Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

OKAY TO STAY PLAN INFORMATION FOR PRACTICES

Background Information

The Okay to Stay plan has been developed by a partnership across Sheffield's health, social care, and voluntary sectors, with strong patient engagement and representation.
It was conceptualised by community nursing with the aims of;

1. **Helping patients with long term conditions manage acute exacerbations of their long term conditions at home,**
2. **Avoiding unnecessary hospital stays**
3. **Facilitating successful discharge from hospital after admission, at the earliest opportunity.**

The OK to Stay plan captures important information about what matters to a patient, for example how they manage day to day, and who helps them when they need help (e.g. friends, neighbours, carers, medical and social care staff). The plan contains information about their own unique "normal" values e.g. blood pressure, oxygen saturations. Ok to Stay plans encourage the development of a holistic action plan to help in the event of the person becoming more unwell. The plans encourage an enabling and self-help approach, and aim to increase confidence for patients and carers to manage their own conditions and access expert help at the appropriate time.
Other medically relevant sections are included e.g. past medical history, medications, allergies, and DNACPR information.

A completed plan is printed and given to the patient to share as they wish. It can also be accessed by the GP collaborative and SPA (single point of access) to support decision making around admissions/ care in the patients home.

The OK to Stay plan is available on SystmOne. It can be found using the search function (bottom left of the screen) and it is linked to the Person Centred Care Planning Locally Commissioned Scheme (PCCP LCS) template on SystmOne; work is currently under development to incorporate OK to Stay onto EMIS.

<u>Application and Use of Okay to Stay Plan</u>

The OK to Stay plan is likely to be most appropriate for people who are very frail, nearing the later stages of their lives, often housebound. The plans have been usefully employed for many patients on the Virtual Ward pilot.
Completion of The Okay to Stay plan should be the outcome of a person centred approach and the decision to complete an OK To Stay Plan will have been made with the individual, carers and family. Plans should be completed collaboratively, and typically will be started by community nurses/ matrons or GPs with input from appropriate people involved with the person's care e.g. wider community nursing teams, community support workers, therapists, GPs and other staff who work within the social prescribing arena including voluntary and third sector. (As part of the Virtual Ward Pilot, Age UK in Sheffield has been supporting the staff to complete plans).

People with an Ok To Stay Plan are still required to have their long- term condition reviews to ensure that they are receiving good quality care, just as they would if they were to attend the practice.

Ok to Stay plans should be reviewed every 3 months with the person.

The Ok to Stay plan does not replace, but can complement the Person Centred Care Locally Commissioned Scheme, which is aimed at developing a systematic person centred approach to the management of all long term conditions.

Recommendations

- To take a test and learn approach which will enable the OK to Stay Plan to be used in primary care, with **those people identified as being at high risk of admission**
- Practitioners to be aware of Ok to Stay plans and, for a **particular cohort of people** (very frail, nearing the later stages of their lives, often housebound) to consider initiating them as a tool to capture the conversations and important information shared during person centred care planning.

For Practices signed up to the PCCP LCS and using a Virtual Ward approach:

- OK To Stay plans **can be used** as an outcome of the Person Centred Care Planning
- As part of the PCCP LCS Practices will be able to include a proportion of OK to Stay Plans as part of the LCS monitoring. **For example**: if the practice cohort is identified as people with newly diagnosed diabetes, then the proportion of OK to Stay Plans included may be small; if the identified cohort is housebound people then their proportion of OK to Stay Plans could be higher

For Practices signed up to the PCCP LCS and are NOT involved in a Virtual Ward:

- Practices **will not be expected** to include OK to Stay plans as part of the PCCP LCS monitoring, but using the plan is an option to aid delivery of holistic care.

For Practices not signed up to the PCCP LCS but are part of a Virtual Ward:

- Use of OK to Stay plans are an option but **will not attract reimbursement** under the contractual arrangements of the PCCP LCS

Evaluation, Governance and Monitoring

OK to Stay is being evaluated with Huddersfield University and as part of the Virtual Ward pilot. Monitoring will be through the CCG Person Centred Care Planning Evaluation and Learning Group. Measurements may include:

- Rationale for choosing Ok to Stay Plan
- Review schedule and outcome
- Numbers of plans completed
- Individuals completing the plans
- Impact on hospital admissions

Governance is through the Active Support and Recovery programme.

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