

Personalised Care and Support Planning

Personalised Care and Support Planning (PCSP) is a series of facilitated conversations in which the person actively participates to explore the management of their health and well-being within the content of their whole life and family situation.

What does a good personalised care and support plan look like?

Person centred care: People are central in developing and agreeing their PCSP including deciding who is involved in the process.

What Matters: People have proactive, personalised conversations which focus on what matters to them, paying attention to their needs & wider health wellbeing.

Outcomes: People agree the health and well-being outcomes they want to achieve, in partnership with the relevant professionals.

Shareable plan: Each person has a sharable PCSP which records what matters to them, their outcomes and how they will be achieved.

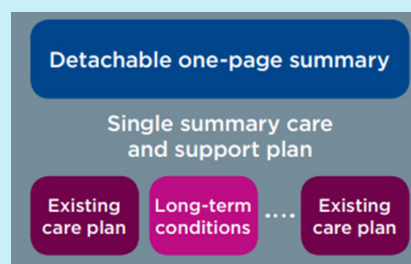
Review: People have the opportunity to formally and informally review their care plan.

What is a single summary care and support plan?

A single summary care and support plan is a single plan that acts as an overview for all other plans.

Education, Health and Care Plan (EHCP): For children and young people with SEND, the EHCP is the IPC single summary care and support plan.

Advanced Care Plan (ACP): For people with life threatening or life limiting conditions, a single plan may be in the form of an ACP.



PCSP and long-term conditions (LTCS)

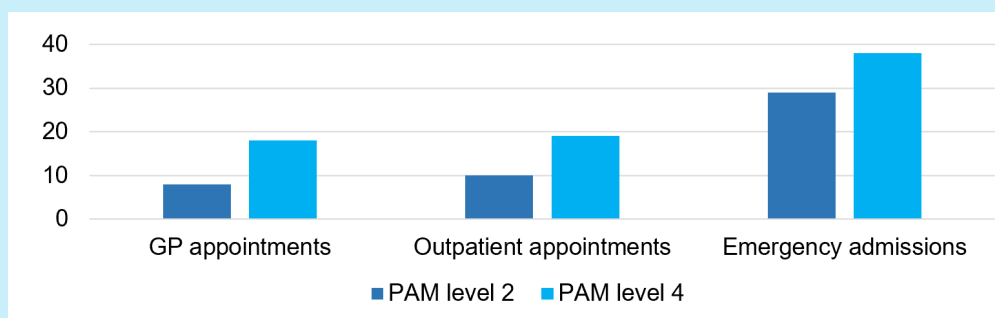
Long-term conditions are becoming more common in England, increasing from 52.2% in 2018 to 56.1% in 2023. In Herefordshire and Worcestershire, 58% self-reported an LTC in 2023. ²

PCSPs can increase patients' knowledge, skills, and confidence in managing their condition (i.e. patient activation). In comparison to PAM level 1, people with higher activation had few GP appointments, outpatient appointments and emergency admissions. ³

Cancer: People with cancer found the most helpful part of the Holistic Needs Assessment (HNA) process to be the discussion between the health care professional (HCP) and the individual. ⁶

Asthma: People with asthma that use personalised action plans are less likely to have symptoms and time off work or school. They are also four times less likely to be admitted to hospital for the condition. ⁷⁻⁹

Percentage reductions in appointments and emergency admissions by activation level, in comparison to those at PAM level 1 ³ -



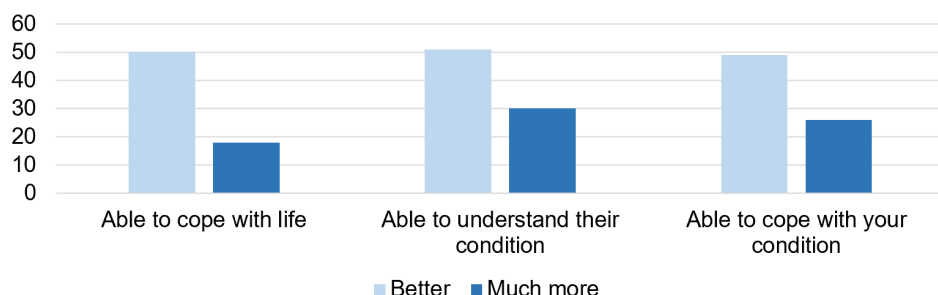
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Following the introduction of care and support planning to the British Heart Foundation programme at Gateshead CCG...

Patients were asked
“How useful was the
preparation letter in
helping you prepare for
your consultation” ⁴



Percentage of
patients that reported
improvements following
their consultation. ⁴

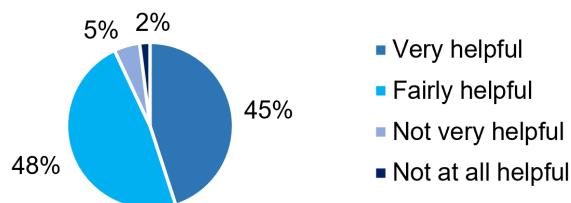


Where are we now?

GP Patient Survey results, 2023 ^{1,2}

- 37% had a conversation with a HCP about managing their condition (national = 36.8%).
- 60% of these had an agree plan with a HCP from their GP practice (national = 58.7%).
- 60% feel confidence in managing any issues arising for their condition (national = 77.4%).

In 2023 GP patient survey, in Herefordshire and
Worcestershire, 45% said they found their plan
very helpful in managing their condition. ²



Quality Outcome Framework (QOF) indicators 2022-23

78% of patients diagnosed with dementia had their care plan reviewed in a face-to-face meeting in the preceding 12-months. ⁵

73% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate. ⁵

94% of patients with cancer, diagnosed within the preceding 24 months, had a patient Cancer Care Review using a structured template recorded as occurring within 12 months of diagnosis. ⁵

References

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