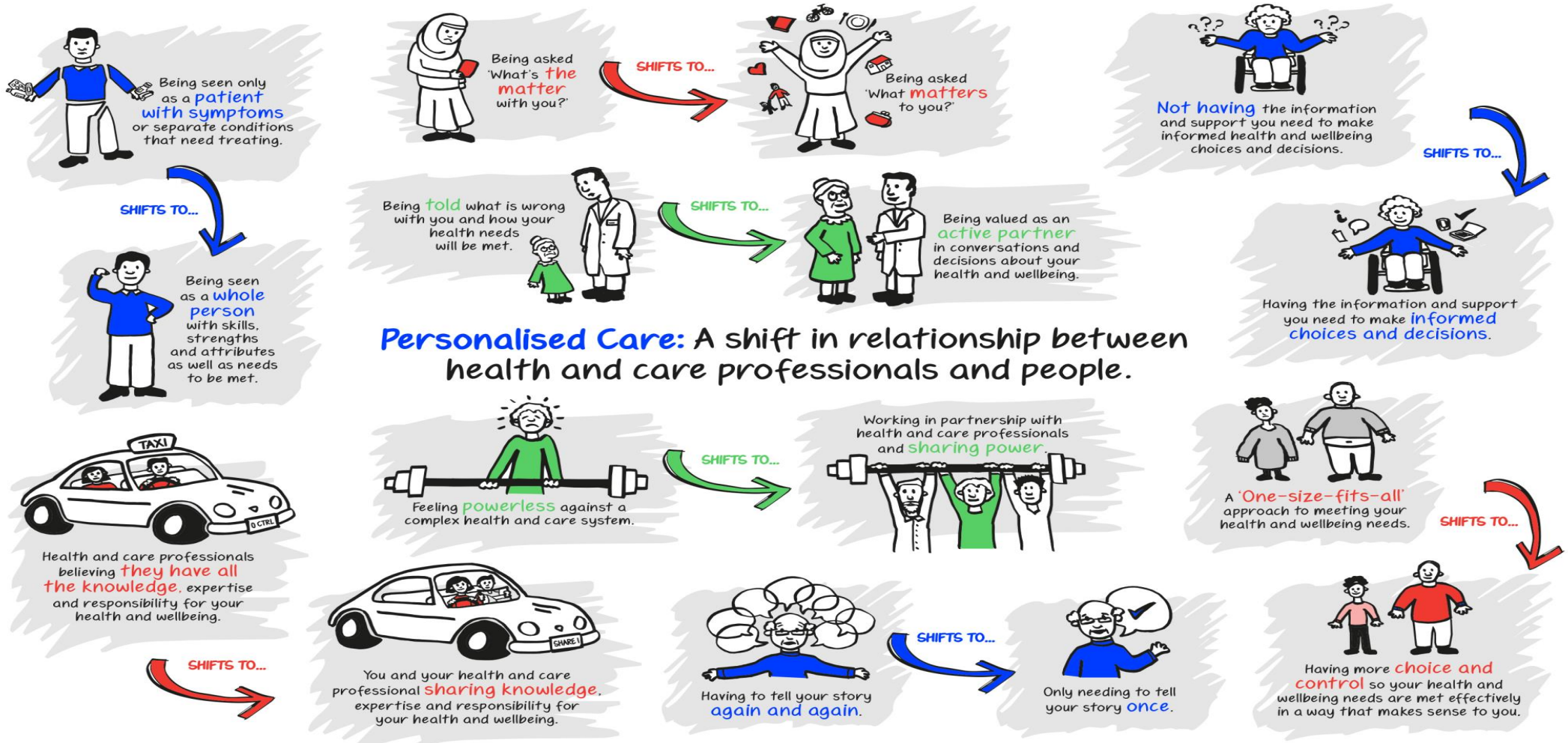

Universal Personalised Care Group

Key components of personalised care and support planning

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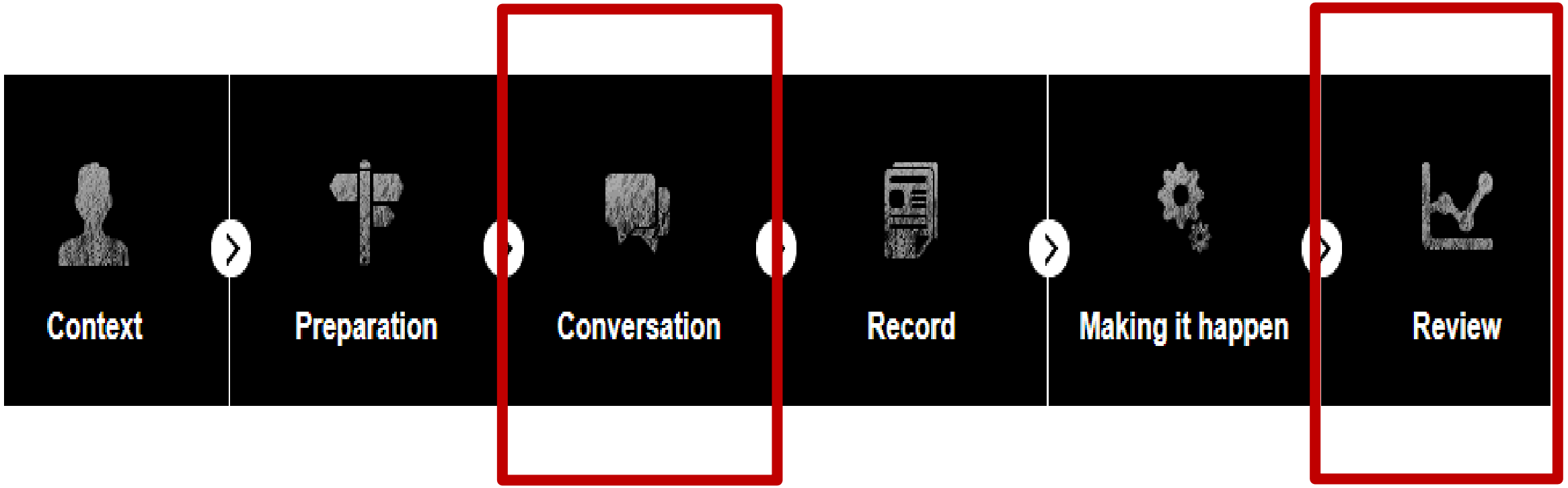

Personalised care and support planning – Key features

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Perspective – this is a way of 'seeing people' and attitude towards them that is fundamental to good Personalised Care and Support Planning

The changed relationship and different conversation will mean that the person:

- Is empowered and builds knowledge, skills and confidence.
- Feels confident that the process and plan will deliver what matters most to them.
- Is central in developing their Personalised Care and Support Plan and will agree who is involved.
- Is seen as a whole person within the context of their whole life, valuing their skills, strengths, experience and important relationships.
- Is valued as an active participant in conversations and decisions about their health and well being.

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Personalised care and support planning – Key features

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Process – this is the overall process of personalised care and support planning

A good Personalised Care and Support Planning process will mean that the person:

- Has the time and support to develop their plan in a safe and reflective space.
- Is able to access information and advice that is clear and timely and meets individual information needs and preferences.
- Feels prepared, knows what to expect and is ready to engage in planning supported by a single, named coordinator.
- Is listened to and understood in a way that builds trusting and effective relationships with key people.
- Is able to agree the health and well-being outcomes they want to achieve, in dialogue with the relevant health, education and social care professionals.
- Has the chance to formally and informally review their personalised care and support plan.

Personalised care and support planning – Key features

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Plan – this is what a good plan looks like

A Personalised Care and Support Plan:

- Is a way of capturing and recording conversations, decisions and agreed outcomes in a way that makes sense to the person.
- Should be proportionate, flexible and coordinated and adaptable to a person's health condition, situation and care and support needs.
- Should include a description of the person, what matters to them and all the necessary elements that would make the plan achievable and effective.

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Preparation tools for the conversation

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Preparation

Preparing the person

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- What matters to you?
- One-page profile
- What is working?
- What is not working?
- Future aspirations
- Can also provide information about what to expect during the meeting

