

# Stepping forward

Commissioning principles for collaborative  
care and support planning



# Contents

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For more details please see [www.rcgp.org.uk/care-planning](http://www.rcgp.org.uk/care-planning)

<b>Forewords</b>	<b>5</b>	<b>Building blocks for delivery</b>	<b>15</b>
<b>Aims of this guidance</b>	<b>7</b>	1. Actively lead the culture shift	16
What is Collaborative Care and Support planning?	7	2. Take the long view	18
Why is CC&SP important?	8	3. Engage people with lived experience, and their carers, in service design	19
<b>Core Principles of CC&amp;SP</b>	<b>9</b>	4. Facilitate a bottom-up approach to change	20
1. Plan around the person not the disease(s)	10	5. Train the workforce	20
2. CC&SP is the core delivery model	10	6. Invest in IT	22
3. CC&SP requires a whole system approach	12	7. Identify participants	24
4. Encourage a flexible approach to evidence-based guidelines	13	8. Incentivise person centred outcomes	28
5. Implement effective integration of services	13	9. Promote multidisciplinary team working	29
6. Reinforce primary care as a person-centred system with general practice at its core	14	10. Actively work with the third sector and health and social care	31
		11. Contract at scale	32
		12. Nurture and develop communities	32
		13. Harness the assets of general practice and the community	33
		14. Use your learning for quality improvement	33
		15. Support research to find out what works best	35
		<b>Summary</b>	<b>37</b>
		<b>References</b>	<b>38</b>

# Forewords

On Boxing Day 1999, Mum had a stroke right in front of my eyes. She lost her speech and was paralysed on her right side. Being 21 at the time, I had no idea how much our lives would change.



**LIFE AS A YOUNG ADULT CARER**  
 Wasn't easy. I had to navigate the system and found that professionals made decisions without involving us. Our personal lives and cultural needs were not being considered. Things became easier when I started questioning these decisions because our personal lives and cultural needs were not being considered.

Mum is an insulin-dependent diabetic and I was trained to administer her injections. Nobody asked if I wanted this and I thought I could not say 'no'. This had a huge impact on my social life: I couldn't go out with friends as I had to be back at the same time each day to give Mum her injections. This was not working for our family so I decided to speak up.

I built a relationship with the diabetes specialist. We changed my mother's support plan so it would fit into both our lives. The community nurse gave injections so I could

have more freedom; we designed a diet that included Caribbean food; and discussed what insulin was best. From this point on, Mum was the driver of the plan and I was her facilitator and voice.

Being involved in shaping Mum's care and support plan has meant we can have a mother and daughter relationship again. We are independent from one another and we have more choice and control. We feel empowered to work in partnership with professionals so we can meet our needs and aspirations.

We no longer rely on the system and are able to make our own decisions.

People who use health and care services should be empowered to co-create their own care and support plans. People are experts in their own life and conditions, and have more time to investigate innovative ways of meeting their health and care

needs; we can take pressure off the professionals. Co-production is a fantastic way to work but it does take time to build trust and relationships. However, if that time is put in right from get go it means the individual will rely less on the system and take control of their own plan. I believe in this model so much that I've set up a care and support planning non-profit, Peer Partnerships CIC<sup>1</sup>. Person-centred care and support planning works for me. As a carer my view counts; that's essential for me to do my caring role and live my own life.

**Keymn Whervin**  
 Carer, Director of Peer Partnerships, and National Co-production Advisory Group member



**THERE IS NOW A GENERAL** consensus amongst policy makers, professional bodies, health charities and NHS managers that safe and effective care can only be achieved when patients are ‘present, powerful and involved’<sup>2</sup> at all stages. However, collaborative care and support planning (CC&SP) is still not the norm in NHS clinical practice.

The findings of patient surveys have been consistent in reporting that we (the clinicians, the managers and the patients) are not delivering person-centred care, nor is it being implemented “at scale” in any meaningful way. In a recent survey<sup>3</sup>, for example, only 3.2% of patients with long-term conditions (LTCs) report involvement in developing their own care and support plan. The gap between the rhetoric and the reality remains uncomfortably wide.

This guide from the RCGP addresses that gap and provides principles and building blocks for commissioning CC&SP for people with long-term conditions. One of the keys to delivering person-centred care is a whole-system approach with the involvement of commissioners. The House of Care framework, which is illustrated in the following guide, has been used to successfully improve the care of people with diabetes in Tower Hamlets and can guide the necessary system change to implement CC&SP within the local health economy.

If patients and carers are to become fully engaged and informed in care and support planning processes, it is essential that clinicians, managers, services and systems *invite, enable and support* an active role for patients. ‘Changing the conversation’ between clinicians and their patients

requires no less than a fundamental shift in culture and practice. Kate Granger<sup>4</sup> has transformed the consultation with her request that all clinicians begin their consultations with “*Hello, my name is...*”

Just imagine a world in which patients addressed their clinicians with “*Hello, my plan is...*”

**Professor Nigel Mathers**  
Co-Chair of the Coalition  
for Collaborative Care,  
Honorary Secretary RCGP



# Aims of this guidance

This guidance is designed to support commissioners and general practitioners to implement Collaborative Care and Support Planning (CC&SP) in their locality. We explain what collaborative care and support planning is and why it is so important that we introduce this approach for people with single or multiple Long Term Conditions (LTCs). We then give guidance on how to commission this approach.

**CCGS HAVE BEEN GIVEN** the opportunity to take on new powers through co-commissioning. Those with ‘joint’ commissioning responsibilities will share the duty of commissioning primary care services with NHS England, through a joint committee. CCGs with ‘fully delegated’ powers will go a step further to commission the majority of primary care services themselves, under the supervision of NHS England. This guidance can be applied within a range of commissioning arrangements, but is likely to be most suited to CCGs (and equivalent in the devolved countries) with joint or fully-delegated commissioning powers. We aim to show how commissioners can use these new powers to improve quality and outcomes for people with single or multiple long-term conditions.

Recognising that there is no ‘one size fits all’ approach, we seek to provide non-prescriptive recommendations, upon which CCGs and local authorities can embed CC&SP as the core component of their models of care for people with LTCs. We provide some principles and pragmatic building blocks for delivery, illustrating these with case studies from CCGs around the country.

This guidance builds upon the thinking of the 2011 RCGP report ‘Care Planning: Improving the Lives of People with Long term Conditions’<sup>5</sup> and the RCGP ‘Inquiry into patient centred care’<sup>6</sup>. We set out a vision where primary care teams are given the time and space to take a population-based view, and work proactively to improve outcomes and reduce health inequalities for their patients.

We envisage all health care professionals becoming enthusiastic about working in partnership with people and their carers, and with other organisations and the wider community. This would ensure an integrated way of working and to achieve truly personalised, proactive, person-centred care.

