



Royal College of  
General Practitioners

# Collaborative Care and Support Planning:

Ready to be a reality



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# Executive summary

Medicine is a science, but it can also be an art of building relationships which enable people to reach their full potential in life. Embracing person-centred care gives GPs time to use their expertise and knowledge to benefit patients in a joint decision and sharing process. By developing and allowing primary care to work within new integrated teams we can rekindle the fire in general practice.

This paper was written by the **RCGP's Collaborative Care and Support Planning (CC&SP) programme team** and submitted to RCGP Council in June 2016. As a result, the RCGP has officially endorsed a set of recommendations based on this paper and the programme. The full recommendations can be found below.

The landscape of the NHS and primary care is changing; an ageing population, increasing multimorbidity and frailty, and an overburdened workforce means that primary care needs a more effective way of addressing the bio-psychosocial elements of health; it requires a shift towards prevention, self-care, and integrated care. Collaborative care and support planning offers a framework for these requirements, in line with the RCGP's "An inquiry into patient centred care in the 21st Century" which recommends a holistic approach to care, flexible and tailored care, and a collaborative approach to care<sup>1</sup>.

Care planning can identify underlying conditions that might otherwise go unnoticed, promotes continuity of care and integrated care, offers part of the solution to multimorbidity (as highlighted in the new NICE guidelines, published in September 2016<sup>2</sup>), offers the opportunity for patients to engage with other primary healthcare professionals easing the pressure on GPs, and importantly increases professional satisfaction and therefore has the potential to help relieve the recruitment and retention crisis.

Care planning is a journey rather than an endpoint, and the CC&SP programme has endorsed the 6 stage model of context, preparation, conversation, record, making it happen, and review. Whilst this paper goes into more detail on each of the stages, the end point of the care planning process is person-centred care; care that is coordinated and tailored to the needs of an individual, which ensures that people are always treated with dignity, compassion and respect.

Through a systematic curriculum review and suggested changes, development of tools and resources, workshops, publications and the formation of a UK-wide CC&SP Network of Champions, the CC&SP programme team have been working to promote collaborative care and support planning to RCGP leadership and members, as well the wider healthcare community, and to embed it into formal education structures.

<sup>1</sup> RCGP (2014). *An inquiry into patient centred care in the 21st Century*. Available at: <http://www.rcgp.org.uk/policy/rcgp-policy-areas/inquiry-into-patient-centred-care-in-the-21st-century.aspx>

<sup>2</sup> NICE (2016). *Multimorbidity: clinical assessment and management*. Available at: <https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0704>

# RCGP position on collaborative care and support planning, as endorsed by RCGP Council

The College officially endorses the delivery model for CC&SP as outlined below as key to delivering person-centred care in the context of the growing prevalence of multimorbidity

The College supports the inclusion of the process of care planning in the curriculum and training programmes reflecting the centrality of CC&SP into the work of a general practitioner

The College endorses care planning by the whole primary care workforce as part of the solution to address the growing issue of multimorbidity

The College recognises that the term 'person-centred care' more accurately reflects the type of care required by people with long term conditions

The College recognises the link between care planning and increased professional satisfaction for GPs, and its use as a lever to bringing some of the 'joy' back into general practice and addressing the current recruitment and retention crisis

The College encourages care planning to be a legitimate part of the Personal Development Plan in annual appraisals



# Collaborative Care and Support Planning: Ready to be a Reality

Personalised Care Planning now needs to be a core part of a general practitioner's role.

## 1. Introduction

The future landscape of the NHS and primary care is changing; with an increasing ageing population experiencing more multimorbidity and frailty, and a workforce of GPs that are fatigued due to increasing workloads and difficulties recruiting, it is feasible that without change the service cannot survive in its current form. Primary care needs to find a more effective way of addressing the bio-psychosocial elements of health, to identify the issues that surround and influence an individual's health and their likelihood of developing disease. If it doesn't, the need for secondary care and hospital admissions will continue to rise, which will continue to draw financial resources away from primary care.

