

## OFFICIAL

## 11. Personalised care and support planning

<b>Indicator 11</b>	
<b>Indicator name</b>	Personalised Care and Support Planning
<b>Indicator weighting (% of CQUIN scheme available)</b>	0.25%
<b>Rationale</b>	<p>More than half of the population live with long term conditions and 5% of these people account for more than 75% of unscheduled hospital admissions. Many of these people (35%) indicate they have low or very low levels of knowledge, skills and confidence to self-care, in order to manage their health and wellbeing and live independently. These people have a poorer quality of life, make more unwarranted use of public services and cost more to public services.</p> <p>Changing this situation is not a short-term fix. There are, however, steps we can take, supported by the CQUIN scheme to incentivise the change in behaviours and methodologies that allow patients to take greater control over their health and wellbeing. A core component is personalised care and support planning which is; a) an intervention that supports people to develop the knowledge, skills and confidence to manage their own health and wellbeing and that leads to the development of a care plan and b) an enabler that supports patients to understand the local support mechanisms that are available to them.</p> <p>We envisage that the first year of the CQUIN is an opportunity to introduce the requirement of high quality personalised care and support planning, whilst recognising that not all health systems will have the technological means nor the workforce capabilities of making these happen. In future years there will be a need to increase the expected levels of achievement so that by 2020/21 personalised care and support planning is fully embedded across the service as the norm.</p> <p>The Realising the Value report 'At the heart of health' describes how personalised care and support planning is a key enabler to allow the proliferation of self-care support packages such as health coaching, peer support and self-management education. In this context it can be seen as the foundation for the behaviour change needed to support improvements in self-care.</p>
<b>Description of Indicator</b>	This CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long-term conditions. In the first year, activity will be focused on agreeing and putting in place systems and processes to ensure that the relevant patient population can be

## OFFICIAL

## Indicator 11

identified, the relevant workforce receives appropriate training, and that personalised care and support planning conversations can be incorporated into consultations with patients and carers. The second year will focus more on delivery of personalised care and support planning, the quality of conversations and the impact on individual levels of knowledge, skills and confidence.

**Year 1 – 2017/18**

In year one there are three components:

**1: Establishing provider systems** to ensure that personalised care and support planning conversations can be incorporated into care delivery and can be recorded as an activity. Also to ensure relevant cohorts of patients who would benefit most from the delivery of personalised care and support planning can be identified on IT systems.

For the purpose of the CQUIN, personalised care and support planning conversations are defined as:

- *Conversations between a care professional, a person with long-term conditions and their carer (if applicable) to understand what is important to that individual and what support they need in order to help build their knowledge, skills and confidence to manage their health and wellbeing.*
- *Follow a process of sharing information, identifying support needs, discussing options, contingency planning, setting goals, developing an action plan, and monitoring progress.*
- *Consider how to co-ordinate the individual's care across a number of different care settings, linking to other existing care plans, particularly for people with multiple conditions.*
- *Consider physical and mental health as well as wider holistic wellbeing.*
- *Resulting in an agreed, recorded, document that the patient and carer owns.*

Providers should develop and agree a plan outlining their approach to delivering personalised care and support planning and how this will be recorded as an activity, taking account of the pioneering work of the national Integrated Personal Commissioning team, the latest iteration of the TLAP personalised care and support planning tool<sup>54</sup> and the NHS England handbook on personalised care and support planning<sup>55</sup>.

<sup>54</sup> <http://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/>

<sup>55</sup> NHS England & Coalition for Collaborative Care (2015) *Personalised care and support planning handbook* - <https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/>

## OFFICIAL

## Indicator 11

**2: Identifying relevant patient populations.** Providers should develop and agree a plan outlining how they will identify the relevant patient population with one or more long-term conditions and with low levels of knowledge, skills and confidence (activation) to manage their health and wellbeing who would benefit from personalised care and support planning. They will need to take into consideration cohorts of patients who may already be participating in personalised care and support planning, for example people with learning disabilities, people with severe mental health issues who are part of the Care Programme Approach, people with complex needs who have personal health budgets or are part of the Integrated Personal Commissioning programme. This may require planning with commissioners and other providers to agree who will lead the care planning process, and also how multi-disciplinary teams can work together.

To identify the cohort providers should:

- Identify patients with one or more long-term conditions as defined by the GP patient survey (see below). People may be identified on clinical IT systems, for example using ICD10 codes or using risk stratification tools. People may be additionally identified through contact with care professionals as someone who would benefit from personalised support<sup>56</sup>.

