DIGITAL PERSONALISED CARE AND SUPPORT PLANNING

DON REDDING
NATIONAL VOICES

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IN THIS PRESENTATION

• What is personalised care and support planning?
• Who needs it?
• Where does it happen and how will it spread?
• How was the record standard created?
• What does it contain?
• What’s next?
WHAT IS PERSONALISED CARE AND SUPPORT PLANNING?

• 3 Principles

• “a proactive and transparent process, supported by preparation, that enables conversations between people and practitioners focussed on what matters most to the person; so that they are involved in decisions about their health and wellbeing, and are more in control of living their life with their conditions”
WHAT IS PERSONALISED CARE AND SUPPORT PLANNING?

• 3 Principles

• The process brings together all of the person’s physical and mental health and wellbeing as well as social needs within a single conversation and coordinates access to personalised care and treatment, psychosocial support and supportive community activities.’
WHAT IS PERSONALISED CARE AND SUPPORT PLANNING?

- 3 Principles

- “replaces current approaches to routine care and is a continuous not a one-off process”
WHO NEEDS IT?

- Anyone with long term or recurrent/fluctuating health conditions – physical and/or mental – should have the offer
- In particular, people with multiple long term conditions – the NHS ‘core customer’ from now on
- And with targeting – segments of people with lowest health literacy, greatest burden of illness and greatest burden of treatment (health inequalities impact)
WHERE DOES IT HAPPEN AND HOW WILL IT SPREAD?

• Care planning is a recognised approach in: adult social care; SEND (young people); severe mental illness; end of life care; learning disability

• Care planning is not happening in primary care – only 3% of people with LTCs

• The ten year plan is likely to have big ambitions on personalisation, and how to spread care planning to all who need it’.
METHODOLOGY

NEW PRSB STANDARD

Publication → Endorsement → FINAL DRAFT → Expert group → 3rd DRAFT

Safety Case Lessons Learned

1st DRAFT

PID Comms plan → Evidence gathering

1st DRAFT

2nd DRAFT

Online survey

Better records for better care
EVIDENCE AND CONSULTATION

• Reviewed existing care and support plans across the UK
• International evidence review
• Workshop and on-line consultation with 623 responses
• Engaged with 8 leading care communities, in addition to NWL
• Engaged with organisations shaping the agenda
# Care and support plan

## Strengths, needs, concerns or health problems

Any strengths and assets, needs, concerns or health problems an individual has that relate to their health and wellbeing.

## Goals and hopes

The overall goals, hopes, aims or targets that the individual has. Anything they want to achieve that relates to their future health and wellbeing.

Each goal may include a description of why it is important to the person. Goals may also be ranked in order of importance or priority to the individual.

## Actions

Actions or activities the individual or others plan to take to achieve the individual’s goals and the resources required to do this.

For each action the following may be identified:

- **Stage goal** – a specific sub-goal that is related to the overall goal as agreed by the person in collaboration with a professional
- **What** – what the action is and how it is to be carried out?
- **Who** – name and designation (e.g. person, carer, GP, OT, etc.) of the person, or a team, carrying out the proposed action, and, if relevant where action should take place
- **When** – planned date, time, or interval, as relevant
- **Suggested strategies** for potential problems
- **Status** – Not started, Started, Completed, Not applicable
- **Confidence** – how confident the person feels to carry it out
- **Outcome** – the outcome of the stage goal
- **Date** when action/activity record was last updated
- **Review date** – when the stage goal and action need to be reviewed
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcomes</td>
<td>Outcomes of each of the individual’s goals, aims and targets. Includes comments recorded by the individual, date and status: fully achieved, partially achieved, not achieved, on-going, no longer applicable.</td>
</tr>
<tr>
<td>Agreed with person or legitimate</td>
<td>Indicates whether the plan was discussed and agreed with the person or legitimate representative.</td>
</tr>
<tr>
<td>representative</td>
<td></td>
</tr>
<tr>
<td>Planned review date/interval</td>
<td>This is the date/interval when this information will next be reviewed.</td>
</tr>
<tr>
<td>Responsibility for review</td>
<td>This is a record of who has responsibility for arranging review of this information. Should include their name, role and contact details.</td>
</tr>
<tr>
<td>Care funding source</td>
<td>A reference to the funding source and any conditions or limitations associated.</td>
</tr>
<tr>
<td>Other care planning documents</td>
<td>Reference other care planning documents, including the type, location and date. This may include condition-specific plans, advance care plans, end of life care plan, etc.</td>
</tr>
<tr>
<td>Person completing record</td>
<td>This is the person contributing to the care and support plan. Should include their name, role, grade, specialty, organisation, professional identifier, date and time completed, contact details.</td>
</tr>
<tr>
<td>Date this plan was last updated</td>
<td>This is a record of the date that this care and support plan was last updated.</td>
</tr>
</tbody>
</table>
Contingency plan (These are the things to do and people to contact should an individual’s health or other circumstances get worse.)