While the GP Forward View is certainly a step in the right direction primary care is currently underfunded and under resourced, and yet still required to see more patients than ever before<sup>3</sup>. This is likely to become ever more extreme with predictions that the population of the UK with long term health conditions, already over 15 million (just under one third of the population), could rise to 18 million by 2025<sup>4</sup>. This 30% of the population accounts for 70% of cost across the health service, making up 50% of all GP appointments, 64% of outpatient appointments and 70% of all inpatient bed days<sup>5</sup>. People with chronic long term conditions (LTCs) and multiple morbidities are being managed mainly in the reactionary model of medicine delivery in primary care, better suited to more acute, urgent problems. A ten minute appointment, the average for most GPs, encourages a doctor led, paternalistic, information sourcing and solution delivery consultation. There isn't time to embrace a holistic person-centred approach.

**“The ageing population and the increased prevalence of chronic diseases require a strong reorientation away from the current emphasis on acute and episodic care towards prevention, self care, and care that is well coordinated and integrated.”<sup>6</sup>**

To divert from this crisis, patients need to be engaged differently – in a way that is more suited to the management of LTCs and multimorbidity. Across the globe, including the UK, organisations are turning to a person-centred approach to care as they realise that one type of care does not fit all, and when it doesn't fit it can be costly and ineffective. Collaborative care and support planning (CC&SP) is a way to incorporate person-centred care into general practice.

**“We stand on the cusp of a revolution in the role that patients – and also communities – will play in their own health and care. Harnessing what I've called this renewable energy is potentially the make it or break it difference between the NHS being sustainable or not.”**

Speech to the NHS Confederation Conference (June 2014) Simon Stevens, Chief Executive, NHS England



<sup>3</sup> Department of Health (2010), Improving the health and well-being of people with long term conditions. World class services for people with long term conditions: information tool for commissioners.

<sup>4</sup> [http://www.yearofcare.co.uk/sites/default/files/pdfs/dh\\_improving%20the%20h%26wb%20of%20people%20with%20LTCs.pdf](http://www.yearofcare.co.uk/sites/default/files/pdfs/dh_improving%20the%20h%26wb%20of%20people%20with%20LTCs.pdf)

<sup>5</sup> Department of Health (2012). Long term conditions compendium of information. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/216528/dh\\_134486.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf)

<sup>6</sup> The King's Fund (2011). *Transforming our health care system: Ten priorities for commissioners*. Candace Imison, Chris Naylor, Nick Goodwin, David Buck, Natasha Curry, Rachel Addicott, Paul Zollinger-Read. [http://www.kingsfund.org.uk/publications/articles/transforming\\_our.html](http://www.kingsfund.org.uk/publications/articles/transforming_our.html)

## 2. The benefits of care planning

Care planning should not be a tick box exercise resulting in a piece of paper with a QOF code. Care planning is a journey which the individual and healthcare professional embark on together, both experts in their own fields; one in their own life and conditions and the other schooled in the understanding of the medical problem. It gives space to start a discussion around the individual, for joint decision taking, patient activation and self management. It takes the conversation from “your HBA1C is still too high, you need to change your diet and exercise more. Here are some handouts and let’s test again in 6 months” to “your sugars still look on the high side, how do you feel about that?”. It moves the discussion on from advising on best evidence medicine to an individualised plan encompassing the psychosocial domains and personalised risk taking of an individual.

*Personalised care and support planning encourages care professionals and people with long-term conditions and their carers to work together to clarify and understand what is important to that individual. They agree goals, identify support needs, develop and implement action plans, and monitor progress. This is a planned and continuous process, not a one-off event*

Coalition for Collaborative Care, 2014

### 2.1 Identification of underlying conditions

Care planning not only enables a review of the present medical situation, but exploration of an individual’s understanding and wishes for their health and well being. It can identify underlying psychosocial problems which are affecting physical conditions. Evidence shows that 30% of people with long term conditions also have mental health problems<sup>7</sup>, which can impact on their ability to cope and comply with treatment for these conditions. Building on this, personal self-identified goals owned by the individual can be agreed and plans put in place as to how to achieve these.

### 2.2 Continuity and integration of care

The personalised care plan can then be shared across all the health and social care interfaces as a “finger print” of an individual’s health and wellbeing, unique to them, where their wishes and goals are routinely available but also at a time of crisis. This promotes continuity of care and encourages services to integrate.

## 2.3 Multimorbidity

Collaborative care and support planning is an effective way of managing multimorbidity, a growing problem highlighted in the policy paper “Responding to the needs of patients with multi-morbidity: A vision for general practice”<sup>8</sup>.

