Health Action Planning Policy

‘Health action planning needs to be person centred in both process and outcomes. It should keep the person at the centre, reflecting what is important to them, now and in the future and minimise health barriers to achieving life goals.’ (Action for Health – health action plans and health facilitation, department of Health (2002))

1. What is a Health Action Plan

A Health Action Plan is a personal support plan, which details what a service user or those who support them can do to maintain or manage any existing health concerns and stay healthy. It should:

- List any support or help others need to know to help service users to stay healthily and / or maintain health.
- Help to make sure that service users get the services and supports they need to stay healthy.

2. A good Health Action Plan should be all of the following:

Person centred in both process and outcome, it should keep the person at the centre.

- To be developed with the service user (where possible) and those people closest to them and know them well.
- Take account of a service users concern and/or those closest to them know.
- Be unique to the person
- Recognise what is important to a person and clearly details what good support looks like for the person.
- Encourages a person to be as independent as possible
- Individual lifestyles, cultural and health issues must be taken into account when developing and reviewing a health action plan.
- Support the Valuing People values of Rights, Independence, Choice and Inclusion.
- Where appropriate involved Primary Care, and other ordinary health service staff.
- Service users should know what is in their plan, what part they play and are an
active participant in maintaining it or making it happen.

- The plan is ‘live’ with a focus on action, not just on the plan. The plan must include an initial planning date and a date for review. The plan should continuously be evolving, as with any person centred plan.

- The plan should clearly state how the person wants / needs to be supported around specific health related issues. Person centred tools can be used to do this for example – ‘How to support me on a good day / how to support me on a bad day…. / using a one page profile for a specific purpose – for example – supporting me to take my medication

- Is in a format meaningful for the person – easy read, pictorial, DVD.

- Is evidence based e.g., National Service Framework / NICE guidance.

- A plan fits in with other assessments and planning processes so that things are clear, not confused or duplicated.

NB: It is important to remember to balance ‘what is important for a person’ with ‘what support is needed to help keep a person healthy and safe’. They must work hand in hand.

Where people cannot make decisions on their own consideration must be made to The Mental Capacity Act 2005 and mental capacity assessments and best interest decision making agreements must be completed following the core principles of the Mental Capacity Act (See Mental Capacity Policy)

3. Developing A Health Action Plan

There is no set format for developing a Health Action Plan, it must be unique to the individual and reflect their needs. See appendix 1 for guidance on areas that should be considered when developing a health action plan

4. The Two Types of Health Action Plan

4.1 Enhanced Health Action Plan (sometimes referred to a Level 1 Health Action Plan)

Enhanced Health Action plans are based primarily on complexity of a health not numbers of health issues.

The following areas are considerations for an Enhanced Health Action Plan:- Where there are significant health risks/needs.

- Where health conditions are unstable.
- Where immediate action is needed during deteriorating health condition.
- Where there is a degenerative condition needing regular review.
- During life threatening illness

The completion of an Enhanced Health Action plan should (where possible) involve other
multidisciplinary team member’s players i.e. learning disability nurse other specialist nurse from local Primary Care Services.

NB: Local referrals, protocols or procedures for local involvement may have to be followed/submitted.

4.2 Standard Health Action Plan (sometimes referred to a Level 2 Health Action Plan)
People who know the service user will help draw Standards Health Action Plans together. This could be a support staff, family, friend or advocate. This person is often referred to as the Health Facilitator.

4.3 End of Life Planning
There are different processes for end of life planning which provide additional information to support someone well at the end of their life. These include what is important to the person, what makes a good day / bad day, how to support someone well, how would I like to be remembered. Support teams are advised to access local services for support around end of life planning.

5. Temporary Health Action Plans
Temporary Health Action Plans should be formulated to cover acute hospital care or other episodes of acute illness. They can be formulated with the help and support of other professional involved in the support and care of individuals and should contribute to better communication for hospital admissions and discharge planning processes.

Each service user will have been supported to complete an admission into hospital document. This will follow local protocol, for example east Lancashire use Hospital Passports and these are recognised by all local hospitals. A copy must be kept in house and also on the electronic records under reports.

Action Plan: A temporary Health Action Plan will be formulated by the Team Manager.

6. Health Facilitation
A health facilitator should be someone who the service users likes and feels comfortable with and preferably be someone who cares about them and who is committed to supporting the person to make things happen for them.

A health facilitator should be familiar with the principals of Person Centred Planning, they should have at least attended a Personalisation Workshop.

7. Role of Health Facilitator
A facilitator is responsible for ensuring that:

- Identify and record health targets
- Supports access to health services.
- Ensure Health Action Plan is part of a Person Centred Plan.
- Identify and meet health education needs.

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• Monitor health outcomes.

A good one to one health facilitator:

• Is known and trusted by the person.
• Puts the person at the centre of the plan and is a good listener.
• Works closely with the individual and those who love and support them.
• Knows a lot about the individual’s health needs, wishes and rights.
• Knows how to access local health services, dentists, opticians etc.
• Is a good communicator; and
• Knows how to format a plan to make it useful for the individual.


8. Action Planning Process

8.1 It is the Team Manager’s responsibility to ensure that health action plans are in place and kept up to date as part of a Person Centred Planning process.

However, all staff have a responsibility to ensure they are aware and understand their role in achieving identified actions and maintaining the appropriate records, including electronic records, refer to Maintenance of Individual Records Policy

Operational Network Managers will monitor and ensure compliance.

8.2 Health action planning discussion must always form part of a person centred review meeting/review usually under the section called “What support and help (the person) needs to stay healthy and safe.”. Information from discussions must be added/form part of the service users person centred plan.