One Page Profile

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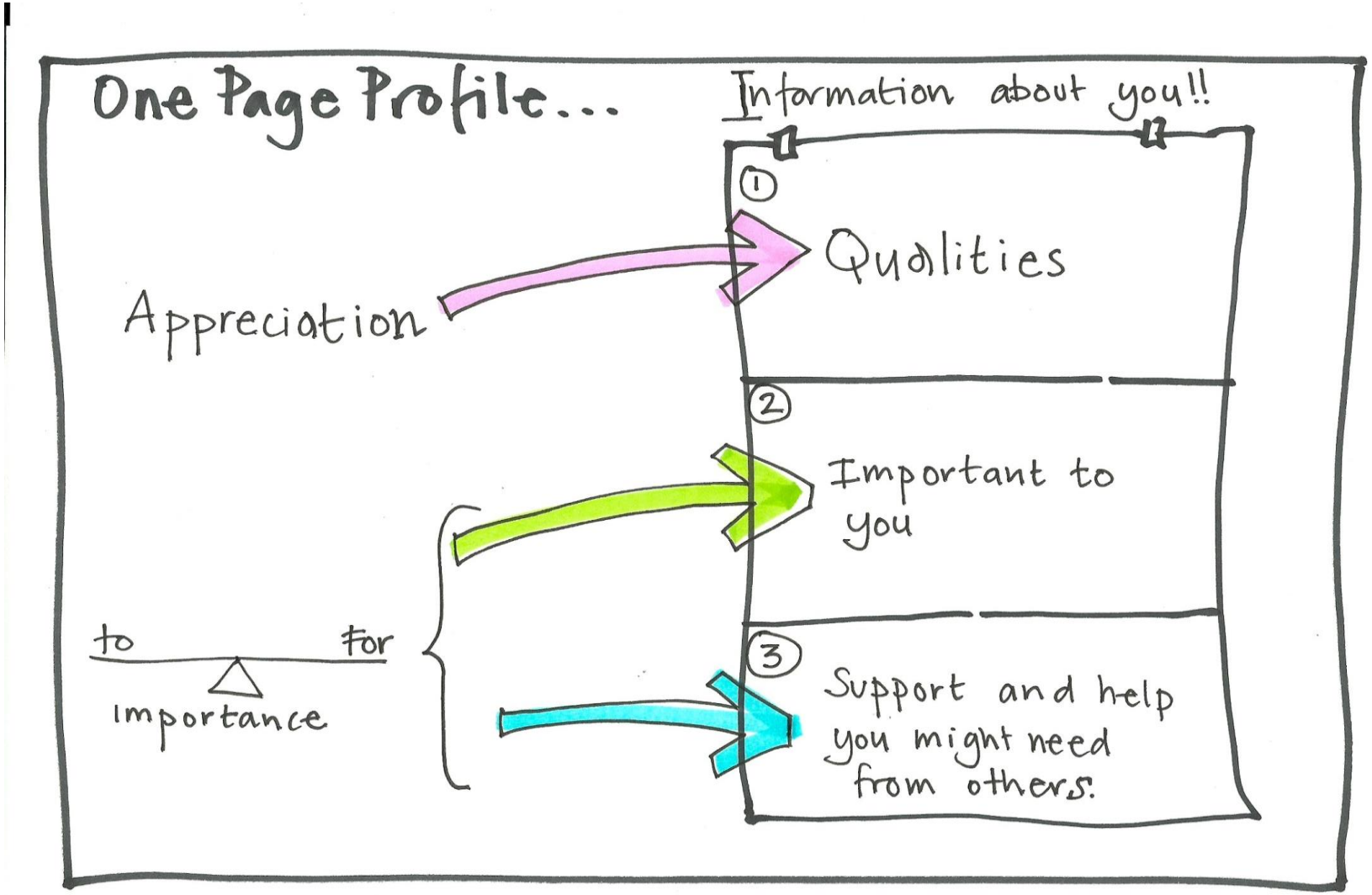

What's working and not proforma

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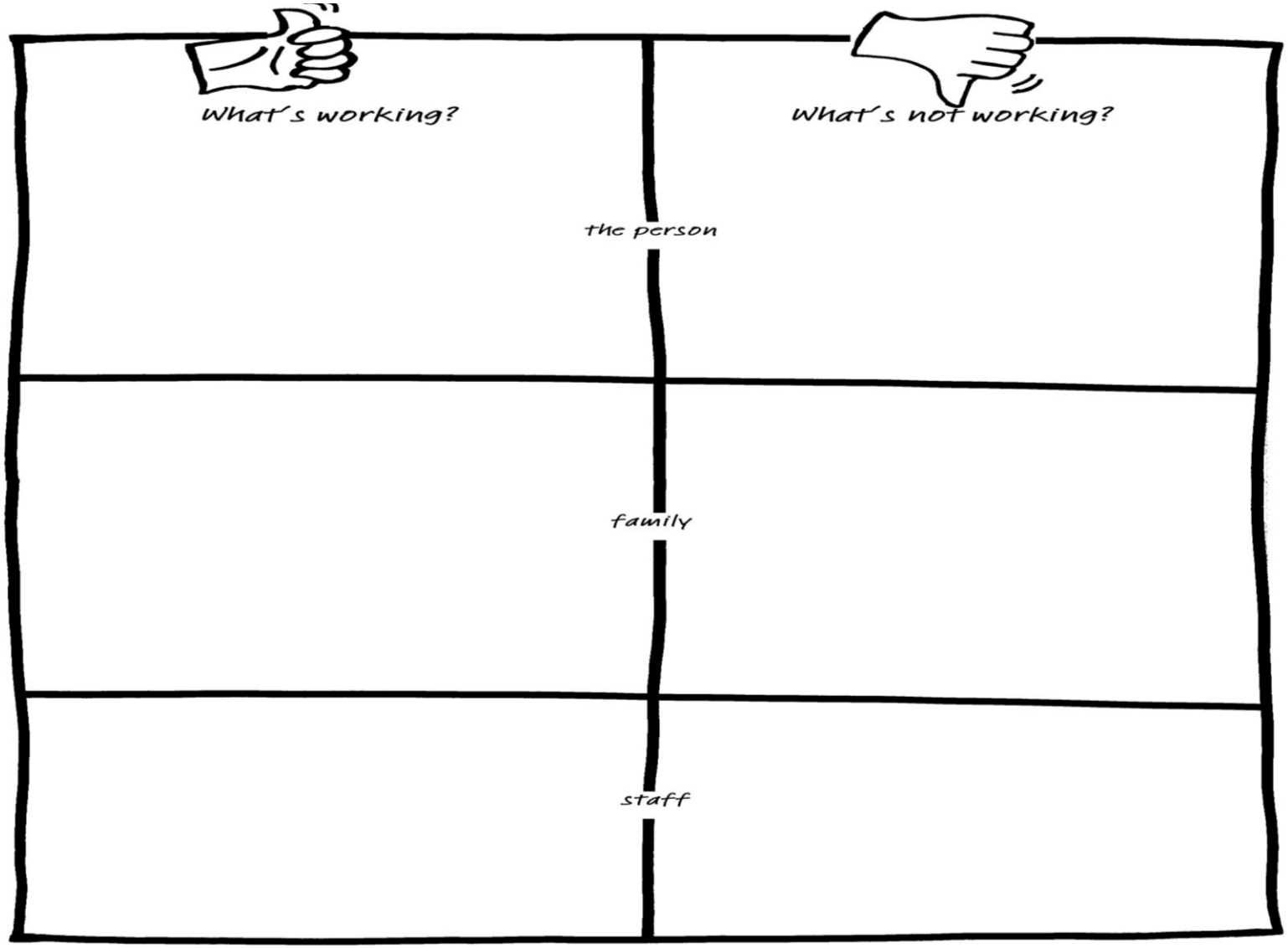