## What is Collaborative Care and Support planning?

Collaborative Care and Support Planning (CC&SP) is a process designed to enable people with LTCs, and their carers to work in partnership with health and social care professionals, to design their care shaped by their own assets, goals and priorities. The process encompasses key steps (preparation, conversation, recording,

making it happen and review) focussing on improving the doctor-patient consultation by making it more clearly a partnership. People are given information and time to prepare in advance of the conversation, where they are empowered to discuss their preferences with a professional, and co-create their care plan to achieve their goals.

We can separate the activities of general practice into three key streams:

- Urgent access
- Routine care
- Population-based, proactive care

CC&SP sits in the latter and, as a proactive model of care, is an excellent tool for prevention and reducing health inequalities.

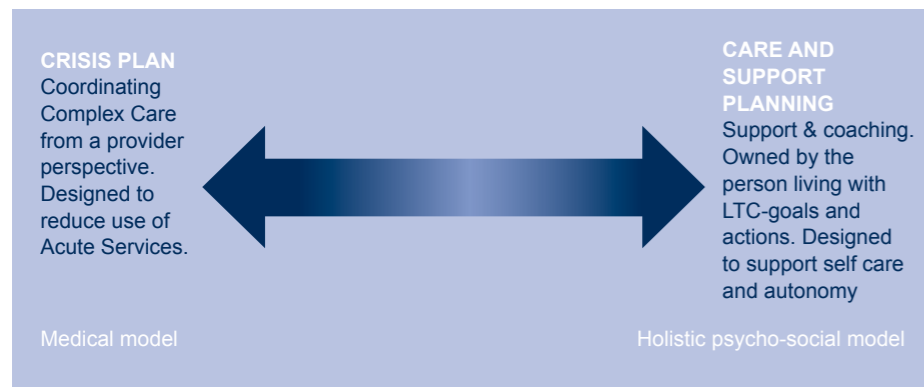
**Why is CC&SP important?**

The 'Five Year Forward View'<sup>7</sup> sets out a clear vision for the future of the NHS. Recognising the increasing burden of single and multiple long-term conditions, the 'FYFV' describes the need for improved prevention and proactive models of care. The report states that we should give people 'greater control of their own care' and 'break down the barriers to how care is provided'. CC&SP offers a solution to these calls – it puts

patients in the driving seat of their care and wraps services around the person. Implementing CC&SP takes additional time and resources but the benefits for patients, carers and professionals far outweigh the costs. CC&SP can increase patient activation, health literacy and self-management<sup>8</sup>. Professionals report greater job satisfaction and improved patient outcomes, and commissioners can find better continuity of care and greater use of voluntary and community services. Ultimately, however, we should just do CC&SP because it is the right thing to do for the patient and the GP.

# Core Principles of CC&SP

Figure 1: Medical vs. holistic model



“ I think we should do collaborative care and support planning because it's a good thing in its own right to share decisions explicitly with patients, and to be person-centred. *Professor Chris Salisbury, University of Bristol* ”

Our core principles express how proactive, personalised care planning would look at the highest level. Commissioners can use these ‘core principles’ to guide their strategic aims for CC&SP within their local context. The CC&SP process should lead to improved outcomes. These outcomes will be person-centred and measurable e.g. quality of life, health literacy, patient activation. Commissioners must set expectations, and then use their powers to create ‘space’ and ‘time’ for providers to deliver these outcomes.

**1. PLAN AROUND THE PERSON NOT THE DISEASE(S)**

The 2012 National Voices ‘I Statements’<sup>9</sup> express how successful person-centred integration of services looks for a person living with one or more LTCs.

The ‘I Statements’ show that people with LTCs want to be empowered and have all the information they need. They want to experience continuity of care and communication across the system, and be supported to develop the confidence to share decision-making and self-manage where appropriate. This is particularly challenging for the large number of people living with multi-morbidities and mental health conditions, who need to benefit from a single, co-ordinated, person-centred care plan that encompasses all their needs. The Care Act<sup>10</sup> requires an integrated approach – one planning process across a person’s whole needs, not separate ones for health and social care. The process needs to be designed in partnership

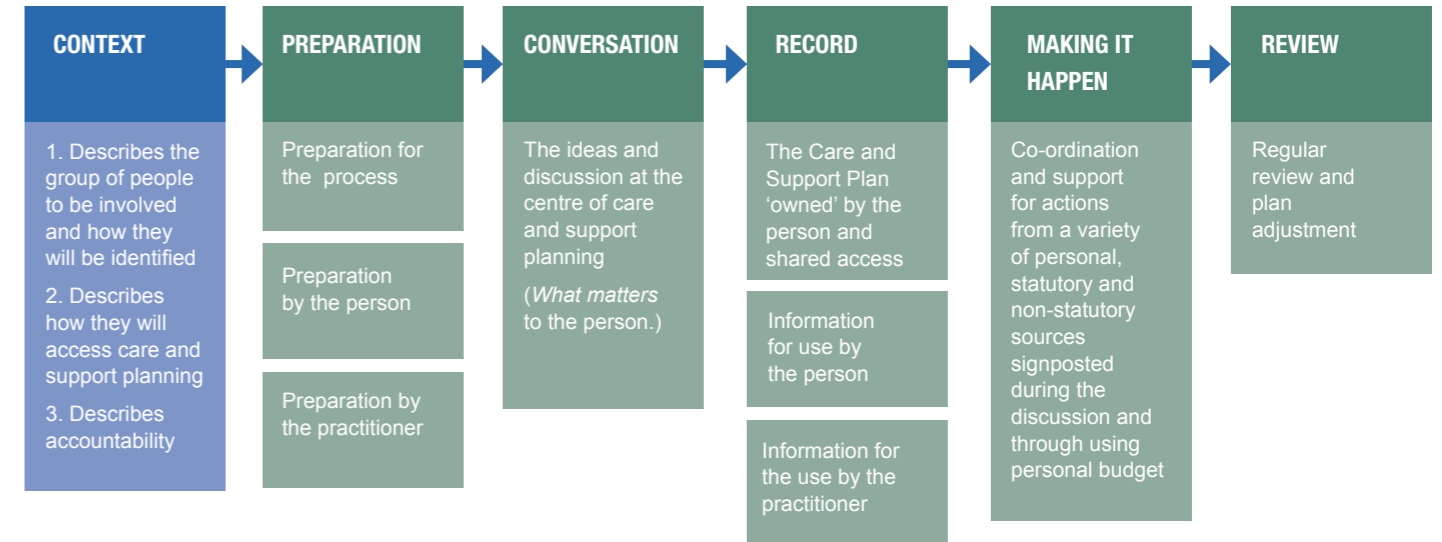
with people and organisations, and work towards the goals and outcomes that they want to achieve, rather than assumptions about their needs. Commissioners and practice teams need to routinely ask whether available services and wider sources of support are aligned with the preferences that patients and carers identify.

**2. CC&SP IS THE CORE DELIVERY MODEL**

Many organisations are considering how to introduce self-management tools, shared-decision making and other person-centred approaches into practice. It is useful to think of CC&SP as the umbrella process, in which all of these tools and techniques can be undertaken as needed by the individual.

