‘MY LIFE PLAN’ – PRACTITIONER GUIDANCE NOTES

Background

All key providers of services to people with long term conditions agreed in April 2014 to have one single personalised care and support plan template for use across Somerset, which is known as ‘My Life Plan’. Since then more than a hundred people, including people with long term conditions, carers, clinicians in the community, primary and secondary care, therapists, social care workers, the voluntary sector, prescribing and medicines management group and others have had input to the development of this plan.

We have tested 3 versions of ‘My Life Plan’ in GP practices who have had attendees on the House of Care Personalised Care Planning training course, and with the Symphony and Social Prescribing Test and Learns, as well as obtaining feedback from Somerset Partnership and Adult Social Care.

After each version we have amended the Plan to incorporate the feedback we have received. We will continue to receive suggested amendments as the plan is now being more widely used. These should be e-mailed to Sarah.Attree@Somersetccg.nhs.uk. Annually, or sooner if required, these suggestions will be reviewed, and then changes agreed and incorporated in to the next version.

Purpose

Overall the use of personalised care and support planning and My Life Plan should empower people to better self-manage their conditions and their life, reduce their emergency admissions to hospital and GP practice attendances, and improve their independence and quality of life.

My Life Plan saves people having to repeat their stories every time they see a new practitioner, and means different practitioners can share information so that more appropriate treatments/services can be provided to people.

In developing this plan we had to recognise that there are a lot of ‘care plan’s’ already in use but most of these are actually treatment/assessment/support plans and not personalised holistic care plans. The Avoiding Admissions DES Care Plan Template is also not an holistic care plan.

‘My Life Plan’ is Somerset’s overarching personalised care and support plan for people with long term conditions and supports and is a tool for use in collaborative care and support planning consultations between a practitioner and a person.

It is a folder of information owned by the individual and is designed to identify what a person wishes to achieve in terms of goals/outcomes and how these can best be
achieved. My Life Plan is a central source of information for people so that they, for example, have a better understanding of their condition/disability and medications so that they feel more in control of their health and wellbeing, know what local support services are available, have information to help them stay as well as possible, and know how to manage in their home and how to use community resources.

It is up to the person to keep their folder safe and whether they hold all the information on their health and wellbeing in the folder or just some of it. The Plan is divided into sections and so if a section is not appropriate this can easily be removed.

The Sections include:

**Section 1 – My Information Sharing Agreement**

It is up to the person who they share their information with. Most people share their plan with their care and support network including their friends, carers, GP, specialist nurse, hospital staff, supporting volunteers and social care team so that they can give them the personal care and attention they need.

People must be asked to complete the Information Sharing Agreement in Section 1, either before or at the start of their first care and support planning consultation, to identify the people they wish to share their plan with, and to sign the agreement. The law (Data Protection Act 1998) states that we must have their agreement that they are happy for us to share this information.

A copy of this signed agreement should be scanned in and attached to the patient’s record in the GP practice. It should be reviewed with the person each year.

**Section 2 – This Is About Me**

This is important basic information about the person which should be kept up-to-date. This information could be electronically downloaded and printed from the patient record system, however many practices felt that patients had been on their registered list for a very long time and therefore it was useful for people to complete this so that the GP practice and other practitioners had the most recent information.

**Section 3 – Care And Support Planning Consultations**

Page 15 (the balloons) is an optional discussion ideas page. Here people can highlight issues they would like to talk about. So many people come out of a consultation and then remember they forgot to discuss an issue they had wanted to talk to the practitioner about. This page is just an aid to help them discuss all the issues they want. If they feel this is unnecessary then they do not have to complete it. A further copy of the discussion ideas page can be found at the end of this section and can be copied for use for follow up consultations.
Pages 17 – 18, My Plans and key action points for Outcome (goal) 1, is a preparation sheet and should be completed by the person, or someone who knows them well, and then taken to their first appointment. If they want to achieve more than one outcome/goal, they can complete the preparation sheets on pages 23-24, Outcome 2, and/or sheet 29-30 which can be used for multiple outcomes.

The aim is to help you as practitioners understand their wishes, and treat and support them in a way that meets their needs and wishes. If required, support should be available to help them complete this section. We have suggested they ask their practice receptionist who should be able to put them in touch with someone to assist them. This may for example be a peer, a member of the voluntary sector, a well-being advisor, health connector, or village agent.

The ‘Key Action Point’ sheets (19, 25, 31) for each goal(s) should be completed and agreed by the person and you, as their practitioner, during their consultation.

For their follow up review(s) they should complete ‘How my plans are going’, pages 23, 27 and/or 31, and these should be discussed at their consultation with you. If they have a number of outcomes they wish to achieve, they and you, may prefer to complete a single review sheet which you can find at the back of this section on page 37.

Section 4 – About My Health (Physical and Mental Health)

This section is not designed to list all the person’s health conditions and medications from the GP patient record system, but for clinicians to appreciate what the person understands about their conditions, what medications they are actually taking, and if they have any allergies, particularly severe allergic reactions. People are asked to fill in as much as they can in this section and to then discuss this and complete it with their clinician. It will enable you as clinicians to better understand their health, views and wishes and advise them accordingly.