The multimorbidity paper presents collaborative care and support planning as an intervention to improve outcomes for people with multimorbidity, identifying shared decision making, proactive goal setting, use of multidisciplinary teams, longer consultations and continuity of care as key components to this approach.

NICE multimorbidity guidelines which are due to be published this year will also recommend care planning as a possible solution. The draft guidelines refer to an ‘individualised management plan’, the process of producing which includes “establishing the person’s preferences, values and priorities” and “review[ing] this regularly”<sup>9</sup>.

The College took the opportunity to comment on the draft guidelines, and the response included references to the language used (“The RCGP feels that terms like “tailored care” and “management plans” give the guidelines a paternalistic doctor-centric feel. The RCGP recommends terms such as an individualised/personalised care plan as alternatives”) and recommended a greater focus on patient decision (“The RCGP would like to see greater mention in the guidance of how a person’s health literacy, activation and capabilities would be assessed and how this could have an impact on the development of any care plans”)<sup>10</sup>.



<sup>7</sup> The King’s Fund (2012). *Long term conditions and mental health*. Available at: [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf)

<sup>8</sup> RCGP Council (June 2016) Item 8a, C/79 *Responding to the needs of patients with multi-morbidity: A vision for general practice*

<sup>9</sup> NICE (2016). *Multimorbidity: Clinical assessment and management*. Available at: <https://www.nice.org.uk/guidance/GID-CGWAVE0704/documents/draft-guideline>

<sup>10</sup> RCGP response to NICE multimorbidity guidelines 2016

## 2.4 Bringing the 'joy' back into general practice

It is well recognised that primary care is in crisis; GPs are at a high risk of burnout, fewer medical students are choosing general practice and more GPs are taking early retirement. There is disenchantment among GPs, and joy is in short supply.

A report which set out to uncover innovations that would promote high quality care and preserve a positive attitude among primary care practitioners notes that if "physicians seek out the arduous field of medicine, and primary care in particular, as a calling because of their desire to create healing relationships with patients ... 'joy in practice' implies a fundamental redesign of the medical encounter to restore the healing relationship of patients with their physicians and health care systems".

A number of innovations were identified as paramount in this redesign including proactive planned care, pre-visit planning, shared clinical care among teams and improved communication<sup>11</sup>.

CC&SP offers a framework for all of these solutions, and the increased consultation time and treatment of the person as a whole lead to increased job satisfaction for professionals<sup>12</sup>.

The movement toward care planning and integrated care has already started; led by NHS England, many of the Vanguards New Models of Care and key elements of The Five Year Forward View look at redesigning whole health and care systems, are embracing person-centred care, and realising that patient activation and better coordinated care is essential for protecting resources. For example care planning is an integral part of new enhanced primary care at the South Somerset Symphony project. Here care planning is being introduced along with health coaches to support GPs. The care plans sit on an IT system which can not only be accessed by the patient but also all the health care professionals involved in their care.

## 3. Person-centred vs. patient-centred

Care planning is a means to an end rather than an endpoint itself. The endpoint in this case is person-centred care; care that is coordinated and tailored to the needs of an individual, which ensures that people are always treated with dignity, compassion and respect.

The College has long championed a patient-centred approach to general practice putting, where appropriate, patients in the driving seat of their care and wrapping services around the person<sup>13</sup>. While the two terms (person-centred and patient-centred) are often used interchangeably, the College may now need to look at whether, in providing true holistic patient focused care, a more accurate description is person-centred. Defining the care around the person, and supporting them in their lives outside the consulting room, more accurately describes the current relationship that GPs have with their patients. In its work on person-centred care the Health Foundation has helpfully described four principles:

1. According people dignity, compassion and respect
2. Offering coordinated care, support or treatment
3. Offering personalised care, support or treatment
4. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life<sup>14</sup>.

Much like care planning itself where a person's preferences, wellbeing and wider social/cultural background are given the same importance as any symptoms they may be suffering from, this subtle difference in semantics emphasises a holistic approach to care which takes into account the whole person rather than a narrow focus on their condition.