Practitioner and team preparation

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Initial contact:

- Keep the person at the centre
- Who do you want/need to involve? When/how do they need to be involved?
- What will happen and when?
- How do you want information?
- What's working and not working from a clinical perspective?
- Needs assessment.
- Ensure information is shared before the conversation.
- Do you need any further information?
- What are you going to talk about? Why?

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About me

What's important to me?

What's working and not working?

Future aspirations

Explore options tried and learned - possibilities

How my condition affects me?

My health and wellbeing needs

Outcomes

Actions

Managing risk

Contingencies

Budget (amount and type)

Review – Who? / When? / How?

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Recording the conversation

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Format

- Language
- Involvement of the individual
- Equal conversation / equal partner
- If needs change / if PCSP needs to change – how that happens?
- Ensuring the person has a copy before it is signed off and agrees with the plan
- Signatures?
- Single integrated plan?

Review

- Working/not working (from different perspectives)
- Tried/learnt/pleased about/concerned about
- Where do you want to be in the future?
- What are your priorities for change?
- Update outcomes and actions
- Ideas and options

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Developing Person-centred outcomes

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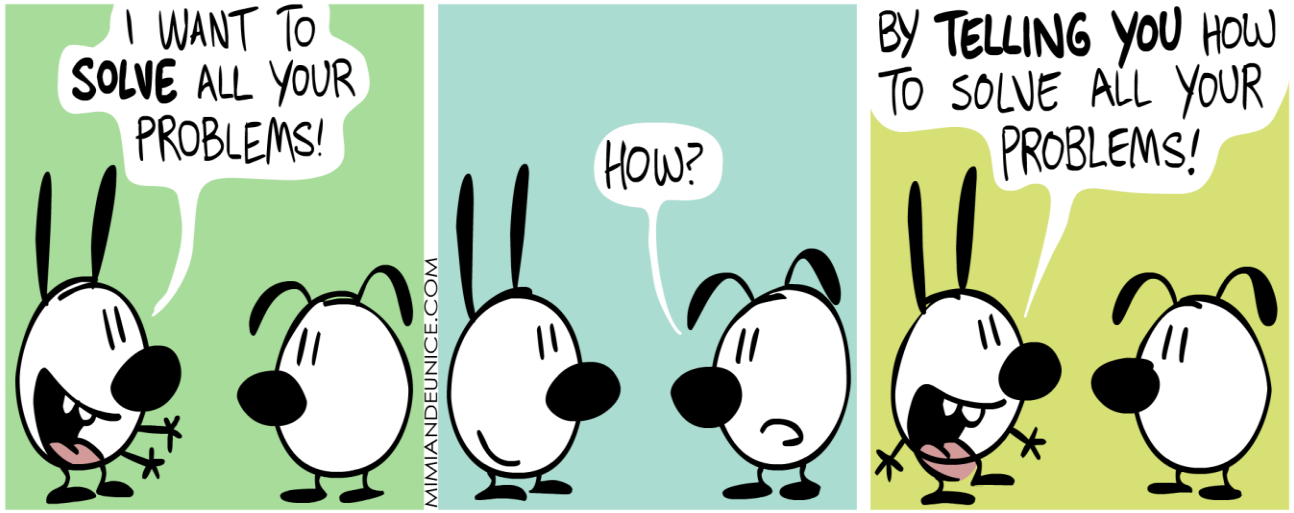
What makes a good person centred outcome ?

The 3 most common mistakes we make with outcomes…



…embedding the solution in the outcome

…not being specific enough

…not linking up the outcome with what matters to the person

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Language

- Is it an equal conversation if only one person knows what is being talked about?
- It’s not a clinical competition
- Use language that the individual uses
- Easy read version of documents
- If you asked them what outcomes you had just discussed what would they say?

An outcome is the WHAT, not the HOW

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Does it keep something that is working?

Is it measurable?

Does it move you towards a future you want?

Is it written from a personal perspective?

Does it change something that isn't working?

Is it specific?