The list of long-term conditions defined in the GP patient survey is:

- Alzheimer's disease or dementia
- Angina or long-term heart problem
- Arthritis or long-term joint problem
- Asthma or long-term chest problem
- Blindness or severe visual impairment
- Cancer in the last 5 years
- Deafness or severe hearing impairment
- Diabetes
- Epilepsy
- High blood pressure
- Kidney or liver disease
- Long-term back problem
- Long-term mental health problem
- Long-term neurological problem

Then **conduct a baseline review of patient activation** for those patients with long term conditions identified above. This

<sup>56</sup> See also NICE guideline on multimorbidity - <https://www.nice.org.uk/guidance/ng56>

## OFFICIAL

Indicator 11	
	<p>means:</p> <ul style="list-style-type: none"> <li>• For those organisations already using the Patient Activation Measure, ensuring that all identified patients and carers have their activation levels recorded<sup>57</sup>; this can be combined to create an organisational score, or</li> <li>• For those organisations not using the Patient Activation Measure, ensuring that all identified patients and carers are asked a local survey using two key questions from the existing GP patient survey (GPPS). Answers to these questions will use the same criteria as the GPPS and be given scores as described below to allow production of an organisational score. These are: <ul style="list-style-type: none"> <li>○ <b>Q32</b> – <i>In the last six months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)?</i></li> </ul> <p style="margin-left: 40px;">Answering ‘yes, definitely’ = 1 point, ‘yes, to some extent’ = 0.5 points. Other answers = 0 points</p> <li>○ <b>Q33</b> – <i>How confident are you that you can manage your own health?</i></li> </li></ul> <p style="margin-left: 40px;">Answering ‘very confident’ = 1 point, ‘fairly confident’ = 0.5 points. Other answers = 0 points.</p> <p><b>Following this review of patient activation, the relevant population to be prioritised for personalised care and support planning will be defined as:</b></p> <ul style="list-style-type: none"> <li>• A cohort of patients with one or more long-term conditions as defined by the GP patient survey<sup>58</sup>; <b>and</b></li> <li>• For those organisations already using the Patient Activation Measure those patients assessed at Level 1 or 2 in their activation level; <b>or</b></li> <li>• For those organisations not using the Patient Activation Measure, those patients who score 0 points on the GPPS questions.</li> </ul> <p>(see <b>Annex A</b> for further guidance)</p> <p><b>Note:</b> For Year 2, the provider will identify and agree a revised Cohort with the commissioner. This cohort will be drawn from the Year 1 Cohort and will thus be a sub-group of those patients</p>

<sup>57</sup> Patient Activation Best Practice Guide (due to be published December 2016)

<sup>58</sup> Final position to be confirmed prior to April 2017. The current expectation is this will include a broad definition (Long term conditions are health conditions that can't be cured, last a year or longer, impact on a person's life, and may require on-going care and support) and a list of the specific conditions that fall under this definition

## OFFICIAL

## Indicator 11

who need further support in patient activation. Please see **Annex A** for guidance on Year 2 Cohort selection.

**3: Ensuring that all relevant provider staff are sufficiently competent** in holding care and support planning discussions with patients and carers, through appropriate training. For the purpose of the CQUIN 'relevant provider staff' can be defined as:

- *Those who have allocated time to support the patient and carer to develop their care and support plan; and*
- *Have specific expertise or training in support for people with long-term conditions; and*
- *Are in a position to be able to liaise with multidisciplinary teams as required to gather information pertinent to the care planning discussion, and to raise issues that are impacting on an individual's care or that need to be considered at an organisational level.*
- *Are a regular (at least annual) point of contact for the patient and carer.*

Appropriate training is defined as training that:

- *Explores the role of care & support planning in empowering patients and carers;*
- *Clearly defines the role and expectations of the member of staff and the patient and/or carer;*
- *Provides a framework for staff to follow in having structured care and support planning conversations based around what is important to the person living with a long-term condition and their holistic needs, not just their medical needs;*
- *Helps staff develop skills in motivational interviewing to help them in encouraging patients and carers to actively participate in planning discussions, and how to tailor their approach based on the individual's levels of knowledge, skills and confidence, and their communication needs; and*
- *Helps staff deal with sensitive discussions such as consent, mental capacity, and end of life care.*

#### Year 2 - 2018/19

For Year 2, the provider will identify and agree a revised Cohort with the commissioner. This cohort will be drawn from the Year 1 Cohort and will thus be a sub-group of those patients who need further support in patient activation. Please see **Annex A** for guidance on Year 2 Cohort selection.

