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Personalised care and support planning guidance

Guidance for local maternity systems

Version 1, March 2021

Contents

1. Introduction

Central to Better Births is the principle that maternity care should be personalised and safe. Care should be centred on the woman, her baby and her family; based around her needs and decisions, where there has been genuine choice informed by unbiased information. This is essential to ensuring that women receive the best care possible.

Local maternity systems (LMSs) bring together maternity providers, commissioners, women using services and other stakeholders, who have a local plan to transform maternity care in line with the Better Births vision. They work towards a deliverable goal that all women will have a personalised care plan.

Chapter 1 of the NHS Long Term Plan makes personalised care business as usual across the health and care system. Local integrated care systems (ICSs) and sustainability and transformation partnerships (STPs) have an objective to implement personalised care and support plans (PCSPs) in maternity, long term conditions and end of life care. This gives the wider context to the maternity deliverable and provides further guidance on the NHS model of personalised care.

PCSPs are not an end in themselves, but a tool to support and document the conversations and decision-making processes which lead to the development of an agreed plan.

2. Universal personalised care

As described above, the Long Term Plan sets out an ambitious target for the implementation of the comprehensive model for personalised care across the health and care system.

Universal personalised care: Implementing the Comprehensive Model describes personalised care and support planning as: "People [having] proactive, personalised conversations which focus on what matters to them...and [pay] attention to their clinical needs as well as their wider health and wellbeing."[1]

[1] *Universal personalised care: Implementing the Comprehensive Model* (Jan 2019), p19: https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf

The strategic planning LTP technical definitions that provide guidance on the LTP metrics state that a plan can only be designated as a PCSP if it meets the five technical criteria outlined in the universal personalised care model:

1. People are central in developing and agreeing their PCSP, including deciding who is involved in the process.
2. People have proactive personalised conversations that focus on what matters to them, paying attention to their needs and wider health and wellbeing.
3. People agree the health and wellbeing outcomes they want to achieve in partnerships with the relevant professionals.
4. Each person has a sharable PCSP that records what matters to them, their outcomes and how they will be achieved.
5. People are able to formally and informally review their PCSP.

Information on how to apply the five technical criteria to maternity PCSPs is outlined in section 8.

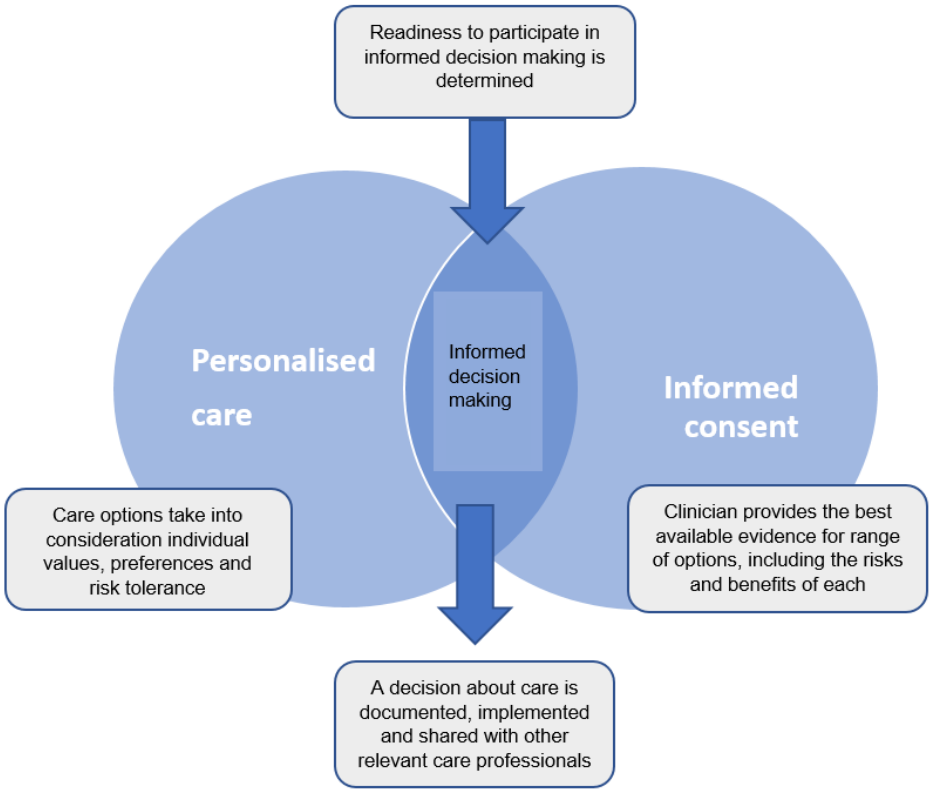
3. What is personalised care and support planning?