Exercise - Let's have a go

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- Increasing mobilisation at home
- 3 homecare visits a day for medication administration
- Support to go to the day centre

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Some examples of how not to write person-centred outcomes and what to write instead	
Instead of this	**Write this**
Increasing mobilisation at home	I am confident walking from the lounge to the kitchen and bathroom every day
This isn't well written because: it's not specific or measurable and the use of language isn't personal to the person	
3 homecare visits a day for medication administration	I have the right support at home to ensure I take the correct dose of my medication at the right time of day
This isn't well written because: the solution is embedded in the outcome	
Support to go to the day centre	I will spend time at least twice a week with people who share my interests. I like gardening, chess and old movies
This isn't well written because: The solution is embedded in the outcome	


Coffee Break

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Developing outcomes from Working /Not Working tool

Four step process

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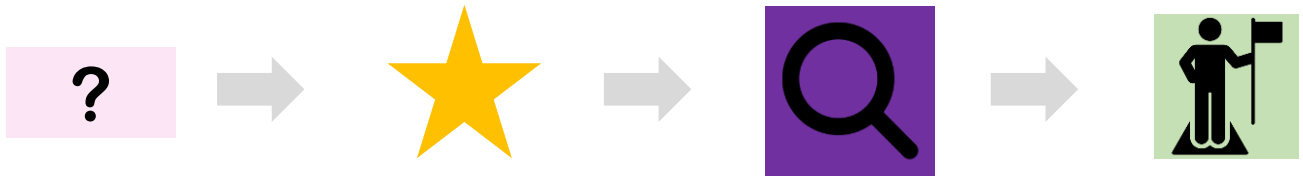

What's not working?

What is the positive change that we want to see happen?

Now make it specific

Is it achievable?

Is the solution embedded in the outcome?
Is it measurable?
Does it keep something that is working?
Does it change something that is not working?
Does it move the person towards a future they want?
Do you know your starting point?
Is it personal and not expressed from a service perspective?

One page profile: Cecilia

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Qualities: Funny, organised, a good listener, like to talk to people, positive.

Important to me: My husband, 2 children, keeping in touch with my sisters – we call each other once a week, my high school friends – we used to meet up once a month for lunch, I love a good cup of tea (fine bone China cups only).

Support I need: Unsteady on my feet – use a walker but sometimes forget I need it. CPAP, medication, help with physical tasks following stroke.

Working / Not working

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✓Live with my husband – been married for 36 years

✓Speak with my sisters weekly

✓Excellent specialists and consultants know me really well

✓New stoma service provider is brilliant – much more confident now

✗ I can't go out for lunch with my friends – often waiting for district nurse. Feel left out

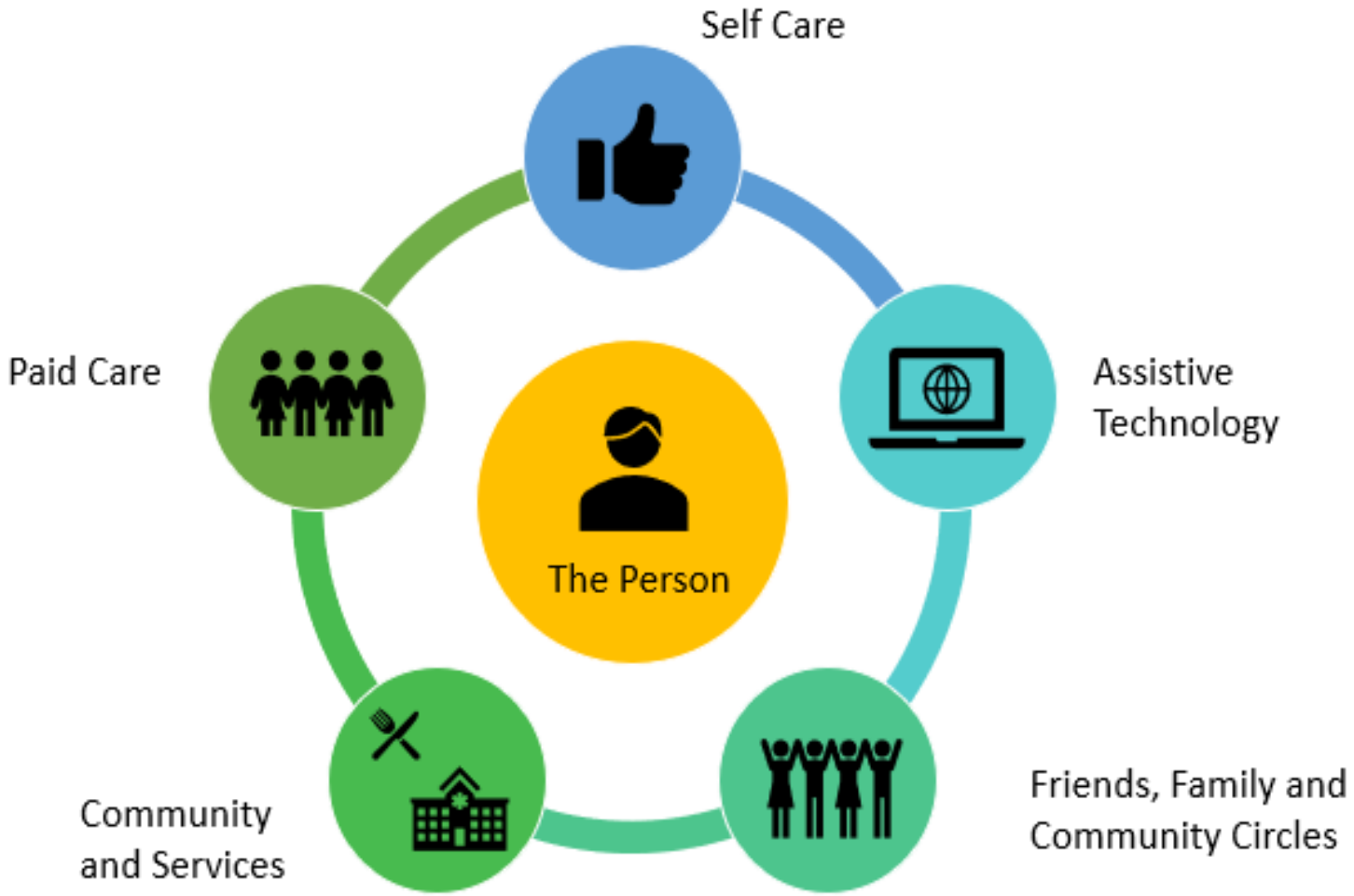
✗ I miss being able to keep the garden nice