“ I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me. ”

Figure 2: CC&SP model



The approach to CC&SP needs to be flexible around the individual’s goals and the practice’s resources. TLAP, in association with Helen Sanderson Associates and Year of Care Partnerships, have built on the existing models to provide a comprehensive six-stage process.<sup>11</sup>

**Preparation**

Includes organising processes of care, performing assessments, providing

feedback to the patient and ensuring the individual and their families/carers have sufficient information, support and time to prepare for the discussion.

**Conversation / Discussion**

The care planning meeting allows for a longer conversation (usually 20 – 40 minutes) where the individual’s goals and psycho-social need are given equal prominence to their bio-medical needs. The conversation

should be with the most appropriate person, who may not be a health professional. Many models exist with people producing their plan with support from family and peers, health coaches and ‘health navigators’ allied to the practice. If a health professional is the most appropriate person this might be the GP, but it could equally be the practice nurse, a social care professional or other allied health professionals. The

conversation covers what people can do themselves to live well and maintain their independence, and what support might be needed to help them achieve their goals. The most important thing is that the conversation is tailored to be appropriate for the person.

The discussion also needs to provide an opportunity to consider an individual's future needs. This could include preferences for end-of-life care or advanced care planning if they were to become unable to make decisions for themselves. It could also include contingency planning in case of deterioration in their health and wellbeing.



Rather than starting each appointment with 'How can I help you?' I now start all my appointments by asking 'What would you like to talk about?.'

*Dr Katie Coleman*



### Recording / Documentation

The care plan is written up, owned by the person and included in their records. Relevant documents are shared with team members to enable coordination of care around patients' preferences and goals.

### Making it happen

This stage is about coordinating and supporting the actions agreed in the conversation. It may include ongoing support such as booking appointments, managing medicines and, if appropriate, the finances and processes around obtaining a personal budget.

### Review

The frequency of reviews reflects the patient's needs and wishes. The care plan is reviewed both in terms of success and records actions against goals, and the individual's changing needs.

### 3. CC&SP REQUIRES A WHOLE SYSTEM APPROACH

Successful delivery of CC&SP requires a whole-system approach, as illustrated by the House of Care model<sup>12</sup> (right). The model places holistic, person-centred care at its heart. The conversation is key and the other elements of the house are there to support it. All the elements are needed to make CC&SP a reality. Without engaged patients there will be no demand. Without organisational processes such as call and recall, the practice can't deliver. If professionals do not commit to partnership working there can't be the necessary continuity of care. We need to commission the right services to be responsive to the needs and preferences of the local population.

If CCGs are serious about implementing CC&SP they must commit to organisational change across the entire system.

Figure 3: House of Care



### 4. ENCOURAGE A FLEXIBLE APPROACH TO EVIDENCE-BASED GUIDELINES

Current models tend to follow disease-specific guidelines formed from a biomedical evidence base. These guidelines have real value and should not be lost, but need to be incorporated into a new way

of working around the individual and their priorities and needs.

Building upon Dr David Sackett's original definition of Evidence Based Practice<sup>13</sup>, we emphasise the importance of 'Patient Values & Preferences' in shaping decisions about treatment. With the increasing

complexity of conditions and co-morbidities (particularly in later life); mental health issues and functional problems may outweigh biomedical issues for patients. This is a consideration that needs to be built into shared decision-making frameworks. It can be argued that the Quality Outcomes Framework (QOF) has led to an increasingly target-driven culture. By considering alternative models we can put the focus back on people rather than numbers. It is essential to create mechanisms for discussion across professional groups – for example, with multidisciplinary teams – especially where decisions about reducing or stopping treatment are being made.

### 5. IMPLEMENT EFFECTIVE INTEGRATION OF SERVICES

We need to move towards a whole-system, integrated model for delivery of care. Providers need to work together to ensure seamless, joined-up delivery of services that are organised around the patient and their carers. The delivery of person-centred care depends on us breaking down the



current disease- and organisation-based, working silos and opening up the system to better communication. Patients and their carers should only have to tell their story once.

We need to actively coordinate specialist services around the individual's personal care plan

rather than burdening them with numerous disease-based pathways. True integration should lead to increased efficiency and a better experience for patients.

Personal Health Budgets and similar new approaches, mean that individuals who may have felt

that current care models were not meeting their needs, can move away from traditional routes of provision to funding more innovative models of care around their preferences.

#### 6. REINFORCE PRIMARY CARE AS A PERSON-CENTRED SYSTEM WITH GENERAL PRACTICE AT ITS CORE

We need to work with secondary care to move some specialist services into the community. General practice spans mental, physical and social health; holds the patient registers; has an on-going relationship with people and their carers; is firmly rooted in the community and is able to offer continuity of care. It is therefore in a unique position to offer people a personalised service. General practice acts as the gateway to other services, and can bring together people, communities, health and social care, and align their objectives around the patient.

## Building blocks for delivery



**Our building blocks identify the key changes and processes that need to be put in place to enable the implementation of CC&SP. How these building blocks fit in context, will be unique to each CCG, but our recommendations should act as a useful starting point.**

### 1. ACTIVELY LEAD THE CULTURE SHIFT

Leadership and championing needs to be present at all levels. Practices should identify a 'person-centred care lead' (this does not have to be a clinician, though clinician "buy-in" is essential to successful implementation) to drive the culture shift on the ground, ensure that outcomes are measured, processes adhered to, and act as the practice representative at the cluster and CCG levels. Commissioners need to provide resources for leadership.

Strategic leadership is needed at the CCG level to provide oversight and guidance.

Thames Valley Strategic Clinical Network accredit much of the success of their care and support planning programme to leadership and mobilisation at all levels:

**A**DOPTION OF CC&SP HAS BEEN driven in different ways in CCGs within Thames Valley Strategic Clinical Network (SCN). In Chiltern early adopters engaged trainers and championed the approach through word of mouth, whilst in Ayelsbury Vale, the CCG incentivised adoption. What we have learned is that whatever the approach, it is crucial that people have somewhere to go to express their interest, and that enthusiasm is captured and actively propelled forward.

One of the keys to the success of the programme has been the expert hub of champions that work across Thames Valley. These champions have provided leadership at strategic and grassroots levels, making the case for change and promoting the adoption of care and support planning across the network.

Activities have included:

- Presenting to all Thames Valley CCG Clinical Chairs and Accountable Officers, setting out the compelling case for person-centred care through the adoption of CC&SP. This resulted in all CCGs endorsing this approach. CC&SP now features in all CCG plans within LTC care or in specific new models of care i.e. diabetes.
- Sitting on programme and steering groups, providing expert input on strategy and plans for the adoption and sustainability of CC&SP.
- A number of clinical champions are trainers; they contribute to the CC&SP training courses and provide follow-up mentoring to support implementation. They also run local CC&SP taster sessions. The impact of local clinicians who are working in this way and can relate directly to GPs and practice nurses is immeasurable.