All women have a plan for their maternity care but personalised care and support planning goes much further. It is a series of facilitated conversations in which the person actively participates to explore the management of their health and well-being within the context of their whole life and family situation so that all considerations that may impact on safe care are accounted for.

Personalised care and support plans

The PCSP is developed following an initial holistic assessment of a woman's health and well-being needs. The woman works hand-in-hand with her healthcare professionals to complete this assessment. The agreed personalised care and support plan should set out the decisions she makes about the care and support she wants to receive, taking into account the information above.

Figure 1: Development of PCSP



The agreed plan will cover antenatal care, birth plan and postnatal care. It should be reviewed by the midwife and/or obstetrician with the woman at each contact.

The plan may be recorded in a paper record or app held by the woman. Over time, all trusts will have electronic patient health records which can be accessed by both the woman and her health care professionals.

- **Further information:** personalised care and support planning

4. Improving personalised care

Shared decision making in the NHS is a collaborative process and is the philosophy that underpins personalised care and support planning. It is a conversation that brings together:

- the clinician's expertise, such as treatment options, evidence, risks and benefits

- what the patient knows best: their preferences, personal circumstances, goals, values and beliefs.[2]

Based on stakeholder consultation, in line with Human Rights legislation and our commitment that the woman is the ultimate decision maker, in Maternity Services we refer to this as **informed decision making**.

Informed decision making means people are supported to:

- understand the care, management and support options available and the risks, benefits and consequences of those options
- make a decision about a preferred course of action, based on evidence-based, good quality, timely information and their personal preferences.

It is a process in which clinicians and individuals work together to select tests, management or interventions, based on evidence and the individual's informed preferences. This is most effective where there is continuity of carer.

The woman can change her decision at any point in her pathway and contingency plans should be agreed in case of changing circumstances.

Women will need evidence based information in advance of decision making so that they are well prepared. For example, women will need information about possible interventions in labour prior to birth.

Informed consent – Montgomery vs Lanarkshire Health Board

The decision of the Supreme Court in Montgomery vs Lanarkshire Health Board concluded that: when seeking consent to treatment, the question of whether the information given to a patient is adequate is judged from the perspective of a reasonable person in the patient's position.

Before Montgomery, a doctor's duty to warn patients of risks was based on whether they had acted in line with a responsible body of medical opinion (known as the Bolam test).

[2] https://www.england.nhs.uk/publication/shared-decision-making-summary-guide/

Instead, doctors must provide information about all **material** risks – that is, risks that might matter to the woman, and any reasonable alternative or variant treatments.

- **See also**: GMC guidance – *Consent: patients and doctors making decisions together*

5. What should LMSs do?

5.1 Understand your position

You will need a baseline to understand how you are currently undertaking personalised care and support planning, including women's experience and staff readiness. Personalised care depends on conversations between women and clinicians. Both the woman and the clinician need to be able to share all material information and to agree a plan based on this. The clinician should have the right skills and the right training to undertake this discussion including trauma-informed care training.

The baseline could be made up of:

- Collection and monitoring of maternity services data set (MSDS) data on PCSPs
- Auditing the quality of any PCSPs (a suggested audit tool can be found in Appendix 1)
- Collecting information on women's experience of care. As well as working with your maternity voices partnership (MVP), you could consider:
  - CQC annual maternity survey
  - Friends and Family Test
  - Monitoring of complaints and compliments
- Staff readiness to deliver PCSPs including drawing on the findings from culture surveys and training needs analysis
- The number of staff who have undertaken the personalised care components of the Core Competency Curriculum.

5.2 Work with your MVP

LMSs should work with MVPs from the outset in co-producing the PCSP process and paperwork, to ensure it will meet women's needs.

To understand whether personalised care and support planning has been successful, LMSs will need to know if local women feel their choices in pregnancy and birth have been heard and respected, and if they were offered sufficient information to plan their care.