<table>
<thead>
<tr>
<th>Contingency plan name</th>
<th>Name of the contingency plan – what condition or circumstances it is addressing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trigger factors</td>
<td>Signs to watch out for that may indicate a significant change in health or other circumstances.</td>
</tr>
<tr>
<td>What should happen</td>
<td>To record guidance on specific actions or interventions that may be required or should be avoided in specific situations. This may include circumstances where action needs to be taken if a carer is unable to care for the individual.</td>
</tr>
<tr>
<td>Who should be contacted</td>
<td>Who should be contacted in the event of significant problems or deterioration in health or wellbeing including, e.g. name, relationship and contact details of persons.</td>
</tr>
<tr>
<td>Anticipatory medicines/equipment</td>
<td>Medicines or equipment available that may be required in specific situations and their location.</td>
</tr>
<tr>
<td>Planned review date/interval</td>
<td>This is the date/interval when this contingency plan will next be reviewed.</td>
</tr>
<tr>
<td>Responsibility for review</td>
<td>This is a record of who has responsibility for arranging review of this information. Should include their name, role and contact details.</td>
</tr>
<tr>
<td>Date this plan was last updated</td>
<td>This is a record of the date that this contingency plan was last updated.</td>
</tr>
<tr>
<td><strong>Additional supporting plan name</strong></td>
<td>The name of the particular additional supporting plan, e.g. dieticians plan, wound management plan, discharge management plan.</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Additional supporting plan content</strong></td>
<td>This is the content of any additional care and support plan which the individual and/or care professional consider should be shared with others providing care and support. It should be structured as recommended for the care and support plan and if it contains additional detail, it may be referenced here.</td>
</tr>
<tr>
<td><strong>Person completing record</strong></td>
<td>This is the person contributing to the care and support plan. Should include their name, role, grade, specialty, organisation, professional identifier, date and time completed, contact details</td>
</tr>
<tr>
<td><strong>Planned review date/interval</strong></td>
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</tr>
<tr>
<td><strong>Date this plan was last updated</strong></td>
<td>This is a record of the date that this information was last updated.</td>
</tr>
<tr>
<td>About me</td>
<td>This is a record of the things that an individual feels it is important to communicate about their needs, strengths, values and preferences, etc to others providing support and care.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Supported to write this by</td>
<td>Where relevant, this is a record of name, relationship/role and contact details of the person who supported the individual to write this section e.g. carer, family member, advocate, professional.</td>
</tr>
<tr>
<td>Date</td>
<td>This is a record of the date that this information was last updated.</td>
</tr>
</tbody>
</table>

