

NHS Modernisation Agency

Good care planning for people with long-term
conditions: updated version

September 2005

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1.0 Project aims and approach

Following the publication of the National Service Framework for People with Long-Term Conditions (NSF)¹, Matrix was commissioned by the NHS Modernisation Agency to identify and report on the key elements of good care planning for people with long-term conditions. The NSF focuses on neurological conditions. While this was also the key focus of the project, it was agreed that our findings should also be more widely applicable to people living with other long-term conditions.

The key objective of the project was to produce user-friendly guidance and tools to assist local health and social care service providers to implement evidence-based, person-centred care planning for people with long-term conditions. The guidance should be based as far as possible on existing, effective approaches already in use². This report begins with a context-setting discussion and then sets out the benefits of care planning, the barriers to successful implementation and the critical success factors. The appendices contain good practice case studies and a self-assessment toolkit to help the development and implementation of care planning.

Our approach to achieving this project involved engaging a wide range of stakeholders in face to face interviews, telephone interviews and a workshop. While not necessarily representing the views of the groups from which they came, those involved were able to provide perspectives from the following organisations or groups:

- Department of Health;
- NHS Modernisation Agency;
- National Diabetes Support Team;
- Brain and Spine Foundation;
- Headway;
- Carers UK;
- NHS Connecting for Health;
- Long-Term Conditions NSF external reference group (ERG); and
- Integrated primary and social care teams.

This work is therefore intended to contribute to and link in with a wide range of other initiatives to create person-centred health and social care services. Some of the main initiatives are set out in section 3.2.

¹ Available at <http://www.dh.gov.uk/assetRoot/04/10/53/69/04105369.pdf>

² Tender specification

2.0 Summary

Care plans, care planning and the “care programme approach” have variously been introduced and promoted across health and social care as a means by which care for people with long-term conditions or vulnerabilities can be tailored to individual needs and involve the individual in their development.

There are a number of potential benefits to implementing successful care planning, including continuity of care, managing risks for both the individual and the organisation and helping individuals to control and manage their condition. All of these can potentially help to achieve other service targets, generally those contained within moves towards developing a person-led service and specifically the public service agreement (PSA) target to improve health outcomes for people with long-term conditions through personalised care planning.

There are also barriers which hamper the efforts expended to implement care planning successfully. These include workforce issues such as training, skills and experience in delivering care planning, the challenge of cross-boundary working and incentive structures, all of which require substantial organisational change to overcome them. This report contains discussion and guidance which aims to help organisations to work to remove the barriers to implementation. Figure 1 summarises the scope of the guidance contained within the report.