Health Action Plan documentation: In order for Future Directions CIC to monitor planning meetings, progress on actions and achievement of outcomes, Team Managers will be required to complete a monthly governance spreadsheet with the dates of last reviews/checks. Documents must be uploaded to an individual’s record file (electronic or paper based dependant on contract) and actions updated at least once a month. However, all service users must be offered their own copy in a format that is meaningful to them, for example, easy read, pictorial, DVD.

Enhanced Health Action Plans – Local service paperwork/action plans, will be used. If a service user’s chooses they must have their own copy in a format meaningful to them.

NB: Where other planning styles are used (i.e. ELP, Path, Map, Personal Futures Plan etc.) a health action plan will need to be developed to work in conjunction with the planning method used.

8.3 Action plans, where appropriate should be in consultation with service user’s (where possible) and dependant on the complexity of health issues involve other individual particularly focusing on:
• Health Issues which are important to the service user?
• Health issues that are linked with the learning disability?
• What support and care is needed to manage or maintain existing ill health?
• What support or care is needed to prevent ill health developing: including tests or investigation, education and/or life styles changes?

The challenge is to look at health through the eyes of the service user as well as through the perceptions of the disability system and find a balance that works for both.

NB: If large-scale life style changes are required they should be prioritised not to overload the person or their support team. Priorities must be agreed with the service users and other professional in the person’s life i.e. GP, Dietician, Practice or Learning Disability Nurse etc.

8.4 An action plan must be devised and agreed upon using SMART objectives.

Specific – specify what wants to be achieved. Be clear so that people know what is expected from the action.

Measurable – you should be able to measure if you are achieving the action.

Achievable – is the action achievable and attainable?

Realistic - is the action do-able?

Time – specify a time by which the action will be achieved.

Equal emphasis must be placed on implementation of the plan as to its formulation.

9. Reviews

Health Action Plans should be reviewed fully annually with a six month update review or more frequently if service users need change.

10. Confidentiality

10.1 Sensitive Information
Where the service user is sensitive about an issue that needs to be widely known, i.e. seizure disorder not fully controlled by medication, sexual wishes etc people at the meeting must work out with the service user the most respectful way of sharing the information. This should be with the permission of the service user, wherever possible.

Where a service user is not able to communicate their wishes verbally a best interest decision must be taken i.e. if going to the dentist do they need to know about a person’s sexual health the answer is no.

10.2 Storage
Where a service user lives in shared accommodation and they choose to keep their own health record consideration needs to be given to the safe storage of the document. A copy must be stored in the individuals record file (paper based or on electronic
11. **Training**

All staff will attend a Personalisation Awareness Workshop either through Future Directions CIC or accessed through local services.

Team Managers will ensure that everyone is familiar with the operation of this Procedure.

12. **Audit**

This procedure and its operation will be subject to random and systems monitoring process as determined by the Future Directions CIC Governance Calendar and requirements of Commissioners.

Information from the audits will be shared with Future Directions CIC Directors, Care Quality Commission and Commissioners of the service.

13. **Useful Websites and Resources**

The ‘do once and Share’ (doAS) project for health action planning describes the components of a health action plan. It also takes readers through an integrated care pathway to support people with learning disabilities and family carers to make decisions about their health.

- [www.easyinfo.org.uk](http://www.easyinfo.org.uk) – accessible information for various health related issues
- [www.clearthoughts.info/](http://www.clearthoughts.info/)
- [http://valuingpeople.gov.uk](http://valuingpeople.gov.uk)
- [www.helensandersonassociates.co.uk](http://www.helensandersonassociates.co.uk)
- [www.pcp4me.net](http://www.pcp4me.net) – can download hospital passports used in East Lancashire
- [www.gov.uk](http://www.gov.uk) – easy read information and guidance about Health Action Planning
- [www.pmldnetwork.org](http://www.pmldnetwork.org) – example health action plan from Mencap
- [www.nhsdirect.uk](http://www.nhsdirect.uk)
- [www.nice.org.uk](http://www.nice.org.uk)
- [www.nhs.uk/nhsegland/NSF](http://www.nhs.uk/nhsegland/NSF)
14. References


Actions for Health – Health Action Planning and Health Facilitation, Department of Health 2002

Accessible Service Users Personal Record – Hyndburn & Ribble Valley PCT

Action for Health – Health Action Plans and Health Facilitation, Department of Health (2002)

Health Action Planning and Health Facilitation for People with Learning Disabilities – Good Practice Guide (2009)

Raising Our Sights: Services for Adults with Profound Intellectual and Multiple Disabilities – Report by Jim Mansell (March 2010)
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Appendix A

- Records of any screening / annual health checks
- Details of health interventions – for example flu vaccination
- Fitness and mobility (manual handling considerations)
- Oral and dental
- Eyes and vision
- Hearing and ear care
- Podiatry
- Personal hygiene
- Continence care – bowel movements / fluids / continence aids
- Skin care / protection / tissue viability / pressure care
- Diet and nutrition
- Weight management (under and over)
- Communication
- Pain Management (how people display pain and how to support – DISDAT) – recommendation from Raising Our Sights: services for adults with Profound intellectual and multiple disabilities
- General health and well being
- Medication taken and side effects (self administration)
- Keeping me safe
- Emotional needs
- Mental health and wellbeing
- Behavioural needs
- Relationships
- Allergies
- Sexual Health
- Epilepsy (refer to policy)
- Diabetes
- Autism (refer to policy)
- Dementia
- Sleep
- Over 60’s
- Lifestyle considerations – smoking, drugs, alcohol
- Specific syndromes – for example down Syndrome, Williams Syndrome
- Ethnicity
- Family history (a separate record must also be stored on the electronic records)

NB: This list is not endless and must be adapted for each individual person.