

Chapter 9

Health coaching and care and support planning

This chapter is written for commissioners, organisations and individuals who want to understand care and support planning and how it relates to health coaching. It describes:

- **What is meant by care and support planning**
- **Evidence of its effectiveness and policy context**
- **The five steps to care and support planning**
- **Its relationship with health coaching**

What is care and support planning?

Care and support planning is a structured and formal process which enables people to identify what is important to them, what they can do to live well and manage their own health and what support they need from both formal and informal services.

The process results in a plan detailing the person's goals and how they will be supported to achieve them. If appropriate, the plan will also detail how the person's personal budget will be spent. The plan is reviewed on an annual basis to reflect on what is working and not working, and make changes.

Care and support planning brings together contributions from family, friends, community, statutory health and social care services, and the voluntary sector around the person and their outcomes and goals. It is proactive rather than reactive and determines how services will be designed and organised around the person.

Is it central to government policy?

Person-centred care and support planning has been a central component of government policy for social care for many years, firstly for people with learning disabilities¹, and more recently as a core aspect of the personalisation policy².

At a glance

Care and support planning is a five-step process that enables people with care and support needs to identify what is important to them, what they can do to live well and manage their own health and what support they need from both formal and informal services. The process results in a plan detailing the person's outcomes and how a person will be supported by others.

Key facts

- There is a legal duty to provide plans as set out in the Care Act⁴
- The process improves physical and psychological health⁷
- Including people in the process leads to best outcomes⁹

"If care and support planning like this had been in place earlier, I would have more control from the beginning... and everything would have been a lot easier"

Alex, cancer survivor

Useful resources

Support Planning Tool¹⁰
Think Local Act Personal Care

In 2014, The Care Act³ made it a legal duty for local authorities to provide a care and support plan that reflects what is important to the person and their aspirations. The act also stressed that plans should be integrated across health and social care. More recently NHS England's Five Year Forward View⁴ recognises care and support planning as the key to achieving a new partnership between health services and people and communities and it is a fundamental ingredient of its New Care Model Vanguard and Integrated Personal Commissioning (IPC) 'demonstrator' programmes.

“By April 2015 everyone with long-term conditions, including people with mental health problems, will be offered a personalised care plan that reflects their preferences and agreed decisions.”

The NHS mandate⁵

What is the evidence for care and support planning?

The Cochrane systematic review⁶ brings together the evidence base for care and support planning. It states that:

“Personalised care planning leads to improvements in certain indicators of physical and psychological health status, and people's capability to self-manage their condition when compared to usual care. The effects are not large, but they appear greater when the intervention is more comprehensive, more intensive, and better integrated into routine care.”

The Year of Care programme⁸ demonstrated that person-centred approaches not only benefit the

individual, but can also lead to improvements for care professionals and commissioners.

More than 80% of over 4,000 people surveyed reported that a personal budget had made things better or a lot better when it came to dignity in support and quality of life. The study also showed that when people were included in the process of planning their support e.g. through care and support planning, they were twice as likely to report good outcomes⁹.

What is the process for care and support planning?

A proactive five-step approach has been developed that provides a bridge between the two traditions of planning in health and social care¹⁰ (Figure 14).

1. Preparation

Both practitioner (sometimes called ‘partner’ or ‘supporter’) and the person (‘patient’) need to be prepared by sharing information beforehand and allowing time for reflection. This means:

- a) **Preparation for the process** – making sure that the person knows what care and support planning is, why it is important and what will happen when. This step involves ensuring that the person is at the centre of decision-making, and that all information is accessible to them.
- b) **Preparation by the person** – the person is supported to think about what matters to them, what is working and not working, and their aspirations for the future. The support may be ‘prompt sheets’, through a telephone call, videos and guides, or someone supporting them to reflect and answer these questions. Here the person sets their priorities for the conversation.
- c) **Preparation by the practitioner** – the practitioner ensures that any relevant tests or assessments are completed (including indicative allocations for a budget if necessary) and that this information is shared with the person before the conversation.

2. The Conversation

The conversation starts with what matters to the person, what is working and not working for them, and where they want to be in the future – therefore setting their agenda, and moving towards the outcomes that the person wants to achieve. Together the person and practitioner:

- **Agree what is important to the person and what outcomes they want to achieve**
- **Look at the information**
- **Consider what support is available locally**
- **Explore the available resources, including personal budgets where applicable**
- **Work out what support the person needs and what they need to do themselves – this includes support from traditional/formal services, and community-based/informal supports and support for self-management**
- **Discuss any risks e.g. of not having or not having a certain treatment**
- **Work out the actions needed to put those supports in place**
- **Agree how to review progress**

3. Record

The Care Act requires that there is one plan. The record - the written element of care and support planning - needs to provide the information that the person wants, the information that practitioner needs, and inform commissioning through aggregated data¹¹.

4. Making it happen

The actions that are agreed to meet the outcomes may be ones that the person simply does themselves, or with help from family, friends or a circle of support. People may use their personal budget to employ personal assistants, use traditional and/or specialist health or social care services, universal services or community resources that are available

like Timebanking. Timebanks are community groups where members earn time credits for helping each other out or giving practical help, which can then be spent on getting help when the person needs it¹². Universal services are the places (libraries, parks, community centres), services (swimming lessons, health services), groups (sports clubs, church groups) and businesses (shops, cafes, hairdressers) that are available to everyone in the community.

5. Person-centred review

The conversation that happens at review is as important as the initial conversation. Here the person will review what has worked and not worked, or what they have tried and learned. This may result in new aspirations, outcomes and actions. The process is not finished here, but is ongoing - with action, planning and review on a continuous loop.

Health coaching and shared decision making

Health coaching and care and support planning are entirely complementary and both key to delivering person-centred care. The care and support planning 'conversation' will be very similar to a health coaching conversation. Both conversations:

- **Aim to empower people to take control of their lives and conditions**
- **Require a mindset in which people and practitioners are both seen as experts**
- **Enable shared goals or priorities to be set**
- **Can be powerful catalysts for self-management**
- **Require good communication skills and an empathetic relationship between the professional and the person they are supporting**

Health coaching mindset, skills and techniques (chapter 2) can be used in the conversation at key stages of care and support planning stages two and five (Figure 14).

The main difference is that health coaching is particularly focused on the interpersonal dynamic between the practitioners and the person they are

supporting, and uses communication techniques, principally to achieve behaviour change. Care and support planning on the other hand also involves a conversation where a clinician's and person's expertise are equally valued, although ultimately its purpose is the co-creation of an annual plan.

Figure 14. The five stages of care and support planning