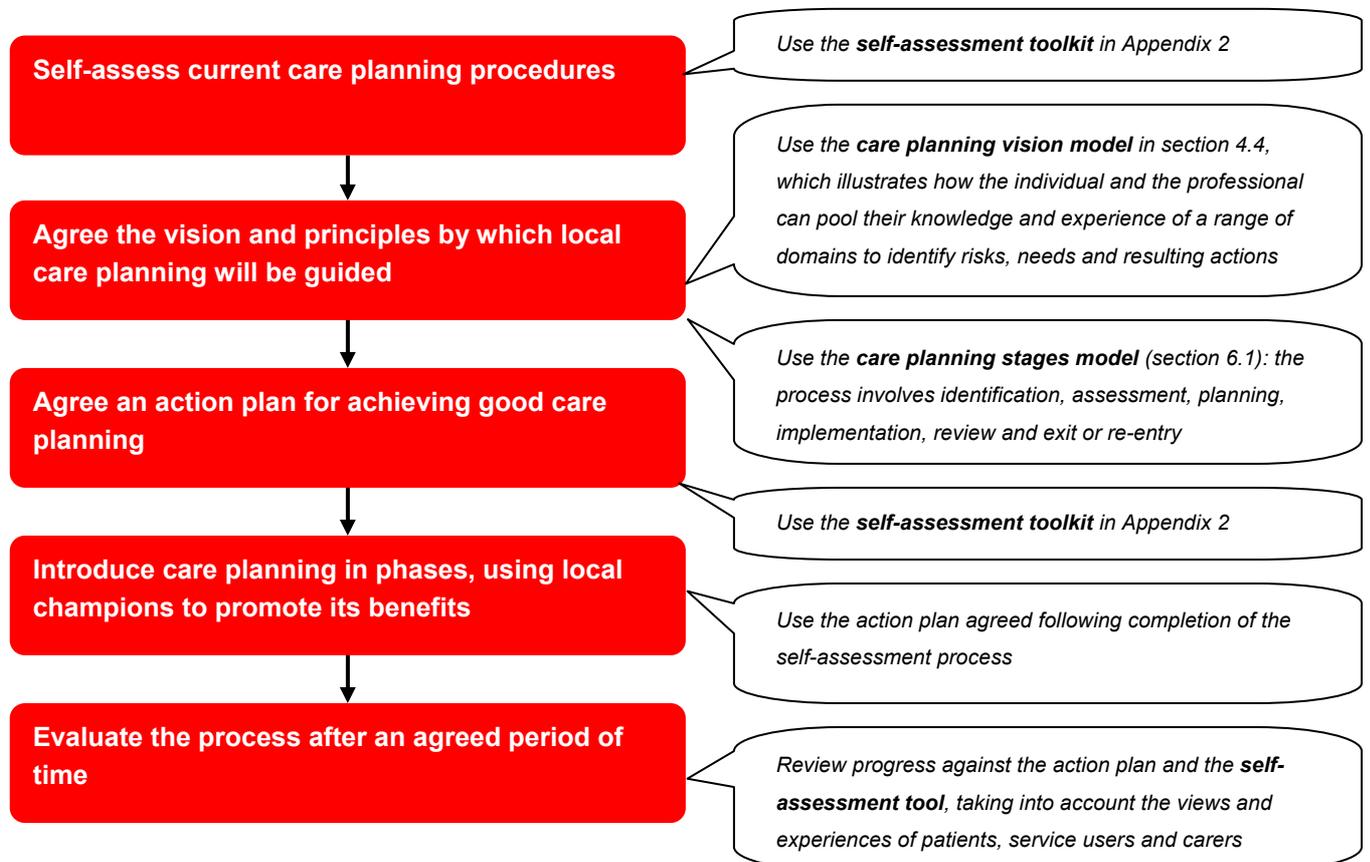


Figure 1: Scope of key elements of good care planning and guidance provided within this report

3.0 Context

The development of an effective, person-centred care planning process is increasingly seen as one of the most important ways in which health and social care can be transformed into integrated services with the individual or their carer at the centre of the package of care. This section summarises what is meant by the terms “care plans” and “care planning”, and also discusses how these link strategically with other ongoing service improvement initiatives in health and social care.

3.1 Care plans and care planning

3.1.1 Person-centred care

The two strongest views which emerged from this work were that care planning should be regarded as a process rather than a physical item, and as a means to an end, rather than an end in itself. It is therefore about the negotiation, discussion and decision-making that takes place between the professional and individual rather than about the document which might be produced recording the process. Furthermore, the process needs to be embedded in a person-centred culture³, so that professional and organisational boundaries, which may be meaningless to people with long-term conditions, do not create artificial barriers. Likewise, the care plan itself needs to be worded in a way which is accessible both to the person who owns the plan and to all professional disciplines using it. Consultation undertaken as part of this project revealed that care planning of this nature is not taking place widely.

3.1.2 Flexible and responsive care planning

Even within the Long-Term Conditions NSF, which focuses on people with long-term neurological conditions, the range of needs and complexity of conditions experienced by people is vast. Beyond the NSF, the wide membership of the Long Term Conditions Medical Alliance⁴ demonstrates the diversity of conditions for which care planning is intended to be an option. National guidance on approaches to care planning must therefore be flexible and responsive enough to offer the appropriate level of intervention and involvement for each person, and to be able to increase or decrease the intensity of care as their well-being improves or deteriorates. Where a person's condition goes into remission sufficiently for them to be able to exit from the care planning process altogether, there needs to be a facility for them to re-enter the system easily, should they need to do so, and the professionals involved need to be able to respond to this according to the needs of the individual.