- Champions cover clinical, managerial and education expertise; providing comprehensive support to CCGs and practices.
- Reflecting the range of expertise and networking at local, regional and national levels, champions are now also actively contributing to the promotion of CC&SP beyond the Thames Valley area.

Our approach at the SCN has been designed so that rather than telling practices or CCGs what to do, we support them to adopt this new way of working themselves. By providing expert contribution and resources; constructive criticism; and supporting and facilitating; we encourage adoption from the bottom-up, which will deliver a change with long-term sustainability.

#### KEY LEARNING POINTS:

1. Champions can provide expertise and strategic support.
2. As advocates with first-hand experience, champions garner buy-in at all levels.
3. A bottom-up approach is key to sustainability.

## 2. TAKE THE LONG VIEW

Introducing CC&SP requires organisational changes and a culture shift that will take some time to be effective. Furthermore, commissioners will need to consider CC&SP in the context of increasing numbers of people with personal health budgets or integrated personal budgets. To allow time for the necessary quality improvement processes, co-production and partnership building, commissioners need to plan around a longer-term strategy. In addition, improvements in biomedical indicators and wider health outcomes may take longer than a year to be demonstrable. We recommend producing a three to five year CC&SP commissioning strategy with annual operational cycles working within this.



## 3. ENGAGE PEOPLE WITH LIVED EXPERIENCE, AND THEIR CARERS, IN SERVICE DESIGN

Care and support planning should be done “with” not “to” people with LTCs. It is crucial to recognise that people with experience of living with LTCs, and their carers, are the experts in their care. Commissioners need to ensure that they help recognise and release the assets that individuals can bring to both service design and indeed delivery. People with lived experience need to be engaged from the outset at both the practice and the CCG level. Patients and carers provide a strong narrative as to why change is needed; and they can give invaluable support to commissioners when conducting the needs assessment, identifying gaps in services. Outcomes must be co-produced with patients so that they are designed to improve person-centred outcomes and give a clear view of what we are trying to achieve.

Islington CCG are employing value-based commissioning through a lead provider model to deliver CC&SP to diabetes patients in their Diabetes Integrated Practice Units (IPU). Commissioners in Islington recognise that patient perspectives are crucial when taking a value-based approach.

Historically, care has been organised and paid for around volume of services delivered, rather than value. Value-based health care is about developing a shared common purpose to achieve the best possible outcomes for patients per pound spent. Developing a shared common goal unites the interests of all – patients, commissioners, and providers – in support of a sustainable and high quality health care system. Value is defined from the perspective of the patient, and depends on results or outcomes that matter to them, rather than inputs or volume of services delivered.

The project is focused around the development of two sets of outcomes – one based around clinical indicators and the other entirely based on

outcomes that are meaningful to patients themselves. The project has been a collaborative effort from the very start which began with a full day workshop where a large set of patient-centred outcomes were devised.

These were then refined during the course of several smaller scale workshops and patients were involved in all subsequent service design meetings. An extra set of patient-only groups were later convened before the IPU was signed off, in order to get a wider service user opinion.

A lead provider model for VBC was eventually agreed and patients have also been included as members of the procurement group, contributing to the final decision on appointment of the lead provider.

### KEY LEARNING POINTS:

1. Define value from the patient perspective.
2. Involve patients and carers in service design from the outset.

#### 4. FACILITATE A “BOTTOM UP” APPROACH TO CHANGE

CCGs need to work with practices and the wider community to co-produce their CC&SP strategy, working with those on the front line to understand barriers and needs, and design the services together. Co-production should be actively commissioned, with payments for backfill built into the budget to create the time and space for co-production across the organisation. Commissioning strategies need to be built from the bottom up, investing in integrated teams wrapped around practices, which feed into cluster teams. Clusters of practices need to work with the third sector and social care. Organisations should recognise the importance of social support structures in the community and engage with community and voluntary sectors as strategic partners. All tiers need to be actively included in co-production of CC&SP strategy.

Whilst this needs to be a grassroots movement, it is important to recognise the crucial role that CCGs have in creating the space and incentives for innovation. Strategic leadership from CCGs can help to facilitate the change by providing ideas, tools, training and support that practices can draw on.

#### 5. TRAIN THE WORKFORCE

Workforce development for CC&SP, including training, is a strategic commissioning responsibility. Commissioners must ensure that sufficient training is available before practices embark on implementing CC&SP to avoid false starts. Training is needed for all practice team members, not just GPs. Practice managers and reception staff, for instance, will need to understand the care planning process and the administrative processes needed to make it happen. Health care assistants will need to be trained to administer tests and deliver support in understanding results, and practice nurses will need training in health coaching etc. as they are likely to be the ones conducting the discussion

for many patients. Good quality training will result in an upskilled workforce, from receptionists to clinicians and is key to the sustainable delivery of CC&SP. Representatives from the CCG also need to attend training to ensure understanding at the CCG level. There are a range of training providers operating in the UK with courses ranging from ‘taster sessions’ to ‘train the trainer’. There are a number of other skills that professionals can be trained in, which would be hugely beneficial, for example motivational interviewing or understanding patient activation. We strongly recommend that training is designed with sustainability in mind: commissioners need to budget for on-going trainer and refresher courses. It will take time and investment to develop the skills necessary for successful care planning. One way of ensuring sustainability is to invest in developing skills in people and communities – staff move on but people are more likely to stay; peer support and community development can bring valuable added capacity into the process.

NHS Sheffield CCG are running their second Locally Commissioned Service (LCS) for care and support planning. Taking the learning from their first scheme, they are building training in as a core feature of the programme:

**I**N SHEFFIELD’S FIRST CARE AND support planning LCS, there was no central training programme. However, the evaluation of the first scheme expressed a clear need for more training, so for the second LCS part of the core budget was dedicated to this. Training was built into the LCS specification: participating practices were required to send a minimum of a GP, a practice nurse and a member of the administration team to a half-day session organised by the CCG. Training was also open to the community nursing service.

Training gave an overview of, and a rationale for, the scheme; the use of the Patient Activation Measure<sup>14</sup> and the principles of conducting care and support planning, together with interactive role play. The majority of the training was done by a commissioned organisation who had a wealth of experience in the Patient Activation Measure and could speak from the patient point of view. To motivate attendees, the CCG lead clinician presented on his experience of the benefits of care planning and using the Patient Activation Measure. In addition, each practice was asked to have at least one member of staff undertake the PAM e-learning module.

It gave breadth and depth to understanding, to have training delivered by both local people, (with local experience), and people with national knowledge as well as patients themselves. There were, however, challenges in training staff with very different backgrounds and attitudes to person-centred care. Different approaches were needed to support groups who were less convinced about the benefits, to those who were committed to this way of working and wished to learn more. It proved really beneficial to include practice managers and administrative staff so the whole practice would understand what was required. At points training was tailored to the specifics of each person’s role.

To support staff to improve the conversation between the professional and the patient, the Community Nursing Service runs training in Motivational Interviewing. Recognising the importance

of this, the CCG will now be funding this training for practice staff and community support workers.

