Care planning definitions

Plan	Definition
Care plan	A care plan is a plan which sets out practical and medical solutions to address a persons clinical needs
Personalised Care and Support Plan	A personalised care and support plan is where the what matters to me and a persons outcomes (goals) are recorded, with the key features outlined in **https://www.england.nhs.uk/ourwork/patient-participation/patient-centred/planning/).** It is an essential tool to integrate the person's experience of all the services they access so they have one joined-up plan that covers their health and wellbeing needs.
Comprehensive Geriatric Assessment (CGA)	A multidimensional holistic assessment of an older person considers health and wellbeing and leads to the formulation of a plan to address issues which are of concern to the older person (and their family and carers when relevant). Interventions are then arranged in support of the plan. Progress is reviewed and the original plan reassessed at appropriate intervals with the interventions reconsidered accordingly **(British Geriatrics Society 2018)**
Personalised care and support planning	Personalised Care and Support Planning is a series of facilitated conversations in which the person, or those who know them well, actively participates to explore the management of their health and well-being within the context of their whole life and family situation. This process recognises the person's skills and strengths, as well as their experiences and the things that matter the most to them. It addresses the things that aren't working in the person's life and identifies outcomes and actions to resolve these. Personalised Care and Support Planning is key for people receiving health and social care services.
Anticipatory care planning	Anticipatory care planning (ACP) helps you make informed choices about how and where you want to be treated and supported in the future. It requires health and care practitioners to work with people and their carers to ensure the right thing is done at the right time by the right person to achieve the best outcome. ACP puts people at the centre of the decision-making process about their health and care needs. By encouraging people to have conversations about what matters to them ACP can help: • manage change in an organised way • prevent crisis • reduce future stress • promote quality of life Included in the NHS Long Term plan 2019 under the PCN DES and enhanced health in care homes (EHCH) agenda
Advance care planning	Advance care planning is a voluntary process of discussion and review to help an individual who has capacity to anticipate how their condition may affect them in the future and, if they wish, set on record: choices about their care and treatment and/or an advance decision to refuse a treatment in specific circumstances, so that these can be referred to by those responsible for their care or treatment (whether professional staff or family carers) in the event that they lose capacity to decide once their illness progresses. (https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/ACP_Booklet_2014.pdf). In addition to this it complements Treatment Escalation Plans and DNRCPR.

Care plan high level comparison

Plan	Sub sections	Trigger	Aligned to	Settings contributing								Components									
				The individual	Primary care	Community	Secondary care	Care Homes	Social care	Housing	Voluntary sector	Physical assessment	Functional Assessment	Social	Environmental	Spiritual	Psychological	Mental Health	What Matters to Me (including DNACPR, POA, financial matters, capacity, best interests	Agreed wellbeing outcomes	Personalised problem list and plan
Personalised care and support planning	**Comprehensive Geriatric Assessment (CGA – frailty triggered)**	Clinician dependent and/or CFS >7	British Geriatrics Society	x	x	x	x	x	x			x	x	x	x	x	x	x	x		x
	Personalised care and support plan	Life events requiring intervention from health and care	NHSE	x	x	x	x	x	x	x	x			x	x	x	x	x	x	x	x
	Anticipatory Care Planning	Individuals with complex needs (older people, housebound living alone, mental health, social support need, families carers under stress). Includes treatment escalation and refusal of treatment (not yet at crisis)	PCN DES EHCH/ Anticipatory Care deliverable	x	x	x	x	x				x	x	x	x	x	x	x	x		x
	Advance care planning	Planning for EOL and/or preferred place of care/death including identification of support required to deliver preferences	NICE	x	x	x	x	x	x	x	x	x	x			x	x	x	x		x

Work in progress, early comparisons 5/11/2021