In year two (2018/19), as in Year 1 above, organisations will either need to repeat the process of collecting individual Patient Activation scores using the Patient Activation Measure, or using the questions from the GP patient survey to ascertain levels of confidence and feelings of support, plus there are two further

## OFFICIAL

Indicator 11	
	<p>components:</p> <p><b>1: Reporting on the number of care and support planning conversations</b> that take place (with the expectation that at least one conversation takes place for each patient but the number of conversations will vary depending on individual's needs and levels of knowledge, skills and confidence).</p> <p><b>2: Conducting a follow up review of patient's knowledge, skills and confidence</b> for the identified patient cohort</p>
<b>Numerator &amp; Denominator</b>	<p><b>Year One:</b></p> <ol style="list-style-type: none"> <li>1. Develop and agree with commissioners a plan to ensure care &amp; support planning is recorded by providers and how patients will be identified Local commissioners will need to be assured that the plan is appropriate and in place in a qualitative way. Plans are <b>NOT</b> to be submitted via SDCS.</li> <li>2. The provider to identify a number of patients as having one or more LTCs compared to the total number of patients served.</li> </ol> <p style="text-align: center;"><b>AND</b></p> <p style="text-align: center;">For all of these patients identified as having one or more LTCs to have a patient activation score recorded.</p> <p>Therefore Year 1 Part 2 indicator:</p> <p><i>Indicator</i></p> $= \left[ \frac{\text{Number of patients identified as having one or more LTCs who have had an assessment made of their activation level and score record (numerator)}}{\text{Number of patients identified as having one or more LTC (denominator)}} \right]$ <p>× 100%</p> <p><b>AND</b></p> <p>To confirm the final cohort as the number of patients with one more LTCs and who have a low activation level (as described above).</p>

## OFFICIAL

## Indicator 11

Therefore Year 1 Cohort :

$$\text{Year 1 Cohort} = \left[ \begin{array}{l} \text{Number of patients identified as having} \\ \text{one or more LTCs assessed AND as} \\ \text{having a low activation Level} \end{array} \right]$$

This data should be submitted vis NHS Digital SCDS.

- The provider to identify the number of staff who have undertaken training in personalised care and support planning.

Therefore Year 1 Part 3 indicator:

*Indicator*

$$= \left[ \frac{\begin{array}{l} \text{Number of staff (identified by the provider} \\ \text{as caring for the identified patient cohort )} \\ \text{who have been (numerator)} \\ \text{recorded as undertaking care and} \\ \text{support planning training} \end{array}}{\begin{array}{l} \text{Total number of staff identified by} \\ \text{the provider as caring for the (denominator)} \\ \text{identified patient cohort} \end{array}} \right] \times 100\%$$

This data should be submitted via NHS Digital SCDS.

**Year Two:**

- The number of patients from the Year 1 Cohort who have undertaken at least one personalised care and support planning conversation across both Year 1 and Year 2.

Therefore Year 2 Part 1 indicator:

$$\text{Indicator} = \left[ \frac{\begin{array}{l} \text{Number of patients in the Year 1} \\ \text{identified patient cohort} \\ \text{who have had a (numerator)} \\ \text{record of care and support planning} \\ \text{conversations} \end{array}}{\begin{array}{l} \text{Number of patients in Year 1} \\ \text{identified patient cohort (denominator)} \end{array}} \right] \times 100\%$$

This data should be submitted via NHS Digital SCDS

- Whether there has been an improvement in individual activation levels following personalised care and support planning.