Sustainability was a priority for the LCS. Therefore, a key feature of our ongoing support after initial training was the development of a Locality Support Team (LST). This is a collection of champions consisting of GPs, practice and community nurses, practice managers, primary care development nurses and community support workers. They have been given additional training, and are paid to offer tailored support and coaching to individual practices depending on their needs. The LST also meets regularly to share best practice and support each other. The CCG hosts information and supporting documents about person-centred care on a dedicated section of its website. This is regularly updated and maintained so that resources are consistently available to practice staff.

#### KEY LEARNING POINTS:

1. Train staff to have better conversations with patients and carers.
2. A network of champions can offer an ongoing training model.
3. Train the whole practice team, not just the GP.



## 6. INVEST IN IT

Investing in the right data and information infrastructure is fundamental to the success of CC&SP. Where possible IT should be an investment priority. A well-designed IT system can operate on a number of levels and allow for inter-organisational data-sharing. At a minimum, systems need to give a population view at the borough level to allow for population planning; at the unitary level for clinical and non-clinical records; and at the patient level for front-ended, patient-facing records.

IT systems need to be procured to actively support the strategy and implementation plan for CC&SP. IT must support integrated working throughout the system, allowing (with informed consent) data to be shared between primary and secondary care.

Stockport, an NHS Vanguard site, has developed a Multi-speciality Community Provider (MCP) model, with objectives to manage people holistically, in the community, within the context of their own goals. The MCP is supported by a transformational technology change.

**S**tockport's innovative technological changes have three key goals:

- **Connect** – Joining technical infrastructure, enabling practitioners and staff to work across any health and social care location. Connecting data and intelligence to move from a reactive to a preventative model of care delivery.
- **Integrate** – Joining records to deliver information to the point of care for safer care. Implementing joint frameworks for data sharing.
- **Empower** – Focusing on delivering consistent digital platforms across services to enable people, to take more control of their own health and care needs.

An Integrated Digital Care Record is already in place, delivering GP, community and palliative care records to over 2000 practitioners at the point of care across the borough. The team is building on this to deliver an even richer data set to a wider group of practitioners. A consolidation of care systems across the borough will provide opportunities for more detailed information sharing, less duplication and the ability to underpin workflow on a wider footprint than previously possible.

Work is underway to connect the local authority to the Stockport Community of Interest Network, which will see them join Primary Care and Stockport Foundation Trust. There will be a joint Wi-Fi network in place across health and local authority in Stockport. This will provide the platform for the much more flexible approach to working locations, estates planning and enable dynamic multi-disciplinary team working that is fundamental to the MCP.

Stockport Foundation Trust will federate in 15/16 with the secure NHS Mail platform joining community, primary care, pharmacy and optometry in the borough, enabling secure electronic communications. Work is also underway to connect health and social care email systems in Stockport. There is growing use of a single GP system across the area including adoption within GP out-of-hours provider, A&E and admissions units.

Stockport is building on patient online to provide access to full, detailed online records for people with long term conditions. Eventually they will join health and local authority schemes to provide the public with a coordinated offer of online and 'app' access to information and services. With support from public and patient groups, Stockport have developed and launched the 'Stockport Health & Care Finder' smartphone app. The app helps to direct the public to the right local services, offers self-care advice, friends and family testing, and provides a method of 'push notifying' the wider public with key communications to their phone. Over 1,000 users have so far downloaded the app.

### KEY LEARNING POINTS:

1. Integration across services and teams is possible.
2. IT can support the flexibility needed to wrap services around the person.

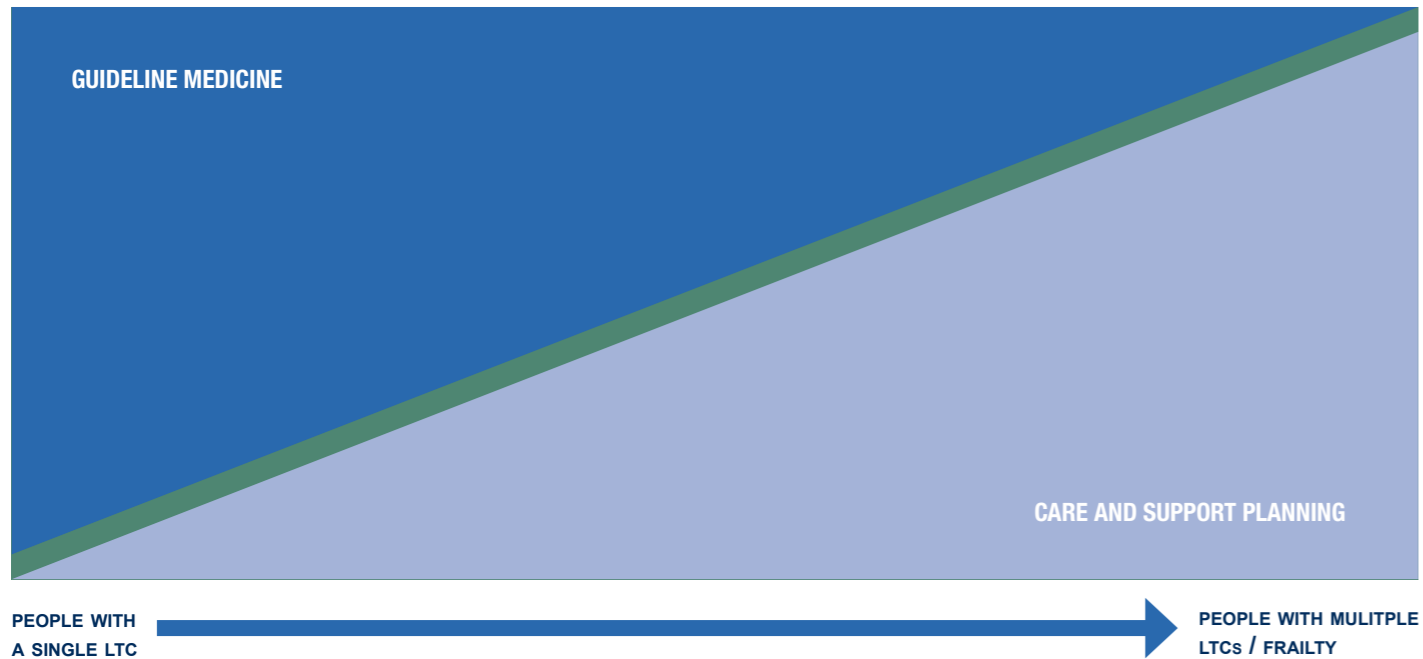
**7. IDENTIFY PARTICIPANTS**

There is no 'silver bullet' for identifying which patients would benefit most from CC&SP. Commissioners and delivery partners need to work together to

agree a systematic methodology for identifying people for CC&SP, that works for their context. Generally speaking, it can be useful to think of the number of long term conditions

a patient has, as an indicator for the level of CC&SP they will need.