Women's experiences of care across the maternity journey can be heard through use of:

- 15 Steps for Maternity
- Walk the Patch
- Voices events
- Surveys
- Community outreach
- Focus groups
- Social media
- Board safety champion walk-abouts.

LMSs should use a variety of methods to ensure that all women's voices can be heard. MVPs could also be involved in staff training and culture change work to ensure that the women's voice is central.

5.3 Get clinical engagement

All clinicians should understand that personalised care – grounded in a relationship of trust between the woman and her clinicians, and based on a robust and continued assessment of an individual's health and social circumstances, values and choices – is a vital prerequisite for safe care.

Women should be able to make choices at each stage of their pregnancy pathway informed by robust and comprehensive clinical information. Each woman should have a personalised understanding of the considerations that apply to her pregnancy with a risk assessment completed and recorded at each contact. Clinicians should know how they can access additional care pathways if needed following assessment.

Maternity safety champions are ideally placed to engage with professionals at a Trust level to ensure that processes are Montgomery compliant, ie that women have all of the material information they need in a timely fashion so that they can make truly informed decisions.

The new maternity advocate role is also likely to play a key part.

5.4 Training for clinicians

All health professionals should have access to training in personalised care, informed decision making, risk communication, and in choice conversations.

Generic training is currently available from the Personalised Care Institute and maternity specific training expected to be ready April 2021. A trauma-informed care e-learning module is also being developed by Health Education England (HEE).

All clinicians should understand the latest guidance on decision making and consent.

- Additional information is available in section 7.

5.5 Ensure equality and diversity

Personalised care has a positive impact on health inequalities, taking account of the wider context of people's lives, with people from lower socio-economic groups able to benefit the most from personalised care.[3]

LMSs should ensure that PCSPs are available to everyone:

- Can you identify who has a PCSP by:
  - ethnicity
  - age
  - complex social factors (NICE CG110)
- Are PCSPs and information to support decision making available in a range of languages and at a range of reading levels?
- Is information available graphically and pictorially as well as in words?
- Are hard copy alternatives available to those experiencing digital exclusion?
- Are staff trained to support cultural competence and recognition/understanding of unconscious bias?
- **Further information:** Cultural competency e-learning

5.6 Review your process

Using the audit tool in Appendix 1, assess your PCSP process and documentation against each of the criteria and determine whether they are compliant and where improvements could be made.

6. Our support offer

- **Maternity transformation programme hub:** On the maternity transformation hub, you will find a range of resources including films, case studies and example PCSPs.

[3] https://www.england.nhs.uk/personalisedcare/upc/comprehensive-model/

- **NHS personalised care:** There are a range of resources and information on personalised care available on the NHS England website.
- **Personalised Care Institute:** The Personalised Care Institute provides free, flexible, accredited e-learning with a core curriculum covering areas such as capabilities to engage people, using different models and approaches and shared decision making.

7. Further resources

- Personalised care: Universal Model
- NHS Long Term Plan implementation guidance
- Making every contact count (HEE resource)
- Birth choices information for women:
  - First time mums
  - Multigravida women
- Winton Centre for Risk Communication: Resources for health professionals
- Transforming perinatal safety
- Maternity self-assessment tool
- LMS resource pack
- Continuity of carer guidance
- National Maternity Voices
- A good practice guide to support implementation of trauma-informed care in the perinatal period
- Cultural competency e-learning
- Information from BSUH trust on gender inclusion
- Easy read guides to screening.

8. The technical criteria for PCSPs

As noted previously, the NHS Long Term Plan technical definitions state that a PCSP can only be defined as such if it meets five technical counting criteria.

However, the MSDS v2.0 does not ask provider organisations to report on the five criteria, only the number of women with a PCSP as a [YES/NO] descriptor.

To support development of PCSPs, each of the technical criteria has been reviewed. A series of statements, developed by a range of maternity stakeholders, has been included to describe best practice when developing a maternity PCSP.

8.1 What does this mean in maternity?

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

In maternity services this means:

- The woman's choices for her individual circumstances are discussed and recorded in the PCSP. This is likely to include:
  - her values and expectations about being pregnant, giving birth and becoming a mother
  - her home/family/professional life and support networks
  - how/if she would like a support partner to be involved
  - her previous experiences of pregnancy and childbirth
  - any fears or concerns she might have.
- The plan should reflect the woman's decisions about location of care, particularly where to give birth and methods of pain management to be used during labour. The plan should reflect ongoing review and continuous risk assessment at all antenatal contacts. It should record a plan B, ie what happens if a complication arises at any point, including during birth.
- The woman has ownership and is the active lead in developing her PCSP to the extent that she wants to be. She will agree who is involved in her care – this should include choice of maternity provider.
- The woman has access to evidence based information, and advice that is clear, unbiased, timely and meets her individual information needs and preferences – including language requirements – eg information on tests and screening, place of birth, pain relief options.