So the challenge is now **how do we spread a nationwide transition to person-centred care with care planning at its core, in a landscape with limited resources and time pressures?**

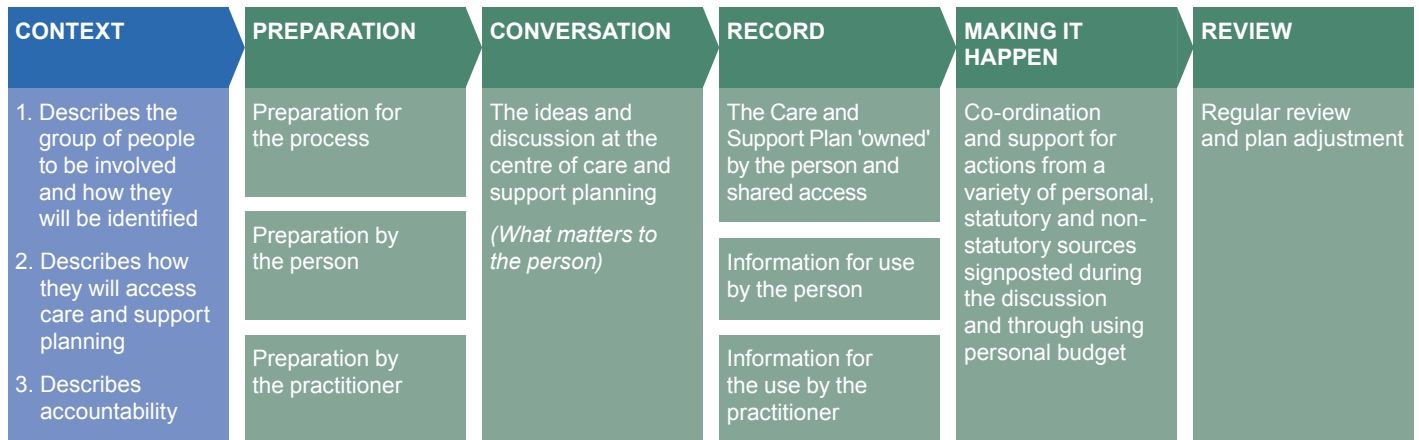
<sup>11</sup> Annals of Family Medicine (2013). *In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices*. Christine A. Sinsky, Rachel Willard-Grace, Andrew M. Schutzbank, Thomas A. Sinsky, David Margolius, Thomas Bodenheimer. Available at: <http://www.annfammed.org/content/11/3/272.full>

<sup>12</sup> Department of Health (2011). *Personalised care planning: improving care for people with Long Term Conditions*. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/215946/dh\\_124048.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215946/dh_124048.pdf)

<sup>13</sup> RCGP (2015). *Stepping Forward: Commissioning principles for collaborative care and support planning*. Available at: <http://www.rcgp.org.uk/~media/Files/CIRC/Care%20Planning/stepping-forward-web-061015a.ashx>

<sup>14</sup> The Health Foundation (2014). *Person-centred care made simple: what everyone should know about person-centred care*. Available at: <http://www.health.org.uk/sites/default/files/PersonCentredCareMadeSimple.pdf>

## 4. The care planning process



Care planning involves 6 distinct phases: context, preparation, conversation, record, making it happen, and review.

Think Local Act Personal (TLAP) describes each of the stages in their comprehensive care planning tool<sup>15</sup>.

### Context

- the groups/characteristics of individuals suitable for personal care and support planning
- how relevant individuals will be identified
- placement on system to prompt person-centred review and initiate process
- accountability for ensuring that care and support planning occurs for each person and meets quality standards.

### Preparation

Preparation is undertaken by both the individual and the practitioner. A discussion between equals cannot take place, unless each understands the purpose and process of personalised care and support planning.

### Conversation

A structured conversation between the person (including family/peer supporters) and health care practitioner:

- what is important to you?
- what is working (assets) / not working and what needs to change?
- what is important in the future? (aspirations)
- decide out outcomes and actions
- next steps
- contingency planning - what to do if you need help in the meantime
- how, when, where to review progress
- confirm agreement for sharing and with whom.

This conversation may identify how involving other health professionals, community or voluntary services could be of benefit. It can also identify where the use of personal health budgets could be used.



<sup>15</sup> <http://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/>

### Record

The record is 'the personalised care and support plan' owned by the individual. It is a summary of the decisions, the outcomes/goals and actions in a format that is useful to both the person receiving the support and the practitioner.