**THIS NEEDS TO BE AVAILABLE TO ALL HEALTH AND CARE PROVIDERS**
# INTEGRATED DIGITAL CARE RECORD (IDCR)

<table>
<thead>
<tr>
<th>GP practice</th>
<th>Social context</th>
<th>Relevant contacts</th>
<th>Allergies and adverse reactions</th>
<th>Medications and medical devices</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP practice identifier</td>
<td>Household composition</td>
<td>Name</td>
<td>Causative agent</td>
<td>Medication status</td>
</tr>
<tr>
<td>GP practice details</td>
<td>Access</td>
<td>Relationship / role</td>
<td>Description of reaction</td>
<td>Medication name</td>
</tr>
<tr>
<td>Individual requirements</td>
<td>Lifestyle</td>
<td>Contact details</td>
<td>Type of reaction</td>
<td>Medication Form</td>
</tr>
<tr>
<td></td>
<td>Smoking</td>
<td>Measures (may be self-monitored)</td>
<td>Severity</td>
<td>Route</td>
</tr>
<tr>
<td></td>
<td>Alcohol intake</td>
<td>Height</td>
<td>Certainty</td>
<td>Dose directions description</td>
</tr>
<tr>
<td></td>
<td>Drug/substance use</td>
<td>Weight</td>
<td>Evidence</td>
<td>Dose direction duration</td>
</tr>
<tr>
<td></td>
<td>Social circumstances</td>
<td>Vital signs</td>
<td>Probability of recurrence</td>
<td>Additional instruction</td>
</tr>
<tr>
<td></td>
<td>Services and care</td>
<td></td>
<td>Date first experienced</td>
<td>Indication</td>
</tr>
<tr>
<td>Legal information</td>
<td>Diagnoses</td>
<td>Patient concerns, expectations and wishes</td>
<td>Allergies and adverse reactions</td>
<td>Person completing record</td>
</tr>
<tr>
<td>Consent for information sharing</td>
<td>Diagnosis</td>
<td>Advance statement</td>
<td>Causative agent</td>
<td>Name</td>
</tr>
<tr>
<td>Lasting Power of Attorney for Personal Welfare (or equivalent)</td>
<td>Awareness of diagnosis</td>
<td>Preferred place of care</td>
<td>Description of reaction</td>
<td>Role</td>
</tr>
<tr>
<td>Advance decision to refuse treatment (ADRT)</td>
<td>Problems and issues</td>
<td>Preferred place of death</td>
<td>Type of reaction</td>
<td>Grade</td>
</tr>
<tr>
<td>Organ and tissue donation</td>
<td>Problems and issues</td>
<td></td>
<td>Severity</td>
<td>Specialty</td>
</tr>
<tr>
<td>Legal safeguarding issues</td>
<td>Comment</td>
<td></td>
<td>Certainty</td>
<td>Professional identifier</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Evidence</td>
<td>Date and time completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Probability of recurrence</td>
<td>Contact details</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Medications and medical devices**

- Medication status
- Medication name
- Medication Form
- Route
- Dose directions description
- Dose direction duration
- Additional instruction
- Indication
- Comment
- Recommendation
- Medication administered
- Medical devices

**Social context**

- Household composition
- Access
- Lifestyle
- Smoking
- Alcohol intake
- Drug/substance use
- Social circumstances
- Services and care

**Problems and issues**

- Problems and issues
- Comment

**Diagnoses**

- Diagnosis
- Awareness of diagnosis

**Measurements (may be self-monitored)**

- Height
- Weight
- Vital signs

**Allergies and adverse reactions**

- Causative agent
- Description of reaction
- Type of reaction
- Severity
- Certainty
- Evidence
- Probability of recurrence
- Date first experienced

**Patient concerns, expectations and wishes**

- Advance statement
- Preferred place of care
- Preferred place of death

**Person completing record**

- Name
- Role
- Grade
- Specialty
- Professional identifier
- Date and time completed
- Contact details
Integrated Digital Care Record

- Demographics
- Relevant contacts
- Legal information
- Social context
- Diagnoses
- Services, support and care
- Medications
- Investigation results
- etc.

About me

Care and support plan

Contingency plan(s)

Information comes from:
- individual, family, professionals, etc.
- initial consultation between individual and professional
- supporting actions with multispecialty input
- each service or discipline where relevant for each condition, disability or circumstance
THE PERSON’S PERSPECTIVE

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”
I work with my team to agree a care and support plan. My care plan is clearly entered on my record.

When I use a new service, my care plan is known in advance and respected. I tell my story once.
NEXT STEPS

Publish digital care and support plan standards → Produce technical (FHIR) specification → Implementation