B. People have proactive personalised conversations which focus on what matters to them, paying attention to their needs and wider health and wellbeing

In maternity services this means:

- The woman is listened to and understood in a way that builds trust and an effective relationship with her midwifery/obstetric/multidisciplinary team – this is best established through continuity of carer.
- Decision making tools are used in the conversation where appropriate and decisions around the woman's and baby's needs and care are documented and reviewed.
- The clinician should have the right skills and the right training to undertake this discussion including trauma-informed care and unconscious bias training.
- The conversation should take account of new information as it arises such as the result of screening and diagnostic tests.
- LMSs should pay attention to the judgement in the case of Montgomery versus Lanarkshire, in relation to enabling women to make informed choices, informed by robust and comprehensive clinical advice that clearly states all the material risks associated with each choice. Each woman should have a personalised understanding of the risks that apply to her pregnancy and be able to make decisions about her plan B. This must include ongoing review as part of continuous risk assessment.
- The trust should have a policy in place for to support women requesting care which is outside of routine guidelines.
- Conversations should work to the four principles of trauma informed care:
    1. Compassion and recognition.
    2. Communication and collaboration.
    3. Consistency and continuity.
    4. Recognising diversity and facilitating recovery.

C. People agree the health and wellbeing outcomes they want to achieve in partnerships with the relevant professionals

In maternity services this means:

- The individual physical and mental health condition of the woman and her baby is assessed, including any pre-existing needs or chronic conditions, results of screening and diagnostic tests, and her experience of this and previous pregnancies, this is essential for safety. An agreed support plan is identified reflecting the woman's decisions.
- This may include specialist support from maternal medicine networks where appropriate for women with long term conditions.
- Using the principals of Making every contact count, the woman is provided with personalised information on the impact of health practices on her pregnancy and wellbeing in order to support informed decisions and choices. This would include consideration of smoking, alcohol and diet and what support she might want with these, taking into account her circumstances.
- There is an ongoing conversation with her care giver to determine the experiences and outcomes that matter to her most in the context of her whole life and pregnancy.
- Particular consideration should be offered to women with complex social needs, as per NICE guidelines CG110.
- If a woman is under the care of a specialist mental health team, it is important that advanced decisions about her care are discussed and documented, in case of loss of capacity.
- This is a process that begins with the first antenatal appointment – or pre-conceptually where possible – and continues into the postnatal period. The process needs to recognise that different women will want different levels of support and be ready to make decisions at different times, and many women will begin to make choices before they first meet a clinician.

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

In maternity services this means:

- The PCSP includes a record of the woman's informed choices, what matters to them and all the elements that would make the plan achievable and effective.
- Best practice is for it to be based on free text; a checklist approach can restrict thinking, although checklists can be helpful as a reminder of the questions to consider whilst the plan is being drawn up.
- The woman holds her own plan or has easy access to a shared digital plan which she can review at any point.
- The hospital care record should also record any information shared and any decisions agreed; until e-patient held records are in place to allow sharing of plans.

E. People are able to formally and informally review their PCSP

In maternity services this means:

- The PCSP is formally reviewed at every contact and any changes are captured and documented.
- The PCSP covers all three elements of a woman's pregnancy journey: antenatal, birth and postnatal.
- The PCSP is held by the woman or is in a shared format that is accessible at any time so that she can review and make changes to it between appointments.

9. Summary

Personalised care improves women's experience of care and health outcomes by:

- empowering women to take control of their health to the extent that they want to
- enabling clinicians to understand each woman's physical and mental health needs – including underlying conditions – and also her past experience of pregnancy and birth, plus her wider social situation that will impact on her current maternity journey, and additional support she might require and the decisions she is willing to make
- building a relationship of trust between the woman and health professional.

This guidance identifies criteria to define personalised care planning and sets out what LMS need to do to ensure personalised care planning is embedded into service delivery.