**Figure 4:** Guideline medicine vs. care and support planning. Adapted from John Young's Frailty Model<sup>15</sup>



There are a number of theoretical approaches to identifying patients to offer care and support planning. Table 1 shows the risks and benefits of each.

**Table 1:** Methods for identifying patients

Approach	Benefits	Risks
Top-down risk stratification	Takes a whole population view	The top 2% with highest risk of admission may not be the best suited to CC&SP model.
Segment into cohorts (e.g. frailty index, disease specific)	Allows incremental up-scale, is a natural starting point	Risks excluding people with high risk that are not in the cohort.
Organic identification by practices	GPs know their population better than anyone	Does not take a whole-population view meaning health inequalities are a risk.
Identify and work with patients with <i>higher</i> levels of activation	Provides opportunity to gather evidence of benefits early on to encourage work later with the less activated.	Delay in working with less activated patients, who may benefit as much, or more, from the process.
Identify and work with patients with <i>lower</i> levels of activation	People who are already more 'active' in relation to their health and wellbeing (who understand the care process and have the knowledge, skills and confidence to take on that role) are more likely to choose preventative health behaviours. Working with the less 'active' could reduce health inequalities.	Risks can exclude people with high risk who are not in the cohort.

It may be that a combination of these approaches would work best. It is crucial that clinical judgement and clinical perspectives (validation) be built into whichever approach is adopted. In short, we need to empower front-line workers to start in the most sensible place for their particular context. Finally, whatever method is used, careful consideration should be given to the impact on health inequalities. Ensure that the process of piloting and delivering CC&SP serves to tackle, rather than exacerbate, health inequalities.

To make the system truly person-centred, patients need to be informed that collaborative care and support planning is available and be educated about the benefits it can offer. Significant effort is needed to ensure patients are informed and engaged so they may opt in or out as they wish.



Barking, Havering and Redbridge Early Implementer Site (EIS), as part of the NHS Improving Quality LTC Year of Care commissioning programme, worked with other early implementers to test different methods for selecting individuals who were likely to benefit from personalised, integrated care.

The main three methods tested were 'frequent flier' (high historical use of A&E services), risk score (risk of emergency admission to hospital) and multi-morbidity (individuals with more than one long-term condition). The multi-morbidity method was based on research by the Scottish Multi-morbidity Research Programme<sup>16</sup>.

Comparison of the selection methods showed that they result in different individuals being identified, and the methods vary in the stability of the patient groups selected from one year to the next. This evidence led BHR to use the multi-morbidity selection method for their integrated care pilot.

In the pilot, the multi-morbidity selection method was rigorously applied. Only individuals with 5 or more long-term conditions were selected – four or more conditions from the Scottish Multi-morbidity list (coronary heart disease, hypertension, heart failure, stroke/TIA, diabetes, COPD, depression or dementia) and at least one from the list of national QOF clinical indicators.

During the pilot, strict application of the patient selection methods highlighted some anomalies. In particular, that a strict top-down approach fails to take account of the professional judgement of health and social care staff and finance managers,

and the wishes of patients. It did not always identify the individuals who were most likely to benefit from personalised integrated care.

Learning from BHR and the other Early Implementer Sites has resulted in some recommendations from the LTC Year of Care commissioning programme: A top-down approach can be used for the selection of the majority of individuals who might benefit from personalised integrated care. However, there should be flexibility in the selection of individuals such that:

1. Care professionals should be able to refer a limited number of individuals for assessment (where the patient's care needs are assessed and a care and support plan is developed) even if these individuals do not meet the strict selection criteria.
2. The assessment process should also include a joint decision by the care professional and the patient as to whether the patient would benefit from, and wants, personalised integrated care.
3. If payment will occur from a dedicated capitated budget, then the professional and a finance manager should make an additional decision about the suitability of paying for the care plan package from within that capitated budget.

#### KEY LEARNING POINTS:

1. Top down stratification can be useful but clinical judgement is key to ensuring vulnerable people don't fall through the net.
2. There is a human behind the algorithm, their preferences may change their service pathway.

## 8. INCENTIVISE PERSON CENTRED OUTCOMES

Current reward programmes such as Quality Outcomes Framework (QOF) or Locally Enhanced Service (LES), provide a useful framework for incentivising quality in management of chronic disease, prevention and improved access. It may be that 'joint' or 'fully delegated' commissioners can use these models as a starting point for incentivising CC&SP. However, measuring person-centred outcomes needs to move beyond a tick box exercise. We are at the early stages of understanding the best way that person-centred care can be measured<sup>17</sup> and how it can best be incentivised. One advantage to commissioning CC&SP is that CCGs can identify personal goals and 'patient-desired outcomes'. If this information is recorded and aggregated it can inform the commissioning of traditional services and non-traditional sources of support ('more than medicine') to support patients' goals. In other words if you commission CC&SP it will inform your commissioning needs.

In Thames Valley, CCGs have adopted varying approaches to incentivise the adoption of CC&SP. These include a local enhanced service (Berkshire West); quality outcome schemes (Bracknell and Ascot); and using the opportunities under the co-commissioning scheme (Aylesbury Vale):

**THE AYLESBURY VALE (AV)** scheme is the most far-reaching and innovative. AV CCG has taken on level 2, 'joint' commissioning responsibilities. The CCG has adopted CC&SP through co-commissioning to be the central spine of new models of care. General practice teams will be supported to embed care and support planning, focusing upon strengthening the infrastructure and encouraging the cultural shift required to make it a success.

The CC&SP scheme was agreed between NHS England (NHSE) and Aylesbury Vale Clinical Commissioning Group (AVCCG) through the primary care co-commissioning joint committee. A key element of the scheme is the leniency associated with the 2015/16 Quality and Outcomes Framework (QOF), which provides a one-year window of opportunity to implement care and support planning.

AVCCG will support the roll out of CC&SP through central resources such as project management and training, however practices are expected to implement CC&SP locally. A small transition payment will be made available to cover the associated costs of changes to care processes and embedding new skills.

The essence of CC&SP sits around the conversation between patient and Health Care Professional (HCP). Identifying outcome measures that evidence the effectiveness of this is challenging, especially where clinical measures are valued and easier to capture than qualitative patient experience and outcomes. The CCG is, however, focussing on incentivising quality; proposing a comprehensive range of measures considering patient and carer experience of CC&SP and HCP satisfaction, to complement established clinical outcomes.

### KEY LEARNING POINTS:

1. Incentivise better conversations and person-centred outcomes
2. Reducing the burden of target-driven schemes creates 'space' to innovate

It is important to remember that whilst practitioners respond to financial incentives, they are primarily motivated by values based practice – greater job satisfaction and improved patient experience are real motivators for GPs and the wider practice team. It is important that biomedical outcomes continue to be measured but additional measures need to be introduced to assess impact on people's knowledge and confidence, quality of life and how things are working from their point of view. These are all measures that go beyond simple metrics.

There are many tools out there that can support practices and commissioners to measure person-centred care. Commissioners need to work with practices, the wider community and with patients and carers to identify which tools work best in their local context.