### Making it happen

Coordinating and supporting a complex mix of actions agreed in the conversation which may include:

- self-care - what I can do for myself
- ongoing support from family and friends
- use of voluntary / community resources
- coordination and ongoing support with necessary appointments and/or medicines management
- implementing the personal budget
- keeping any records needed support the review process
- refinement of the personal care and support plan when/if needed.

### Review

Ongoing phases of care planning allow for a catch up on progress and goal achievement. Continual coaching for improving patient activation, self management skills, and reinforcement that not being able to achieve goals is not seen as a failure.

At this stage it is important to emphasise that CC&SP is not the sole responsibility of the general practitioner. The model is appropriate for other members of the primary healthcare team, and it is important that other key stakeholders in the voluntary and community sector are also engaged<sup>16</sup>.



<sup>16</sup> National Voices (2016), *What is the role of VCSE organisations in care and support planning?* Available at: [http://www.nationalvoices.org.uk/sites/default/files/public/publications/what\\_is\\_the\\_role\\_of\\_vcse\\_organisations\\_in\\_care\\_and\\_support\\_planning.pdf](http://www.nationalvoices.org.uk/sites/default/files/public/publications/what_is_the_role_of_vcse_organisations_in_care_and_support_planning.pdf)



## 5. RCGP supporting the implementation of care planning into primary care

The RCGP has supported the implementation of care planning into primary care for a number of years; from its involvement with the creation of the Coalition for Collaborative Care, to the current Collaborative Care and Support Planning programme. The CC&SP programme was funded by the Health Foundation in May 2014.

The aims of the CC&SP programme have been to:

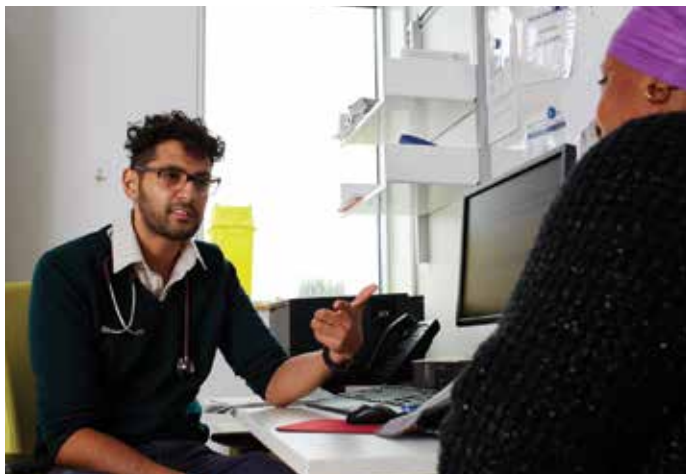
### Embed CC&SP into formal education structures

#### Disseminate and promote CC&SP to RCGP leadership, members and wider general practice

#### Develop tools and training materials to support implementation.

A team has been established to achieve these aims, including three Clinical Leads as well as a Clinical Fellow and a Project Manager. From a methodical review of the curriculum, to the design and production of commissioning principals, alongside numerous workshops, webinars, and conferences, the programme team have been raising the profile of care planning across the UK.

Following systematic scoping of the GP curriculum, recommendations for embedding the care planning process within the curriculum were presented at the RCGP Curriculum Development Team meeting in April 2016. As a result a new module is being introduced to the GP curriculum focusing on the care of people with long term conditions (subject to GMC approval). The CC&SP programme is now working closely with curriculum editors to draft this new module, which once incorporated will ensure sustainability for this way of working with the new workforce of GPs.



Following additional funding from NHS England, a CC&SP Network of Champions has been created to share ideas, function as a think tank for the programme, and to share information within their localities. There are over 30 network champions including GPs already dedicated to implementing change in practice, commissioners, other health care professionals, patients and carers, NHS England representatives, academics, and the voluntary sector. In February 2016 an induction day was held for network champions to meet and discuss how to implement and disseminate the message aiming to reach the majority and not just the early adopters of care planning. The network is able to continually share information and experiences on Basecamp, a web based project management tool for collaborative working.

**“Is this the forum to shape person centred care in primary care (and beyond)...**

**Whatever any of us 'leaders' might think we can publish and suggest, the real change happens at the interface between professionals and people, and how they then take this forward into their lives.”**

Ollie Hart GP, CC&SP Network Champion

The next stage is to identify local practice champions to share their experiences of implementing a person-centred approach to primary care. In this climate of scarce financial and time resources it is important to share the challenges these practices encountered, how they were overcome and what benefit is now being seen to both patient outcomes and staff morale.