The accompanying audit tool (below) should be used annually so that LMSs and regional maternity boards can be assured on the quality of personalised care planning.

Appendix 1: Audit tool

Maternity personalised care and support planning: audit tool

- Effective maternity personalised care and support planning is about having a different kind of conversation based on a robust and continued assessment of an individual's holistic health needs and – through building a trusting relationship – an understanding of her values, choices and wider family circumstances. This leads to an integrated plan that is owned by the individual and accessible to care givers supporting the woman.
- Providers should use MSDS to record the number of women with PCSPs in place, but will need to audit these to ensure that they meet the quality criteria for a PCSP.
- This audit tool will help LMSs work with maternity provider organisations to assess the quality of personalised care and support planning, highlighting areas of strength and areas where improvements can be made.
- The tool is structured according to the five technical criteria and the supporting maternity statements featured in the PCSP guidance.

Using the audit tool

- It is recommended that LMSs audit their PCSPs annually to determine whether they meet the five technical criteria, and identify where personal care and support planning can be improved.
- Good practice is for the audit to be carried out with the local MVP, while recognising the constraints of patient confidentiality and volunteer time.
- LMSs should also carry out a survey of local women's experience of personalised care to validate the results (a validated tool is in development).

- As PCSPs may be held by the woman, they may not be available for audit. In the tool below, the text in blue refers to the PCSP paperwork or digital solution being used and whether this can enable the right information to be shared. This will be the same for all women with a PCSP in the trust/LMS.

  The text in **black** refers to evidence in a woman's care record that personalised care and support planning has taken place.

Audit tool

Technical criterion A People are central in developing and agreeing their personalised care and support plan including deciding who is involved in the process	RAG	Evidence for RAG rating	Action required
The PCSP paperwork or app allows the woman to indicate her informed choices and how she wishes to be supported to achieve these.			
Care records document the information shared to meet individual needs and the woman's informed choice. eg Pain relief options leaflet shared, feeding options discussed, Wellbeing check carried out, signposted to web-based information on birth places May also include information on referral/consultation with specialist, eg obstetric physician, perinatal psychiatrist			

Technical criterion B People have proactive, personalised conversations which focus on what matters to them, paying attention to their needs and wider health & wellbeing	RAG	Evidence for RAG Rating	Action Required
The PCSP paperwork or app can document an ongoing dialogue/ relationship between the woman and a named care giver for the length of the plan			
The PCSP paperwork or app can document how the woman will be supported with her choices			
Care records document that decision making tools have been used where appropriate to enable the woman's preferences, eg paper or online leaflets, guidance, pathways, decision trees			

Technical criterion C People agree the health and wellbeing outcomes they want to achieve, in partnership with the relevant professionals	RAG	Evidence for RAG Rating	Action Required
The PCSP paperwork or app can document the individual physical and mental health condition of the woman and her baby, including any pre-existing needs or chronic conditions, results of screening and diagnostic tests, and her experience of this and previous pregnancies. An agreed support plan is identified reflecting the woman's decisions			
The PCSP paperwork or app can document any identified health practices and what support the woman would like with this – taking into account her circumstances. This includes smoking, diet and alcohol			
Care record documents that there has been a joint discussion on the impacts of any physical or mental health conditions identified through on-going risk assessment together with an agreed support plan based on the woman's choices in relation to these, including any specialist referral.			
Care record documents that there has been a joint discussion on the impacts of any identified health practices and evidence of support planning where complexities were identified.			

Technical criterion D Each person has a sharable personalised care and support plan which records what matters to them, their outcomes and how they will be achieved – in a digital format where possible.	RAG	Evidence for RAG Rating	Action Required
The PCSP paperwork or app can document the woman's choices and key decisions and how these will be supported			
The PCSP paperwork or app is in a format that the woman is likely to understand, eg available in a range of languages/formats			
The PCSP paperwork or app is owned by the woman and sharable with health professionals			

Technical criterion E People have the opportunity to formally and informally review their care plan.	RAG	Evidence for RAG Rating	Action Required
The PCSP or app must cover all three elements of the maternity pathway (antenatal, birth, postnatal) and the woman should be able to discuss these when she is ready to do so as well as reviewing later			
There is evidence in **care records** that plans are reviewed by or with the woman at every appointment.			
MSDS data shows that there is a personalised care and support plan in place covering all three elements of the maternity journey			

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This publication can be made available in a number of other formats on request.

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