✗ It's difficult to see my daughter

✗ Lots of medication changes have left me confused and out of routine. I used to manage them really well

✗ I can't make a cup of tea on my own anymore and new carers never know how I like it

Support options



Thinking differently

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Solution Type	Think Like	How
Traditional		What would traditionally be available to meet the outcome?
Radical		Blue sky thinking – nothing is impossible until you can exclude it Are there any that seem possible to implement?
Different		More conventional than radical but still different to what was traditionally available. If traditional hasn't worked, maybe something a little different will.

Enabling people to achieve good outcomes – a positive approach to risk

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Explore risk in the context of how somebody wants to live their life, their outcomes and solutions.

If a significant risk is identified and needs further exploration, then you could use a person-centred risk process to explore this

- Understand the risk / potential impact on the person
- What risk is the person willing to take?
- What risks are the ICB willing to accept?
- How to mitigate risk?
- Impossible to eliminate all risk – sensible risk appraisal
- Good documentation is key

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How will you embed this in your everyday work?

Consider…

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- What are you already doing?
- What needs to change to make this work?
- Can you send documents out to people in advance of the conversation?
- If the person already has a PCSP from the local authority are there elements that they have already discussed?
- Examples from other areas – don’t re-invent the wheel.

Questions?

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People's experience of Personalised Care and Support Planning (PCSP)

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Quality Health Survey

- Survey of 390 PHB holders in 2018:

- 77% would recommend PHBs
- 89% said PCSP reflected what matter to them
- 86% achieved what they wanted
- 60% process too slow
- 41% difficult to get PHB information
- 47% hard to recruit PAs

When PCSP goes wrong

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- Conversations focussed on traditional services, respite and PA hours – no focus on outcomes, life goals etc.
- No PCSP template
- Very transactional relationship
- One size fits all outcomes – not personalised
- Poor communication – point of contact unresponsive to queries
- Brokers had no training or experience – just focus on personal care
- 16 page document – person only felt their contribution was reflected on 3 of these
- Case manager never met the person receiving the budget – met with Mum only
- Budget only sufficient for direct care
- Budget sufficient but unclear scope and flexibility for budget spend
- Training needs – clear that there are gaps in knowledge and confidence across all staff levels

Top tips

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- Practice makes perfect
- Don’t start with a blank page - use available information to help deliver the process effectively (e.g. DST, working / not working)
- Just start having proper conversations – and involving the person throughout
- Know how to pitch the questions so the person and family can participate throughout
- Seek other areas examples – don’t re-invent the wheel – what worked for them / didn’t work?
- A good plan records a good conversation
- Ask for feedback from people and families on your current PCSP process

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Personal Health Budget Quality Framework

Personal Health Budget (PHB) Quality Framework

February 2023

Classification: Official
Publication approval reference: PR810

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NATIONAL CHILDREN'S BUREAU
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National Development Team for Inclusion
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Purpose of the PHB Quality Framework

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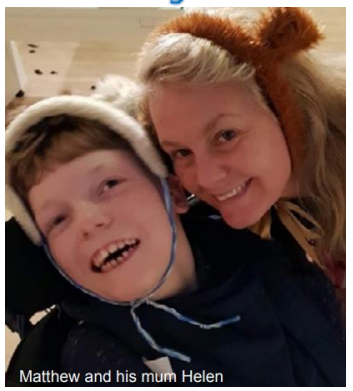
The Personal Health Budget (PHB) Quality Framework co-produced by NHSE and people with lived experience supports integrated care systems (ICSs) to create the conditions to meet PHB performance expectations, with a focus on improving operational delivery.

