

Care Planning

Improving the Lives of People with Long Term Conditions

A Summary



Summary

Care Planning - Improving the Lives of People with Long Term Conditions

Encouraging Partnership; Increasing Quality of Care

What is Care Planning?

Care planning is a powerful way of creating an environment which helps clinicians to support self management by patients of their own *long term condition* (LTC). This means supporting people to understand and confidently manage the condition itself, plus also supporting them to manage the inevitable consequences of living with a LTC, consequences for the way they live their lives (their roles and responsibilities) and the way they think and feel about themselves and their relationships.

This document focuses on people who have long term physical health problems and describes how we as GPs and the other members of the primary health care team can support them to live their lives more comfortably with their condition. It is intended that all patients and clinicians who read it can feel more confident about how to use *care planning* in their daily practice to achieve better health outcomes, improve the efficiency of working together and reduce 'strain' on the NHS and social services.

This document is about how to make *care planning* work in practice.

The Case for Change

There is good evidence that our care of people with LTCs can be improved. Patients tell us that they want us to do more to support their own self-care.

However the evidence also tells us that this is not happening. While 95% of people with diabetes, for example, are seen annually, only 50% discuss a plan to manage their diabetes and less than 50% discuss their own goals for self management.

Despite considerable efforts to tackle the most important area, namely the effectiveness of consultations between patients and clinicians, the most significant problem is the reluctance of clinical staff to provide active support for patient engagement. *Shared decision making* for example, is less common in the UK than in many other countries.

There is also a lack of engagement by patients in consultations, which include a failure to attend follow-up appointments. Uptake of patient education, even when offered is often poor and as much as 50% of the medication prescribed for LTCs is not taken, or not taken as prescribed. All of these issues are likely to be associated with higher admission rates and greater cost to both patients and the NHS.

This document describes the evidence that working in this new way is likely not just to improve the experience for everyone, but also to lead to better outcomes and lower costs in the long run.

Long Term Conditions and Primary Care - Definitions

Long Term Conditions

This document defines a *long term condition* as one that cannot currently be cured but can be managed with the use of medication and/or other therapies. This is in contrast to acute conditions which typically have a finite duration such as a respiratory infection, an inguinal hernia or a mild episode of depression.

There are currently 15.4 million people in England with a LTC. People with LTCs account for more than 50% of all general practice appointments, 65% of all outpatient appointments and over 70% of all inpatient bed days as well as 70% of the total health and social care spend in England.

Support for Self Management

Support for Self Management (SSM) recognises that “people with LTCs are in charge of their own lives and self management of their condition and are the primary decision makers about the actions they take in relation to the management of their condition.” The desired outcome of SSM is someone who is an effective self manager and is a person “with the knowledge, skills and confidence to manage their own health and healthcare.” Various terms have been used for this, ‘engagement’, ‘empowerment’ or ‘activation’ (Wagner model). Whichever term is used, the focus moves from the clinician doing things, to the person, to one which enables clinicians to support people’s confidence and competence to manage the challenges of living with their condition.

Care planning is putting self management support into practice in a systematic way, as part of routine care for people with LTCs.

Improving Our Care for People with LTCs

There is a great deal of evidence of what works best in the care of people with *long term conditions*. The Wagner Chronic Care Model, for example, shows that the best outcomes are achieved when three components of care are integrated.

These components are:

- a prepared proactive practice team
- informed engagement by people in their own care
- partnership working between health professionals and people with LTCs

Improving Our Support for Self-Management (Self Care)

Self management support is the intervention with the most evidence of being effective, much of it gained from primary care settings in the UK and USA. The evidence is strongest for a collaborative interaction between the clinician and the patient.

Recently, a number of different approaches to SSM have been brought together into a theory of change based on patient *activation*, a measurable outcome which has been associated with a wide variety of beneficial improvements. Compared to people with low levels of *activation*, people with high levels of *activation* have a higher quality of life, improved clinical outcomes and make informed and personally relevant decisions about accessing health or social care resources. As a result, people with high levels of *activation* (compared to people with lower levels of *activation*) choose to undergo less surgical interventions and are less likely to be admitted to hospital as an unscheduled admission.

The Diabetes Year of Care Approach to Care Planning

The following lessons from the Diabetes Year of Care programme can be used as an illustration of how *care planning* can be introduced to a practice to improve the care of our patients. Such lessons can be used as an exemplar for other LTCs such as Chronic Obstructive Pulmonary Disease [COPD] using the two visit principle of self reflection on the current condition followed by discussion with the healthcare practitioner.

The annual diabetes review has been replaced by a **two-visit approach**.

1. A data collection consultation (delivered most cost effectively by a healthcare assistant; HCA), followed by the delivery of their test results in a meaningful way to the patient. This allows time for the patient to reflect on their condition and to generate ideas about what would be important for them to cover in the second visit (goal setting and action planning).
2. A second visit then takes place a couple of weeks later and takes the form of a collaborative ‘*care planning*’ consultation to support self management as well as to screen for complications and initiate medical treatment. The personal goals and action plans agreed in the *care planning* consultation are then worked on until the next *care planning* visit.

Making It Happen in General Practice and Primary Care

Pilot Site Experience

The following outlines some of the experiences of the over 50 general practices who have tested the Year of Care model in three diverse pilot PCTs. Teams reported that their experience was that *care planning* is a practical and helpful approach to improving the care of patients with diabetes. It also gave them a good framework to help individuals and teams to reflect on their attitudes, their current ways of working and to generate ideas for change.

Team Engagement and Leadership

When introducing *care planning* to your practice, it is important to have a facilitated team meeting and ask yourselves the sorts of questions which are outlined below.