Care planning can usefully be seen as a dynamic route map, developed in collaboration between the individual and the professionals involved, and guiding all those involved through the process of care. The views collected as part of this project have been formulated into a number of key elements and principles of care planning, which are set out in section 6.1.

³ See for example Quality Requirement 1: a person-centred service, in the Long-Term Conditions NSF.

⁴ <http://www.lmca.org.uk/docs/members.htm>

3.1.3 Care planning: current progress

The concept of applying a joined-up and coherent approach to organising the way in which care or services are provided for individuals living with long-term conditions or vulnerabilities has been explored and pioneered over a number of years across a wide range of disciplines. Evidence gathered as part of this project, and the views expressed by our stakeholders, suggest that this has occurred with varying degrees of success, and section 5.0 includes a discussion of the barriers preventing wide implementation of good care planning.

3.2 Strategic links

For care planning to achieve both its focussed aims (co-ordinated and appropriate care over which the individual has control) and its wider goals (contributing to other initiatives and drivers) it is important that work towards doing this takes place in strategic co-ordination with a number of other initiatives and guidelines. Contributors emphasised the importance of ensuring that new guidance on care planning does not present those implementing it with a whole new set of concepts, and that any guidance should complement that which is already in circulation.

3.2.1 The NHS and social care model for long-term conditions

The guidelines set out here are consistent with the components of the Department of Health's health and social care model for people with long-term conditions⁵, in which a tiered approach to care was established, as follows.

Level 1: Supported self-care	Individuals and their carers who are able to be supported to develop the knowledge, skills and confidence to care for themselves and their condition effectively.
Level 2: Disease-specific care management	Providing people who have a complex single need or multiple conditions with responsive, specialist services using multidisciplinary teams and disease-specific protocols and pathways, such as the National Service Frameworks and Quality and Outcomes Framework.
Level 3: Case management	People with highly complex multiple long-term conditions who require a case management approach to anticipate, co-ordinate and join up health and social care.

Figure 2: The NHS and social care model for long-term conditions

There is a role for care planning (with differing degrees of intensity) at each of these three levels, and indeed, care planning can act as the vehicle for facilitating movement of individuals between the levels of care. The implication of this for health and social care organisations is to ensure that workforce and financial resources can meet the needs of individuals at the level within the model that they require, and that movement between the levels is facilitated rather than restricted by such considerations.

⁵ *Supporting people with long-term conditions: an NHS and social care model to support local innovation and integration* (<http://www.dh.gov.uk/assetRoot/04/09/98/68/04099868.pdf>)

3.2.2 National Service Frameworks

As indicated by the project brief, the NSF for Long-Term Conditions has been one of a series of catalysts in the most recent efforts to develop person-centred care, in which good care planning can play a part. The practical implications of person-centred care are that people need to be better informed about their condition and the options available for managing it. It is also hoped that improved care in primary care and community settings will also reduce the emergency admissions of vulnerable people with long-term conditions.

While all people living with long-term conditions will consciously or not be managing their condition to some extent, the Expert Patients' Programme⁶ has been initiated to help people become expert in managing their own condition with more confidence, skills and knowledge, which, at the end of the scale with minimal professional intervention, can be termed "self-care".

However, the long-term conditions NSF has a key focus on care for people with neurological conditions, and it was emphasised during the interviews and workshop by members of the NSF external reference group and others representing people with neurological conditions that "self-care" is not necessarily a term which is used for or by people living with some neurological conditions.

There is however a strong case to be made for facilitating greater self-care and self-management of care among people living with other long-term conditions such as diabetes. It is therefore important that this work is sensitively linked with the Diabetes NSF⁷ and the ongoing work to support its implementation being undertaken by the National Diabetes Support Team⁸.

Likewise, the Department of Health is working towards the requirements of the Treasury's public service agreements (PSAs)⁹ – of particular relevance is PSA target no. 4, which focuses on:

- improving health outcomes for people with long-term conditions by providing a personalised care plan for those most at risk. This is intended to reduce emergency bed days by five per cent by 2008 and improve care in primary care and community settings for people with chronic long-term conditions.