## 9. PROMOTE MULTIDISCIPLINARY TEAM WORKING

We need to use the resources of the whole primary health care team and distribute workload equitably across a multidisciplinary team working together

across health and social care. CC&SP does not, and should not, have to be done by the GP alone. Teams will need to make changes to build in the longer consultation time needed for the 'discussion' phase. This longer discussion should ultimately replace the multiple appointments currently needed to support people with LTCs. CC&SP should be seen as a core part of the working week and not an additional extra. Activity and job plans must allow time for multidisciplinary team

meetings at both practice and cluster level as appropriate. It is essential that teams also build in time for evaluation, reflection and learning. Team-based continuity needs to be a key objective of partnership working, with shared records and effective flow of communications meaning that patients only have to tell their story once. This will require careful governance from the CCG, regarding consent and data sharing, but is necessary if people are to benefit from a single care plan that spans the system.



In Sheffield, the Locally Commissioned Service (LCS) for person-centred care planning incentivises joint working and practice multi-disciplinary teams:

### THE LCS IN SHEFFIELD RECOGNISES

that in order for person-centred care planning to work effectively, the whole system needs to work together to support it. Accordingly, monthly multidisciplinary team (MDT) meetings have been built into the specification, along with a request to report on outcomes and attendees (beyond practice staff). To complement the work, a CQUIN has been agreed with Sheffield Teaching Hospital, whereby their community nursing service supports the care planning process, and is required to attend the monthly MDTs.

The person-centred-care planning programme has been designated as part of the Integrated Commissioning/Better Care Fund in Sheffield and links to other work within this programme. One of the four elements of this is 'People Keeping Well', and a key part of this is the employment of community support workers and life navigators who work very closely with the GP practices that are implementing care planning. Their interventions range from undertaking the Patient Activation Measure with the patient; attending MDTs to offer guidance; working closely with the patient to support them in meeting social care needs; and acting as a link to other community and voluntary services.

In practices in the more deprived areas of Sheffield, health trainers are jointly funded by the CCG and the local authority. Their remit is to support care planning by working with patients to help them to achieve their goals.

Most recently, Age UK Sheffield, part-funded by the national charity and part by the CCG, is working closely with GP practices to deliver a Life Navigator Service to patients over the age of 55 with long term conditions.

Practices have reported that they have found these services invaluable, particularly in supporting patients with greater social care needs. Such partnership working has also alleviated pressure on resource-constrained local authority teams, where social workers rarely have the capacity to attend practice MDTs. Community support workers have proved a valuable resource in helping to identify the particular needs of patients and support them to find sustainable solutions – helping to prevent avoidable demand on health and social care services.

#### KEY LEARNING POINTS:

1. Build MDT in as a mandatory component of the scheme
2. 'Life navigators' can offer support to patients and ease the workload for practice teams

### 10. ACTIVELY WORK WITH THE THIRD SECTOR AND HEALTH AND SOCIAL CARE

The third sector is an essential partner for providing CC&SP to the population. Third sector organisations can bring specialist skills, knowledge and capacity, along with an alternative view of the needs and gaps in provision that may exist for your population. Third sector organisations can take a significant role in engaging and empowering patients before they enter the care planning process. They can contribute in a number of ways, including providing information; advice and advocacy to help individuals prepare for care planning discussions; leading care planning conversations as an active member of the multi-disciplinary team; and providing services such as education programmes, coaching and mentoring. Active commissioning of third sector services, including as care navigators, is advised and should be written into the budget of the Better Care Fund.

The NHS Greater Glasgow and Clyde House of Care Local Enhanced Service (LES) builds working with the third sector and health and social care into practices' Service Level Agreement (SLA).

### THE SERVICE LEVEL AGREEMENT

sets out the terms for practices implementing the House of Care model. Practices are assured that under the SLA, they are guaranteed a minimum diabetes and CHD Locally Enhanced Service payment of at least what they achieved the year prior to implementing the House of Care. Should outcomes improve, they will be paid the higher sum accordingly. This agreement creates the 'space' practices need to be innovative.

One particular challenge the SLA addresses is the weak connectivity between patients, communities and the third sector.

The SLA calls on practices to: 'Engage and empower patients in sustained health improvement, by making full use of existing community assets (including referring to third sector, health and social care services)' as part of the care planning process.

The SLA offers backfill to support practices to participate in networking and learning opportunities to support shared learning with other practices, third sector organisations and health and social care partners. Furthermore, practices agree to work with third sector organisations and health and social care partners to 'identify and work collaboratively on addressing barriers to managing long term conditions', highlighting the value of the knowledge and resources that these sectors can offer.

#### KEY LEARNING POINTS:

1. Incentivise active partnerships with the third sector and health and social care by building them into the contract
2. Offer backfill for meetings with third sector and health and social care



### 11. CONTRACT AT SCALE

Innovative contract models can promote quality. Originating in the construction industry, alliance contracting is a model where multiple providers sign up to deliver a collective outcome. This contract means that all providers must deliver towards the final outcome, so that if one fails they all fail. The model incentivises consistent quality and means that all contractors share the same risks and responsibilities.

Developing the right system incentives using models such as alliance contracting will take time. Partnership contracting models, where one contract serves a number of practices, are best placed to deliver innovation and change. Alliance contracting for CC&SP can lead to improved collaboration and a more consistent performance across practices, with aligned principles around proactive, person centred care planning.

### 12. NURTURE AND DEVELOP COMMUNITIES

Contracting is only one part of the story – some small and local groups will not be able to respond to competitive bidding processes and some NHS procurement systems may prevent contracts being set up with anything other than limited companies. There is a strong argument for community development and market development, both for capacity to

support care planning processes, and for the kinds of activities that CCGs might fund in order for people to live well, rather than just focussing on traditional services.

NHS Alliance has developed a Community Development Charter for Health<sup>18</sup>, which calls on national and local health bodies to use community development to improve health outcomes. CCGs can build on



what is already going on local. Think Local Act Personal and the Coalition for Collaborative Care are working together to promote community-based approaches and local development. Getting to know the local community is important for a practice but that may not necessarily mean a whole lot of extra work – local authorities and front-line staff are likely to already have good local knowledge and links.

### 13. HARNESS THE ASSETS OF GENERAL PRACTICE AND THE COMMUNITY

General practice is best placed to enable CC&SP. GPs hold the patient registers that enable the population-based proactive intervention that CC&SP can deliver, and can be used to reduce health inequalities and improving outcomes for people with LTCs. Practice teams know their patients, sit within the community and are well placed to identify gaps in service provision and perform in-depth needs assessments.

It is crucial that commissioners and practices see the community as a valuable resource and tap into

- In one example Gentoo Housing Association has taken a 'life coaching' approach to managing its properties and working with tenants. With housing officers and community members trained in life coaching there is potential to group care and support planning outside the GP surgery.
- In another example the Royal Pharmaceutical Society is working with GP Practices and in care homes to investigate the role of pharmacists in helping people to manage long-term conditions.

its local assets. The support we offer people does not need to be a rigid 'one size fits all' offer and the community can relieve some of the pressure on general practice. Think about facilitating a spectrum of support ranging from peer supporters (who have recently undergone the CC&SP process themselves) through to allied healthcare professionals and other frontline workers.