As part of its work to fund person-centred care, the Health Foundation has funded three programmes/posts including CC&SP:

- Clinical Champion and Clinical Support Fellow for Collaborative Care and Support Planning at the RCGP (2014-2017)
- Clinical Fellow in Shared Decision Making (SDM) and Supported Self-management (SSM) at the Royal College of Physicians (2012 – 2015)
- Well Being Our Way Programme at National Voices (2014-2017).

It is imperative to maintain this work of reaching out to secondary, community, social care and the voluntary sector to ensure a wholesale change.

Implementing care planning does represent a culture shift in primary care but there is guidance already available from other organisations, such as NHS England and C4CC's "A Personalised Care and Support planning hand book: a journey to person centred care", The Year of Care Partnership's "House Of Care" which provides a systematic and practical approach to implementing collaborative care planning, and RCGPs Collaborative Care and Support Planning animation.

Care planning does not have to be and nor should it be solely the domain of the general practitioner. It should be shared with other members of the primary care team, practice nurses with LTC training, nurse practitioners, new roles such as health coaches/navigators and integrated working with community and social services. The most appropriate person should be leading or working with that individual. By integrating services and resources, continuity of care and person-centred care will be promoted.

**Where this approach has been used it has brought benefits for people with LTCs and for frontline staff. It links traditional clinical care with support for self-management; helps to better coordinate health and social care; and emphasises the importance of linking people with 'More than Medicine' services such as community activities and social networks that build confidence and provide support in their daily lives.**



## 6. Summary and recommendations

As person-centred care and integration of primary care with community, social and secondary care rapidly seem to be determining the future direction of the NHS, it becomes imperative collaborative care and support planning is core business for general practice, and therefore that we instil the skills that future GPs will require into their training.

We recommend that collaborative care and support planning becomes embedded in the GP curriculum and ideally even earlier in medical schools. Trained GPs need to not only have basic communication skills but an understanding of individuals in the wider psychological and social contexts of living with LTCs and how best to integrate their care in a person-centred way. The art of care planning can then be utilised not only for LTCs, but management of multiple morbidities and end of life planning. The core statement of the RCGP curriculum, 'Being a GP'<sup>17</sup>, begins by highlighting the requirement of the 21st century GP to provide care to an increasingly complex population with multiple health conditions. It is on this basis that collaborative care and support planning becomes such a crucial skill in the GP toolkit and it is for this reason that it is becoming such an integral part of the general practice curriculum. Whether as a continuous theme throughout the curriculum or a stand alone module, the skills and knowledge required for collaborative care and support planning are innovative and going forwards it will be necessary for GPs to be trained in this way of working.

General practice has always focused on building the doctor patient relationship through continuity and trust, but because of an imposed activity driven payment model it has strayed into a box ticking system, where numerical results have become a determiner of good patient outcomes. But who for? We know an excellent cholesterol level does not always match an improvement in quality of life. However we do know that the quality of life for both patients with LTCs and their families and carers is improved by an individual's sense of control over their condition(s) and daily life, by addressing any underlying mental health and psychological needs, and by reducing avoidable emergency admissions<sup>18</sup>. Collaborative care and support planning can help to maintain the doctor patient relationship with an emphasis on collaboration and shared decision making, and promoting quality of life. It is imperative that the value of collaborative care and support planning is recognised, and that it is recognised as a core part of primary care.

Medicine is a science, with well documented evidence based treatments. But it can also be an art. The art is building relationships and understanding them. It is enabling others to reach their full potential in life. Embracing person-centred care gives GPs time to regain some of these skills and regain some clinical autonomy, using their expertise and knowledge to benefit patients in a joint decision and sharing process. We believe this is achievable, and by developing and allowing primary care to work within new integrated teams we can rekindle the fire in general practice.

<sup>17</sup> <http://www.rcgp.org.uk/training-exams/gp-curriculum-overview/online-curriculum/1-being-a-gp.aspx>

<sup>18</sup> NHS England *NHS Outcomes Framework*: <https://www.england.nhs.uk/resources/resources-for-ccgs/out-fnrk/>



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