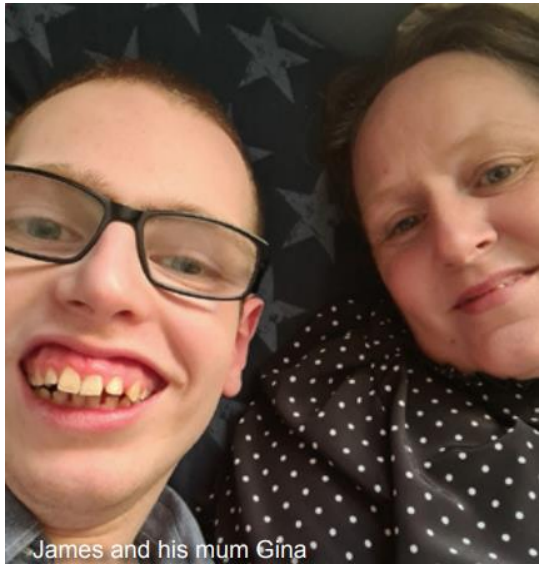
Lived Experience partners


Thomas and his dad Dave


Forzana


Matthew and his mum Helen


Rob


James and his mum Gina


Malcolm and his son Colin

Association of Mental Health Providers

in Control

NATIONAL CHILDREN'S BUREAU

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Benefits of the PHB Quality Framework

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Clarify the role of ICBs.

Create the conditions to meet PHB performance expectations – Right to Have areas and wider expansion, adults and CYP.

Improve operational delivery.

Improve experience and outcomes for people and families.

Develop workforce confidence.

Develop PHB strategy – aligned to system priorities.

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

Current expectations for ICBs

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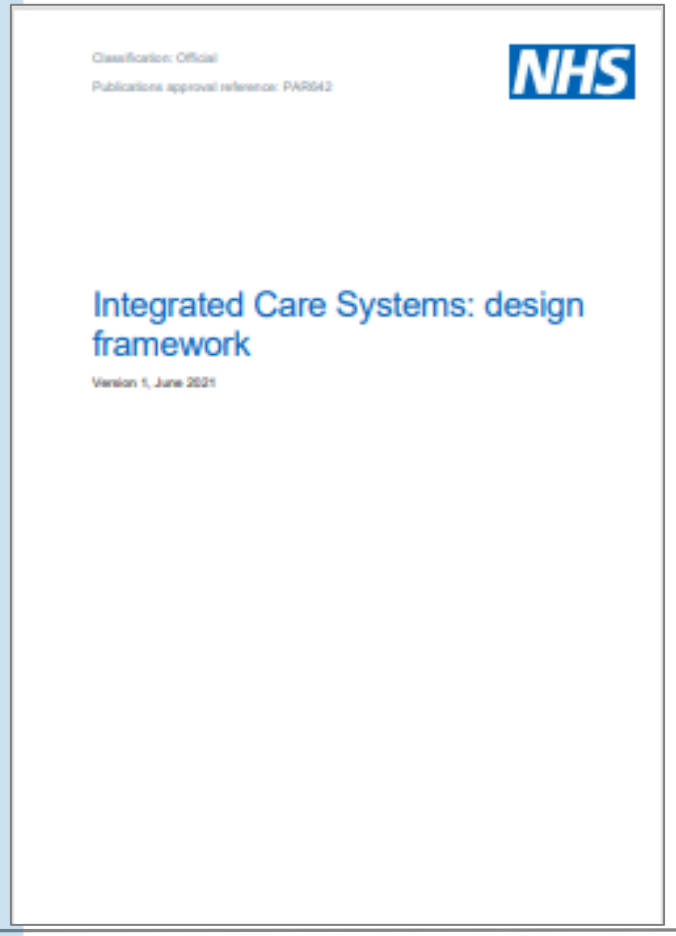
ICS Design Framework



Thriving Places

A shared commitment to quality for those working in health and care systems

Developed by the National Quality Board

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Content overview

Personal health budget Quality Framework

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- Role of ICBs
- PHBs explained, incl. new definition and narrative for PHBs
- I statements – what good looks like for people and families
- Principles and enablers for PHBs
- Quality Standards – strategic and operational delivery
- Case studies
- Additional support and resources

NCL ICB PHB Quality Framework Surveys

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Based on the Framework, NCL ICB has developed PHB Quality Surveys to be completed by the:

- PHB individual after PHB set-up, and at annual reviews (2 in total).
- ICB.
- ICB Service Teams.
- Case Manager.

This will enable the ICB to assess and evaluate local PHB delivery, data, performance and user-experience, as well as pin-point areas for attention and improvement.

Please ask your service manager/clinical lead for more information.

