

## Summary of learning

- Care planning is different from disease surveillance alone, or traditional care provision; it needs specific systems to be in place and HCPs to have specific skills
- Care planning is not just a process to roll out, but requires changes in culture and systems and high level organisational support
- The case for change, underpinning philosophy and potential benefits are compelling, but it is difficult to change established systems and clinical behaviour
- Some cynicism existed as to whether this was driven by policy requirement rather than clinical need; at the same time there was recognition that implementation needs increased imperative and/or incentivisation
- Developing skills to support self-management and collaborative consultations requires increased awareness of approach, reflective practice and specific skills training, which not all HCPs find easy, and often requires ongoing training and support
- The ultimate aim should be for individuals with multiple LTCs to have one care planning appointment encompassing their entire health and wellbeing needs, but making this happen needs further work and careful thinking
- A first step may be to start with implementing care planning in diabetes, and then extending into other specific conditions



One of the challenges with LTCs is we have worked hard to improve the systems or clinics we already have in place, and often that's all patients have come to expect. However the evidence is clear that people don't always feel involved in their care and may not feel able or confident enough to manage their conditions and would like more information.

As you consider whether your practice, service or organisation is doing all it can to support people with LTCs, consider the following:

1. Do you have systematic call and recall for planned, proactive review most people with LTCs? If not, what could you do to ensure that people that would like or benefit from a proactive appointment could receive one?

2. Do you have systems in place to help people 'prepare' for these appointments (agenda setting prompts, or results where appropriate)? If not, what could you do to address this?
3. Have the clinicians attended specific skills awareness and training to support self care and enable partnership working? If not, is there training they could access?
4. Do you routinely measure consultation quality and whether people feel involved in decisions and confident to manage their condition? Do the surveys you currently use help you understand this? Could you incorporate other measures to understand it better?

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## Care planning in long term conditions

Doing *with*, rather than doing *to*

Long term conditions (LTCs) continue to receive particular emphasis within the plans for NHS reform and within the QIPP agenda and understandably so: people with LTCs are the highest users of healthcare services. Fundamental to the case for change is the understanding that LTCs are different. The acute, biomedical model of healthcare simply does not apply.

Truly transformational change is required in order to work more in effective partnership with patients and supporting them to develop confidence and competence in managing the challenges of living with their LTCs, aiming to improve quality of life and clinical outcomes, and enable more effective and appropriate use of health and social care resources.

The evidence for a system that fails to support people living with LTCs is very clear. We are not achieving the health outcomes to which the NHS aspires. People living with one or more LTCs report a poor understanding of their health or treatments, not feeling involved in decisions, experiencing fragmented or difficult to access services which results in an ongoing dependency on the health service. As a consequence, people living with LTCs are the highest consumers of health and social care resources.

Care planning is a fundamental part of transforming the services and support offered to people with LTCs, and a central tenet of health policy over recent years.

The Diabetes Year of Care (YoC) programme has demonstrated that care planning can be delivered routinely, using diabetes care as the exemplar, with significant improvements demonstrated in experience for patient and clinicians, outcomes and productivity. For further details see the YoC website (see back page).

The challenge of transferring this into LTCs can not be overstated. Structured approaches to planned care were already in existence in diabetes; care planning essentially became an extension of the usual annual review. However, the issue was how to provide planned, proactive care in settings outside of diabetes, where such systems are not widespread and, particularly in individuals with more than one long term condition.



### Learning from the north east LTC pilot

The care planning in LTCs pilot across the north east engaged primary care clinicians to extrapolate the learning from the Diabetes Year of Care programme into the context of people with one or more LTCs.

The pilot aimed to help clinicians and commissioners achieve a good understanding of what works well and also identify the challenges and how to overcome them.

Ten GP practices formed a learning collaborative to share ideas and experiences over a 12 month period:

- Auckland Medical Group, County Durham
- Burn Brae Medical Group, Hexham
- Dr Cloak and Partners, Sunderland
- Felix House Surgery, Darlington
- Lane End Surgery, Newcastle upon Tyne
- Wawn Street Surgery, South Shields
- Weardale Practice, Weardale
- Wellway Medical, Northumberland
- West View Millennium Surgery, Hartlepool
- Westoe Surgery, South Shields

For more details contact:  
Simon Eaton LTC Clinical Lead [simon.eaton@nhct.nhs.uk](mailto:simon.eaton@nhct.nhs.uk)  
Mathew Thomas Project Manager [m.thomas5@nhs.net](mailto:m.thomas5@nhs.net)

For further information  
[www.theclinicalnetwork.org](http://www.theclinicalnetwork.org)  
[www.diabetes.nhs.uk/year\\_of\\_care](http://www.diabetes.nhs.uk/year_of_care)

This programme was supported by NHS North East Innovation Funds and included project management, patient focus groups, piloting a patient survey, developing a clinician training programme and a detailed formative evaluation with Community Health and Education Studies (CHESs) Research Centre from Northumbria University.

Each person should be offered a planned, proactive appointment to review current overall care and plan forwards

**Key learning:**

Whilst it was recognised that this approach should be offered to all people with LTCs, it was possible that not everyone would wish to take it up.

One size will not fit all - a flexible, purposeful approach is required.

“ I think (the training) has made us think a lot more about the way we structure our appointments ... I think already it's had an influence on us listening more and asking open questions rather than just giving information which is what we've done in the past. I do feel we've always involved the patients but we have always taken the lead I suppose and now we're maybe stepping back a little bit more than we were, and listening more. ”

**Ongoing challenges:**

This seems to work in diabetes, and may work in other specific conditions such as COPD, but how do we do once for someone with multiple conditions?

