Step Four: Record

Getting agreement - don’t forget this is their plan not our plan for them

This is the process that moves from the planning by the person – supported by an advocate and health professional – to a physical plan on paper or electronic format (or both). Gaining commitment is an essential part of the conversation during stage three.

Translating the planning into a physical reality is no easy task but has a number of purposes.

1. Enabling the person to have a better understanding and take more control of their lives and long term conditions.
2. Enabling the system, especially in urgent care to respond accordingly taking into account the person’s preferences.
3. Underpinning a commitment by the person and statutory services to work together.
4. Informing future commissioning intentions.
The emphasis will depend on the underlying context but we see the planning process as of equal importance to the plan itself. And so it is crucial that the agreement must in the person’s own words with both parties agreeing to use ‘best endeavours’ to making it happen.

While some highly activated people will be very happy to agree their plan by themselves, in many or most cases, other carers/health professionals/advocates working with the person will be involved as they will play an important part of supporting implementation.

It is so easy to forget or become diverted and some people really do struggle, especially if going through this process for the first time to know what they want to focus on and so plans must be sufficiently granular, realistic, relevant to be achieved. It is also crucial to ensure people commit to their goals before leaving in stage three.

Recording
All plans will have basic ‘passport’ details but depending on the context ideally they will also include a:

- care plan articulating the person’s own goals
- management plan including a combination of medical and social prescribing
- escalation plan so the urgent care system can respond appropriately.

The format of any of the care plan must be heuristic as the process of formulating and creating a plan allows people to reflect on what really matters.

Information Governance
It is essential that processes in the surgery support this with clear documentation including recording consent to share within the plan. Concerns around information governance must be resolved within the context of a local system agreement. We recommend practices check with the local CCG or health board on the locally agreed framework for templates and information governance.

While we fully expect that this process will become digital in future, these are not yet well developed systems and the most vulnerable may still prefer paper records. Taking a pragmatic approach is best, allowing surgeries and people to experiment with what works for them.

The care plan should be seen as attempt to support people in taking greater ownership in the condition. It is not legally binding although may include mandates such as ‘do not resuscitate’ or ‘power of attorney’ and as such, health professionals will need to understand issues around mental capacity.

There is an important role for GP surgeries to ensure the right administration processes are in place to support this process.

The local system
- While commissioning systems vary across the four nations, there will need to be a broader system responsibility at either CCG or health and social care board level recognising we are all ‘learning by doing’.
- Working with local surgeries and MDTs to develop care, management and escalation plans.
- Taking into account care and support plans when considering commissioning intentions
• Facilitating CCSP by ensuring there is a quality improvement plan for its implementation at all levels from general practices to teams working in MDTs across localities etc, including the recording into primary care systems by a) developing action learning systematically, b) enabling quality time is set aside to test options with a few surgeries, capture reflections before applying in the local system.

• Enabling plans to be shared easily across the local urgent care system subject to the right information governance framework.

• Providing practical support, including training for surgeries trying to implement the record into primary care system.

• Facilitating conversations with local groups such as Health Watch, local government, community services, ambulance and hospitals about the importance of paying due recognition to care and support plans in day to day clinical practice.

• Ensuring strategies to develop Digital Technology take into account Care Plans.

• Making sure contracts for other services support CCSP reflecting that for the majority of people there will be ‘One Plan’ for each individual embedded within the primary care system.

• Improving Digital Literacy of the local population with partners.

We recommend as with general practices that local planning systems start small, working with willing practices to develop CCSP as they build up organisation learning. This may pass onto new models of care in future work on the rule of thirds.