Step 1 of the PHB Quality Standard – Making Contact and Getting Clear Information

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1. Making contact and getting clear information
2. Understanding the person's health and wellbeing needs
3. Working out the amount of money available
4. Developing a personalised care and support plan
5. Organising care and support
6. Monitoring and review

Home

Step 1 - Making contact and getting clear information

What this means for people

1. I know where to go and who to contact for clear, accessible and timely information and advice about PHBs and the three different ways I can choose to manage the budget – notional budget, direct payment and third party budget.
2. I feel well informed and supported to think about the choices available to manage my health and wellbeing.
3. I have the option to have support from advocacy services or to speak with other people who have experience of receiving a PHB.
4. I have enough time to think about the choices available to me to help manage my PHB.
5. I understand the responsibilities of the different ways to manage my budget and can explore which option works best for me, with my NHS team.

Step 1 of the PHB Quality Standard – Making Contact and Getting Clear Information

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Making contact and getting clear information (1) | Understanding the person's health and wellbeing needs (2) | Working out the amount of money available (3) | Developing a personalised care and support plan (4) | Organising care and support (5) | Monitoring and review (6)

Home

Quality Standards: what is expected from systems / organisations

The ICS PHB strategic plan needs to ensure:

1. A plan is in place to implement the rollout of PHBs to people with a legal right to have one. It includes the expansion of PHBs across local populations, and considers opportunities for integration with social care and education.
2. Oversight and alignment of PHB offers and messaging across systems, taking into account the priorities and needs at place level.
3. Consistent and good quality information about PHBs is available across the ICS.
4. Advocacy support across the system is understood – ICSs consider supporting the development of independent and accessible advocacy services to ensure people have independent support and advice if they need it.

What this means for NHS organisations (operational delivery)

1. The local PHB offer is published on the relevant health body's website, and a local PHB policy is available.
2. Information on PHBs, including about the three different options for managing the money, is available in a variety of accessible formats to meet the needs of all people.
3. A single point of contact is available for people to discuss PHBs with.
4. A range of support services are available including information and advice, independent advocacy, direct payment support, brokerage (the help and support people may need to spend their PHB) and peer support.
5. Staff are able to articulate what PHBs are and are not and how they can be used. They can provide information on the care and support that will continue to be available through commissioned services and not included in the PHB.
6. Information and support is available that is comprehensive, relevant, up-to-date and accessible and responsive to diverse individual and community needs.

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Further reading and support

Local Support

NCL ICB PHB Team **do not hold a central budget for PHB delivery**, but can provide support with PHB development/implementation, advice and guidance. If support is required, please email: **nclicb.personalhealthbudgets@nhs.net**. The PHB Team also support with organising the:

- PHB Panel, held weekly, to review and approve Direct Payment/Third Party set ups and monitoring process by money management services (Chaired by the Caretrack and PHB Specialist).
- PHB Case Management Meetings (used to be known as the PHB Borough Meeting) to provide peer support with solving practical problems faced when delivering PHB (Chaired by the Caretrack and PHB Specialist). Meeting dates for this year will be published shortly.

In process of organising:

- PHB Champions for ICB service areas who support and deliver PHBs, so teams will have dedicated person(s) who support and champion PHB Direct Payment delivery.
- PHB page for the public on the ICB website.
- PHB page for staff on the ICB Intranet.
- PHB Support Services Directory (formerly named PHB Procurement Framework, will resemble a service directory, and will contain a range of PHB support service providers to help people to complete complex personalised care and support planning and brokerage, money management support and other PHB support services (estimated delivery period is Q3 of 23/24)

Following documents are/will be available on the ICB intranet:

- NCL ICB PHB Policy
- NCL ICB Generic PHB Processes
- NHSE PHB Quality Framework Self-Assessment for the business, teams and Case Manager
- PHB tools and resources to help with Personalised Care and Support Planning
- NCL Training Hub - Internet: www.ncltraininghub.org

Further information

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- NHS England website

- Personal Health Budgets Learning Network
  Personal Health Budgets - elearning for healthcare (e-lfh.org.uk)

- Personalised Health and Care Framework
  Personalised health and care 2020: a framework for action - GOV.UK (www.gov.uk)

- Personalised Care Institute
  (Contains e-learning courses on Core Skills, Shared Decision Making and Personalised Care and Support Planning)
  www.personalisedcareinstitute.org.uk

Further information

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- Personal Health Budgets
  https://www.nhs.uk/nhs-services/help-with-health-costs/what-is-a-personal-health-budget/

- Personalised Care Collaborative Network
  https://www.coalitionforpersonalisedcare.org.uk/

- Personalised Care
  https://www.england.nhs.uk/personalisedcare/

- Patient Stories
  NHS England » Personal health budgets in action

- NHSE/I Events
  https://www.events.england.nhs.uk/

Further information & support

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NHS England
https://www.england.nhs.uk/wp-content/uploads/2017/06/516_Personalised-care-and-support-planning_S7.pdf
https://www.england.nhs.uk/publication/personalised-care-and-support-planning/

Helen Sanderson Associates
http://helensandersonassociates.co.uk/person-centred-practice/care-support-planning/

TLAP
https://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/

Questions

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