Who does the patient see? There is a tension between the biomedical knowledge needed to support someone with multiple conditions, and the consultation skills for care planning to support an individual to self manage their conditions effectively.

How to define the population with LTCs? There was concern that people who might benefit, but are not on the major disease registers, may miss out. One option is to code individuals who would like or benefit from care planning in the future.

What systems need to be in place for different groups (such as frequent attenders, non-attenders, specific disease groups) and how to target to people who may get most benefit?

The person should be adequately 'prepared' to enable them to participate in the consultation to the degree they wish

**Key learning:**

This was seen as the most important component as it signalled a change in the system and expectations for the patient, and enabled a change in dynamic in the consultation (the patient's agenda becoming more prominent).

Using the 'Making the most of your appointment' agenda prompt, which was developed with patient focus groups, was valuable - helping people clarify questions and enable a more proactive role in the consultation.

**Care planning in long term conditions**  
Care planning is different from disease surveillance alone, or traditional care provision; it needs specific systems to be in place and HCPs to have specific skills.

It is difficult for the patient to be 'prepared' unless the appointments are planned and the systems to enable preparation are in place.

**Ongoing challenges:**

In diabetes, sending biomedical results has been extremely valuable, but we need to establish what biomedical data adds value in other conditions, how to share it effectively and how to put systems in place to collect and share this prior to the care planning consultation.

Many conditions don't have biomedical markers, and the agenda setting prompt may suffice.

“ We're trying to plan it more generically so one of the things we've been doing is really try to get those tools, so get the communication right for patients, get the documentation right for health professionals to make sure that there's a structure to the whole process as opposed to it being a little bit open ended and potentially wasteful. ”

Healthcare professionals (HCPs) should strengthen the skills they need to work in partnership and provide self-management support

**Key learning:**

Care planning requires a different way of working and skills than usual 'reactive' care. These may not come naturally to many clinicians and may not reflect previous training. The philosophy and skills were identical to those provided by the Diabetes Year of Care (YoC) training programme and the opportunities to reflect on approaches, philosophy and skills were greatly valued by the clinicians. Using simple patient questionnaires to measure consultations was seen as valuable.

“ Before it was very much the doctor's agenda. We set out the scene, in such a way that we thought was the best for the patient so we went on and discussed areas which we felt were important. Care planning involves sharing information, sharing data and we come together with the priorities - so the priorities could be slightly different, but there will be a lot of negotiation between the doctor and the patient. ”

**Ongoing challenges:**

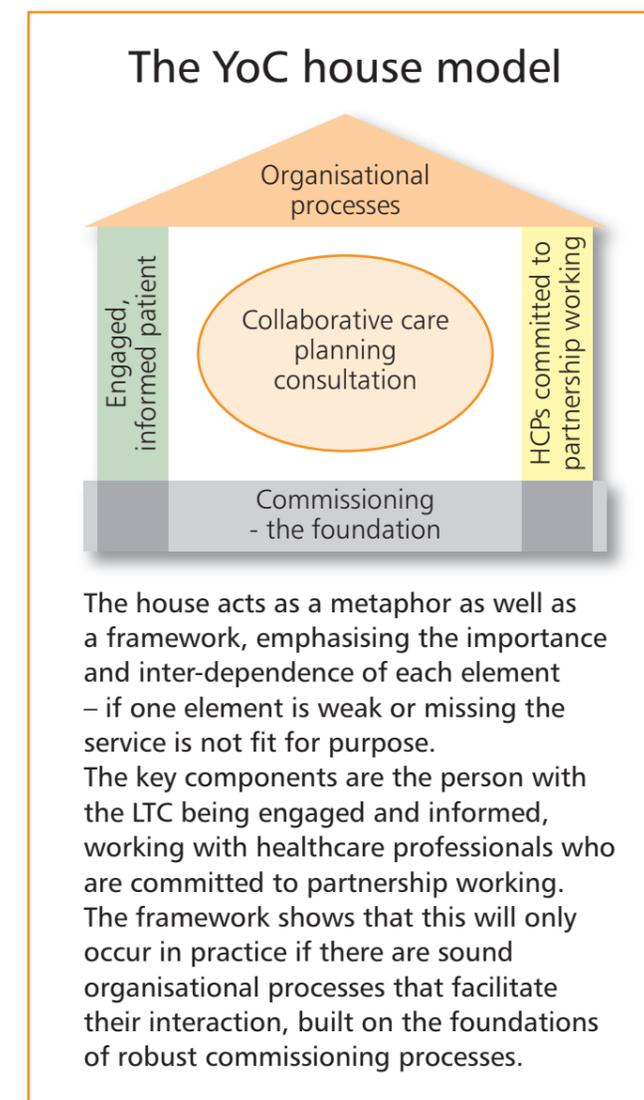
Whilst clinicians recognised greater insight into their current practice and potential ways to improve, they still found it difficult to change established behaviours and implement these - ongoing training needs were identified.

There is a need for individuals to be able to routinely measure their consultations and the value patients get from these, to clarify training needs and further professional development.

Implementing care planning requires a whole system approach exemplified by the 'house' model

**Key learning:**

Care planning consultations can not be seen in isolation, but need to be supported by other system changes, such as patient education, emotional and psychological support or patient access to medical records.



The house acts as a metaphor as well as a framework, emphasising the importance and inter-dependence of each element – if one element is weak or missing the service is not fit for purpose. The key components are the person with the LTC being engaged and informed, working with healthcare professionals who are committed to partnership working. The framework shows that this will only occur in practice if there are sound organisational processes that facilitate their interaction, built on the foundations of robust commissioning processes.

“ We gradually moved on to be less reliant on the results. We use the 'Making the most use of your appointment' leaflet to pick out things which are important for the patients. ”