## OFFICIAL

Indicator 11	
	<p>The provider will identify and agree a revised Year 2 Cohort with the commissioner. This cohort will be drawn from the Year 1 Cohort and will thus be a sub-group of those patients who need further support in patient activation. Please see <b>Annex A</b> for guidance on Year 2 Cohort selection. The Year 2 Part 2 denominator will be the number of patients in the Year 2 Cohort whose Patient Activation was measured, and the numerator will be the number of patients in the Year 2 Cohort whose Patient Activation level improved.</p> <p>Therefore Year 2 Part 2 indicator:</p> <p><i>Indicator</i></p> $= \left[ \frac{\text{The number of patients in the Year 2 Cohort whose Patient Activation level improved (numerator)}}{\text{The number of patients in the Year 2 Cohort (denominator)}} \right] \times 100\%$ <p>This data should be submitted via NHS Digital SCDS</p>
<b>Data source</b>	<p><b>Provider data collection</b></p> <p><b>Year One:</b></p> <ol style="list-style-type: none"> <li>1. Community based providers would need to agree a plan with their commissioner, outlining their approach to delivering personalised care and support planning to an identified cohort of patients, and how they will record this activity in a format that can be aggregated at organisation level.</li> <li>2. Providers would need to identify which patient populations would benefit from personalised care and support planning and should be prioritised; using the list of long term conditions outlined in the GP Patient Survey and the Patient Activation Measure or GP patient survey criteria to assess their level of confidence and perceived support.</li> <li>3. Providers would need to identify relevant staff (as defined above) and record that they have undertaken training in personalised care and support planning (as defined above). To be submitted via NHS Digital SDCS following locally agreed sign off processes by the commissioner.</li> </ol> <p><b>Year Two:</b></p> <ol style="list-style-type: none"> <li>1. Identify the number of care planning conversations taking place for each of the identified cohort from the previously identified local system.</li> </ol>



## OFFICIAL

Indicator 11	
	2. Follow-up use of a survey instrument (the Patient Activation Measure or questions from the GP patient survey) to assess whether the level of patients' skills, knowledge and confidence to self-manage has improved.
<b>Frequency of data collection</b>	Annual in Q4, noting in-year milestones for year 1
<b>Organisation responsible for data collection</b>	Community Providers
<b>Frequency of reporting to commissioner</b>	Annual, noting in-year milestones for year 1
<b>Baseline period/date</b>	The requirements described are new. Baselines to inform Year 2 will be collected during Year 1.
<b>Final indicator period/date (on which payment is based)</b>	31 March 2018 (Year 1) and 31 March 2019 (Year 2)
<b>Final indicator value (payment threshold)</b>	<p><b>Year One:</b></p> <ol style="list-style-type: none"> <li>1. 25% of Year One CQUIN value           <ol style="list-style-type: none"> <li>a. No plan produced = 0% of proportion of CQUIN value.</li> <li>b. Plan produced but recording system not in place = 50% of proportion of CQUIN value.</li> <li>c. Plan produced and recording system put in place = 100% of proportion of CQUIN value.</li> </ol> </li> <li>2. 45% of Year One CQUIN value. Comprised of:           <ol style="list-style-type: none"> <li><b>2.a) Identifying long term conditions (15% of Year One CQUIN value)</b> <ol style="list-style-type: none"> <li>a. Relevant patients not identified or numbers submitted = 0% of proportion of CQUIN value.</li> <li>b. Relevant patients identified and numbers submitted to commissioner = 100% of proportion of CQUIN value.</li> </ol> </li> <li><b>2.b) Undertaking patient activation assessment (30% of Year One CQUIN value)</b> <ol style="list-style-type: none"> <li>c. &lt; 25% of patients in Year 1 cohort have a patient activation assessment = 0% of proportion of CQUIN value.</li> <li>d. 25 to 50% of patients in Year 1 cohort have a patient activation assessment = 50% of proportion of CQUIN value.</li> </ol> </li> </ol> </li> </ol>

## OFFICIAL

Indicator 11	
	<p>e. 50% &gt; of patients in Year 1 cohort have a patient activation assessment = 100% of proportion of CQUIN value.</p> <p>3. 30% of Year One CQUIN value</p> <p>a. No staff identified for training = 0% of proportion of CQUIN value.</p> <p>b. Cohort of staff identified and list submitted to commissioner = 10% of proportion of CQUIN value.</p> <p>c. 33% to 66% of identified staff trained by end of year (including submitted staff list in 'b') = 40% of proportion of CQUIN value.</p> <p>d. 66 to 85% of identified staff trained by end of year (including submitted staff list in 'b') = 70% of proportion of CQUIN value.</p> <p>e. 85% &gt; of identified staff trained by end of year (including submitted staff list in 'b') = 100% of proportion of CQUIN value.</p> <p><b>Year Two:</b></p> <p>1. 50% of Year Two CQUIN value</p> <p>a. &lt; 50% of patients in Year 1 Cohort have evidence of care and support planning conversations as recorded by provider = 0% of proportion of CQUIN value.</p> <p>b. 50 to 75% of patients in Year 1 Cohort have evidence of care and support planning conversations as recorded by provider = 50% of CQUIN value.</p> <p>c. 75% &gt; of patients in Year 1 Cohort have evidence of care and support planning conversations as recorded by provider = 100% of CQUIN value.</p> <p>2. 50% of Year Two CQUIN value</p> <p>a. &lt; 25% of patients in Year 2 Cohort (subgroup of Year 1 cohort) demonstrate an improvement in their patient activation assessment = 0% of proportion of CQUIN value.</p> <p>b. 25 to 50% of patients in Year 2 Cohort (subgroup of Year 1 cohort) demonstrate an improvement in their patient activation assessment = 50% proportion of CQUIN value.</p> <p>c. 50% &gt; of patients in Year 2 Cohort (subgroup of Year 1 cohort) demonstrate an improvement in their patient activation assessment = 100% of proportion of CQUIN value.</p>
<b>Final indicator</b>	30 <sup>th</sup> April 2018/19