What are the motivating forces for your team to make changes?

What are the attitudes within your team about supporting patients to self care?

How do you review your team working, organisational structures and current skill mix?

What improvements do you hope and might you expect to see?

How will you tell if the changes you have made are working?

As part of the discussion, the team need to know why you are making the change, what exactly you hope to achieve by the change and how you will know you have achieved it? Everyone needs to agree to buy in to the work and you will need to nominate a Clinical Leader/Champion for the process, who will be responsible for engaging the team members in the process, energising them and overseeing the introduction of *care planning*. They should also be responsible for reporting the changes and the outcomes to the wider team.

All of the members of the practice team need to understand their roles and tasks, the way in which they work together, have the appropriate attitudes and skills to support patients to self care and to work in an environment which motivates good performance (e.g. benchmarked performance data, incentive payments etc.). Any change on this scale often involves a 'cultural change' as well as time and resources during development.

Organisation

In *care planning* different members of the team are responsible for different components of patient care and, for example, you will need a system in place that ensures the person with a LTC sees the right person in the right place at the right time and all the appropriate tests and processes are completed including communication with other members of the team.

Engaged Informed Patients

For many of us, *care planning* places far greater emphasis on involving patients than we are used to. However, if we are serious about creating the sort of environment which encourages and supports *care planning*, we need to be sure that we have good ways of checking with patients how they feel about the care we're delivering. When we make changes we must work out ways to inform people what these are and what they will experience. This is over and above the information we provide as part of the two step *care planning* approach itself.

Commissioning

To deliver high quality *care planning* for people with LTCs adequate resources are required. In many areas this type of work is supported by enhanced service payments or driven by practice based commissioning savings.

Commissioners will need to support the required training of both patients and staff and ensuring appropriate IT procurement, software set up and staff support to ensure effective data capture and reporting.

Collaborative Care Planning

When we first implement *care planning* within the practice, we need to be sure we allocate enough time for the

first *care planning* consultation. Generally speaking, quite a large part of these consultations are taken up with explaining results to patients and modelling a new way of working. Initially, patients who are more used to a doctor or nurse centred approach to care can find this difficult and may respond to invitations to *shared decision making* by declining to engage: “*I don't know, you're the doctor, you tell me.*” However, in these circumstances where patients are not ready to work in this way, some consultation time needs to be spent exploring their concerns, their views and understanding of their health and their wishes.

A written record of what has been agreed needs to be made for both the patient and the practice. Completing the loop of *care planning* by following up the achievements of goals or objectives is crucial. We should ask our patients: ‘*how did things go in relation to the original agreed plan?*’ Written records should make it clear whom the patient is seeing for follow up and when and care plans will need continuous adaptation in the light of the patient's experience during the year.

Evaluation

The *care planning* approach makes it easier for us to support people with LTCs , improves their experience and their sense of control over their condition and daily lives; things that we know improve quality of life and reduces complications in the future.

But how will we know how we're doing? And how can we do better?

Reflecting, measuring, getting feedback and audit are all ways to support improvement.

Measuring Patient Outcomes

In general practice we know that being systematic and planned in what we do, such as registering and recalling patients for regular review has been the most important driver of the improvements we have all seen in care for people with LTCs .

Accepting an individual's quality of life and their “*knowledge, skills and confidence to manage their own health and healthcare*” (*'activation'*) are important outcomes in their own right, poses newer and harder challenges, but there are a number of tools available to help make such judgements.

Website links to a number of well validated instruments, including the Patient Activation Measure (PAM) (which is not yet available for unlicensed use) across a range of conditions are provided at the end of this report.

Standardised questions, assessing how successful a practice is in enabling people to self manage effectively, that could be useful as part of routine use, for an audit or to benchmark against colleagues.

It is helpful to separate the monitoring of our process of *care planning* from the outcomes of *care planning*, some of which were discussed above. How can we, as practitioners, find out to what extent we are patient centred and to what extent we are supporting people with LTCs to self manage?

For example, we can ask for feedback from patients by giving them a questionnaire to complete at the end of their consultation.

- **The CQI**, either generic or adapted for diabetes care has been shown to be useful for practitioners to use before training by Year of Care.
- **The Patient Partnership in Care (PPIC)** questionnaire has been used to highlight the areas where most improvement can be made.
- The **Health Care Climate Questionnaire (HCCQ)** which contains either 6 (short form) or 15 (long form) items. It asks about how the patient feels about their encounters with you in terms of the balance between being

supported by you or 'controlled' in their consultations with you.

These enable us to see what extent in the last few consultations with us, we have satisfied the patient and helped them look after themselves.

Audit of Care Planning

Care planning lends itself naturally to an audit of your processes and standards.

A practice audit of how far the administration of *care planning* is 'joined up'; e.g. letters sent out, tests obtained at the right time, induction and training of staff, the extent that everyone involved can explain the processes and importance to patients would give a good overview of progress.

Linked to this outcome measure of how well the service is being used overall could include the number of patients who had received their laboratory results before their consultation and brought these with them to their consultation with you. Similarly, monitoring the number of attendances by patients with long-term conditions as a proportion of the total can act as a proxy measure for the quality of your *care planning* services. It is likely that nonattendance rates for planned appointments will be reduced.

Just Imagine...

Just imagine a health service in which everyone with a *long term condition* is engaged in *care planning*: sharing decisions with their clinicians; being confident to manage their condition; knowing when to ask for help; with a better experience of care; better health outcomes and improved quality of life and greater job satisfaction for clinicians...