We have purposely included in this section on page 40 special instructions for practitioners on access to the person’s home if they are unable to go to the door to meet you, for example a key safe number. This keeps this information less immediately visible than if it was at the front of the folder.

The ‘Keeping Well’ sheet on page 49 should be completed with the person at their consultation, so that they understand how to keep as well as possible and how to prevent the need for emergency treatment.

Section 5 – My Patient Activation Measure (PAM)

As practitioners, we want to know more about peoples’ health needs, how activated they are to self-manage and what support they need to be happy, healthy and fit for as long as possible. The better we understand these needs then the better we can develop services which meet their needs.
People who are more activated are significantly more likely to attend screenings, check-ups and immunisations, to adopt positive behaviours (e.g., diet and exercise), and have clinical indicators in the normal range (body mass index, blood sugar levels (A1c), blood pressure and cholesterol).

The PAM is designed to assess an individual’s knowledge, skill and confidence for self-management. It is a 13-item scale and people are asked to rate the degree to which they agree or disagree with each statement. An activation score and level based on their responses is then assigned. Level 1 is the lowest level of activation and Level 4 the highest. It is therefore the people who are at levels 1 and 2 who need the most support to change.

The PAM, which is being used nationally and has a strong and well established evidence base, may not be ideal but it has been agreed by a number of Somerset practitioners at a workshop held on 22 March 2016 to be the best measure currently available.

Included in this section are two PAM surveys. The first is a baseline PAM ideally completed by the person before their first personalised care and support planning consultation. It may need someone to help them understand this but they should not be guided or influenced in their responses by their practitioner. Once completed it should be handed to their practitioner or GP receptionist. Currently these completed PAMs are then sent to Beckie Cooke/Sue Brown at the South & West Clinical Support Unit, Mallard Court, Express Park, Bridgwater, TA6 4RN. If you want the results sent direct to you please include on the sheet your email address, otherwise the results will be sent to your practice manager. We are looking at an alternative more automated process which we hope to make available in the coming months.

The PAM should be completed again by the person in 9 – 12 months' time to see if the personalised care and support planning consultations and support provided have made a difference to their level of activation and self-management.

Whilst for many people the PAM is an appropriate measurement tool we do recognise for some the PAM may not be appropriate, for example for those at end of life or with cognitive impairment.

Other outcome measurement surveys can also be included in this section. For example:

- Warwick Edinburgh Wellbeing Scale
- De Jong Loneliness Scale
- Long Term Conditions (LTC) 6
Section 6 – Clinical Management Plans
This section is for the person to add in any medical documents they may have been given, for example specific treatment plans, escalation plan, clinical communications document and others.

Section 7 – About My Social And Community Care
If appropriate, this section is for people to add in any documents provided by Social Care practitioners, for example ‘Understanding You’ forms, support plans and assessments.

Section 8 - Test Results
This section is for filing test result documents the person has been sent or given.

Section 9 – Any Other Documents
This is used to hold any other additional documents, such as appointment cards, general advice and guidance, useful contact details.

Section 10 - Practitioners Who Are Supporting My Health And Wellbeing
It is important that this section is completed by the person so that all practitioners know who else is treating/supporting them and the practitioners can then if required contact each other to provide a more consistent and joined up service to the person.

Section 11 – Abbreviations Key
This is to help the person understand some of the terminology or words used.

What Happens To Completed ‘My Life Plans’?
People should keep their folder and update it as more information is obtained and things change. They should take it with them to every session with a practitioner. This will save them having to repeat their story and ensure everyone involved with their care and support understands their wishes and is well informed about them, so that they can best treat and support them.

Completed Sections 1 – 5 of the plan should be scanned or copied by the GP practice/practitioner so that records held can be updated. Some pieces of information can be added to the patient record using the EMISWeb input template. For example up to 3 goals (outcomes) patient door access keycode, practice care co-ordinator, carer. For further information on the EMISWeb input templates please email sarah.attree@somersetccg.nhs.uk.
The EMISWeb read code, ‘6AF’ – ‘Care Planning Active’ should be used by practices to denote that the person has started to complete My Life Plan and is having care and support planning consultations. This enables the practice to report on the number of people with a holistic, person centred care plan. Please note that the Avoiding Unplanned Admissions DES care plan template is not a holistic care plan and this code should not be used for these plans.

For people being seen by the Symphony Test and Learns the 8CMR code should be used instead of ‘6AF’.

**How to Order copies of My Life Plan**

To order the My Life Plan folders please email your requirements and delivery contact and address to sarah.attree@somersetccg.nhs.uk.

**Mini Version of My Life Plan**

In response to requests from practitioners, we now have an A5 mini version of My Life Plan for people who are reasonably well activated and have an understanding of their condition(s) and medications. It could also be used as a pre-appointment planner for the fuller version of My Life Plan.

We have printed copies of this mini version on card which can be ordered from sarah.attree@somersetccg.nhs.uk, and for local printing purposes you will find a copy of the template in the Somerset House of Care Resource Library on Somerset CCG’s website.

An electronic ‘easy read’ A4 version of the mini version of My Life Plan is also available in the Somerset House of Care Resource Library.

**Further Information**

If you have any queries and/or require further information please contact nicola.thorne@somersetccg.nhs.uk