## OFFICIAL

Indicator 11	
<b>reporting date</b>	
<b>Are there rules for any agreed in-year milestones that result in payment?</b>	<p>In-year milestones for Year 1 will be as follows:</p> <p><b>By end of Q2:</b> A plan to ensure care &amp; support planning is developed and recorded by providers will be a yes/no requirement. Likewise local commissioners will need to confirm whether the plan has been received and accepted by the end of the year (yes/no).</p> <p><b>By end of Q3:</b> The provider to identify the number of patients as having multiple LTCs AND a low level of activation, who will be prioritised for personalised care and support planning (establishment of Year 1 cohort) compared to the total number of patients served.</p> <p><b>By end of Q4:</b></p> <ol style="list-style-type: none"> <li>1. The provider to confirm what proportion of relevant staff have undertaken training in personalised care and support planning.</li> <li>2. The provider to confirm the number of patients identified for the Year 1 cohort who have one or more LTCs and have been assessed as having a low activation level (as described above).</li> </ol> <p>There are no in-year milestones for Year 2</p>
<b>Are there any rules for partial achievement of the indicator at the final indicator period/date?</b>	<p>Partial achievement of indicators is covered in the differing percentages of achievement within the 'final indicator value' section above.</p>

## OFFICIAL

## Milestones for indicator 11

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Year 1 2017/18	A plan to ensure care & support planning is developed and recorded by providers will be a yes/no requirement. Likewise local commissioners will need to confirm whether the plan has been received and accepted (yes/no).	end of Q2	25%
Year 1 2017/18	Provider to identify the number of patients as having multiple LTCs AND a low level of activation, who will be prioritised for personalised care and support planning (establishment of Year 1 cohort) compared to the total number of patients served.	end of Q3	15%
Year 1 2017/18	Provider to confirm the number of relevant staff caring for Year 1 cohort and what proportion of these staff have undertaken training in personalised care and support planning.	end of Q4	30%
Year 1 2017/18	Provider to confirm the number of patients identified for the cohort who have one or more LTCs and have been assessed as having a low activation level (as described above).	end of Q4	30%

## Rules for partial achievement for indicator 11

The payment details are described in the final indicator value (payment threshold) in the table above.

## Annex A – Cohort Selection

There are two steps to identifying the final cohort of patients who will benefit from this scheme. An initial cohort is identified in Year 1, and then this is revised in Year 2. Which patients are ultimately within each cohort is to be negotiated and agreed by the commissioner and the provider.

The cohort for Year 1 is those patients with a low patient activation level. Whilst Patient Activation Level of 1 or 2 using the PAM, or a score of 0 using the questions

## OFFICIAL

from the GP Patient Survey, should be prioritised for Personalised Care and Support Planning; the final decision on which patients should be included and excluded in the Year 1 Cohort should be made by Trusts and Commissioners in partnership.

The revised cohort for Year 2 should be drawn from the Year 1 Cohort. The patients in the Year 2 Cohort should ideally be those still under the care of the provider trust, rather those who have been discharged. This is to make re-assessing patient activation level easier, as patients will not have to be contacted and followed up after discharge.

**Annex B – Patient Activation Measure Licences**

There are no Patient Activation Measure licences held by NHS England to support measurement of Patient Activation as part of this CQUIN scheme. All PAM Licences procured nationally have been allocated to individual organisations. Whilst, if you do not have licences, it is possible for your trust or commissioner to procure additional licences for the PAM through Insignia Health, you are strongly advised to use questions 32 and 33 drawn from the GP Patient survey instead, as described in Indicator 11 under the *Description of Indicator* section on page 138-139.