### 14. USE YOUR LEARNING FOR QUALITY IMPROVEMENT

Introducing CC&SP into an organisation is a journey – we are all learning by doing! It is wise to build up implementation in a planned and scientific way. Start with change on a

small scale, for example introducing CC&SP into one practice, or introducing it for one disease-type, and then measure the changes that occurs, assess what has worked and what has not, analyse the impact on your staff. Use the learning from this to plan the next scale up of CC&SP and then measure, analyse and learn again. The College has more information on Quality Improvement here: <http://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement.aspx>.

The Keep Well programme was established in 2006 by the Scottish Government to deliver anticipatory care in disadvantaged areas across Scotland, with a major focus on primary prevention of cardiovascular disease. In December 2013, the Scottish Government announced its decision to discontinue funding Keep Well and advised that health check targets would cease from April 2014. NHS Greater Glasgow & Clyde (NHSCCG) have used quality improvement to ensure the programme has a lasting legacy after it closes.

#### IN RESPONSE TO THIS, NHSGGC

discontinued the delivery of Keep Well health checks from 1st April 2014 within general practice, and commissioned an amended one year Keep Well Locally Enhanced Service for the existing 'Keep Well' practices. The aim was to build on the findings from the programme evaluation and support a lasting programme legacy through quality improvement.

The main findings from the evaluation of Keep Well in NHSGGC were translated into the form of an Anticipatory Care Toolkit.<sup>19</sup>The toolkit outlines improvement activities across the following 3 areas of 'high impact change':

- i) Optimising patient engagement and reducing 'Did Not Attends'
- ii) Delivering person-centred consultations
- iii) Supporting behaviour change and self management

During 2014/15, participating GP practices were asked to complete a self-assessment against 'ideas of improvement' outlined in the toolkit using a "Red, Amber, Green" (RAG) approach. Using the self-assessment outcomes, practices identified and prioritised actions, to support delivery and improvement of the programme, with

a minimum of one improvement action for each of the three areas of 'high impact change'.

Practices were encouraged to develop innovative improvement activities in ways that best fit their local context and systems. In addition, we offered public health, primary care support and health improvement networking opportunities and 'Webinars' to support sharing of learning, knowledge and approaches across participating practices.

Overall, practices generally employed systematic and inclusive approaches to quality improvement and identified a wide range of improvement actions. Some practices described working as a whole team in a concerted effort to improve patient engagement and in supporting person-centred care.

A range of clinical quality improvement initiatives were described including: eliciting

and acting on feedback from patients after their annual reviews; use of Significant Event Analysis; and making better use of the time allocated to different types of annual reviews.

Overall, practice staff valued the toolkit as an easy to use and effective tool for planning, monitoring and managing improvement within the practice. It was found to be helpful in prioritising areas of change and developing improvement strategies e.g. to maximise patient engagement. The majority of practices expressed themselves open to using it in future, either in full or in part, as a tool for small but significant changes to the practice.

NHSGGC intends to continue to extend and build on this collaborative approach within the existing CDM LES and House of Care early adopter sites.

#### KEY LEARNING POINTS:

1. Providing practices with a simple toolkit can support structured quality improvement.
2. Quality improvement leads to sustainable change.
3. Simple changes can have a significant impact.



#### 15. SUPPORT RESEARCH TO FIND OUT WHAT WORKS BEST

Many organisations are trying to develop new ways of working to improve patient-centred care. We need to know which approaches work best for which groups of patients. The NHS, through the National Institute for Health Research, is supporting several large-scale projects to evaluate different approaches to improving person-centred care. Co-operate with these national programmes and/or commission your own evaluation, so that you help others learn from your experience.

The University of Bristol is conducting a large multi-centre randomised controlled trial, comparing the new 3D approach (in which patients with multi-morbidity are identified and prioritised for a new model of care which focuses on improving continuity of care, co-ordinated patient-centred reviews, and improved integration with secondary care) versus usual general practice care. Alongside the trial they are also conducting an economic evaluation of cost effectiveness and a mixed methods process evaluation to understand how and why the 3D approach was or was not effective.

**THE PRIMARY OUTCOME MEASURE** of effectiveness is the EQ5D measure<sup>20</sup> of health-related quality of life. The team are also collecting data about patient-centredness (e.g. continuity of care, care co-ordination, self-management and patient experience), 'illness burden' (e.g. self-rated health, mental health, QOF indicators of disease management) and 'treatment burden' (e.g. polypharmacy, medication adherence). They will assess cost-effectiveness in terms of cost per QALY, as recommended by NICE.

It is very important to conduct evaluation of new ways of working before they are widely introduced, and this step is often overlooked. Most new approaches to the delivery of primary care get introduced with much enthusiasm but very little critical reflection or evaluation. There is often little appreciation that new ways of doing things sometimes do not achieve their intended benefits and most initiatives have costs as well as benefits, which are not always considered carefully.

If we introduce change without evaluation this can lead to several problems. New ways of working become widespread, and yet we never really know whether or not they are beneficial. Often innovations are introduced widely and only some time later is there a good evaluation, which shows that the innovation wasn't actually effective. Constant change without evidence of benefit leads to much disruption for both patients and practice staff and this can lead to change fatigue (and sometimes scepticism) from practice staff who then become resistant to further change. Therefore evaluation is vital.

If commissioners work in partnership with researchers it is often possible to evaluate innovations in ways that may be less robust but are quicker and cheaper than the approach we are using to evaluate 3D. This is happening across the country in CCGs that are implementing CC&SP. But where an innovation is being implemented nationally (e.g. care planning initiatives), an evaluation on the scale of the 3D trial is well justified.

#### KEY LEARNING POINTS:

1. Evaluation is vital to assess whether an intervention is actually beneficial.
2. CCGs do not have to invest in a national RCT, but can partner with researchers to conduct smaller-scale, but important, evaluation.

## Summary

Collaborative care and support planning enables us to improve the conversations between health professionals, patients and carers, so that the support provided is tailored to the needs of the individual. CC&SP is part of the person-centred agenda, which outlines the need for the system to radically change the way we deliver care in order to respond to the rising burden of single and multiple long term conditions.

The principles and building blocks in this guidance present CC&SP as the process for delivering person-centred care. CC&SP can help us to deliver a personalised service shaped by an individual's goals and preferences. It supports us to pull services together and wrap them around the person. It enables people to become equal partners in making decisions about their care.

The principles and building blocks in this guide demonstrate that there is no 'one size fits all' approach to implementing CC&SP. We have given recommendations as a starting point for commissioners looking to improve the way people with LTCs receive care in their locality. The most important thing is that we enable health care professionals to have better conversations with patients. Changing the conversation can be as simple as moving from starting your appointments with 'how can I help you?' to 'what would you like to talk about?'

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