3.2.3 NHS Connecting for Health

Part of the process of helping people to achieve greater control over the management of their care involves giving them and the professionals working with them much easier access to their medical records. While in the short to medium term this can take the form of physical "person-held records" that are most commonly held on paper at the moment, the longer-term aim is for

⁶ <http://www.expertpatients.nhs.uk/>

⁷ <http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Diabetes/fs/en>

⁸ <http://www.cgsupport.nhs.uk/diabetes/default.asp>

⁹ http://www.hm-treasury.gov.uk/media/4B9/FE/sr04_psa_ch3.pdf

such records to be held and transferred electronically as part of NHS Connecting for Health¹⁰ and Healthspace¹¹, where it is intended that people will be able to keep their personal health records updated online. Discussion on this at the workshop centred on the need to ensure that care planning is integrated within this initiative, but without this resulting in a loss of flexibility and specificity in the care planning process. Care planning needs to be congruent with moves towards achieving these goals, including guidelines on the sharing of personal information across professional and organisational boundaries.

3.2.4 Single Assessment Process for older people

As discussed in more detail in section 6.0, part of the care planning process involves undertaking an assessment of the individual's needs, and it is important that the approach to this fits with both the moves towards person-centred care and with existing approaches to assessment. Notable among these is the Single Assessment Process for older people¹², which attempts to avoid duplication in the assessments undertaken of older people's needs in relation to different aspects of their health and well-being. There is also a piece of work being undertaken within social care, as part of the recent social care Green Paper¹³, entitled *Streamlining Assessment*, which is exploring ways of making social care assessments more comprehensive.

3.2.5 Choice

In an environment in which integration and appropriate sharing of information is seen as paramount, it can seem as if there are no limits to the areas with which guidance on care planning must be strategically-linked; however, the final key area which should be highlighted is that of the choice agenda. While this is obviously closely related to the development of person-centred care, there are practical implications which are currently at an early stage of development in primary and community care which could be affected by care planning processes. As set out in a recent article¹⁴, it appears that one possible approach to making choice a reality beyond secondary care being considered by the government is for people to control their own budgets for commissioning long-term care. "Direct payments" already take place in social care where the person agrees, and it is possible that healthcare for people with long-term conditions could at some point be provided on a similar basis. It is therefore important

¹⁰ <http://www.connectingforhealth.nhs.uk/>

¹¹ <https://www.healthspace.nhs.uk/index.asp>

¹² <http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SocialCare/SingleAssessmentProcess/fs/en>

¹³ <http://www.dh.gov.uk/assetRoot/04/10/64/78/04106478.pdf>

¹⁴ "Patients could get their own budgets, Number 10 says". *Health Service Journal* 19 May 2005

that guidance on care planning should be capable of accommodating developments such as this.

In conclusion, there is a wealth of different initiatives with which it is important that care planning interconnects, in order for implementation to be achievable and coherent.

4.0 Benefits of care planning

Good care planning can bring benefits to the professionals delivering care and the organisations involved as well as to individuals.

4.1 Continuity of care

Good care planning can improve continuity of care, partly through improving communication within what can be a complex network of people and organisations. Continuity of care can be beneficial for people with long-term conditions as well as to the organisations and people involved in their care (potentially helping to meet the PSA target on reducing emergency bed days, for example). Care planning which is undertaken as a process of collaboration and negotiation between professionals and the individual helps to hand control to the individual, through bringing together professionals from different organisational and geographical boundaries as well as providing a “map” which is owned by all those involved.

4.2 Risk management

It was also felt that care planning is a good way of identifying and managing the risks associated with a person’s individual condition and living needs in a structured and co-ordinated manner and that this would be identified as a specific part of the assessment, and strategies for overcoming them developed as part of the care plan.

4.3 Helping people manage their own condition

According to circumstances, care planning can either support self-care or provide support to people living with their condition, and this again may be of benefit both to individuals, through giving them more control, and to organisations, through reducing the pressure on resources. This can be achieved through individuals being able to make decisions and administer care themselves or through a carer, and becoming experts in managing their condition and, for example, reducing the need for interventions.

4.4 Visualising good care planning

Participants in the workshop devised a model to illustrate how care planning can and should be used across different disciplines to achieve these benefits.

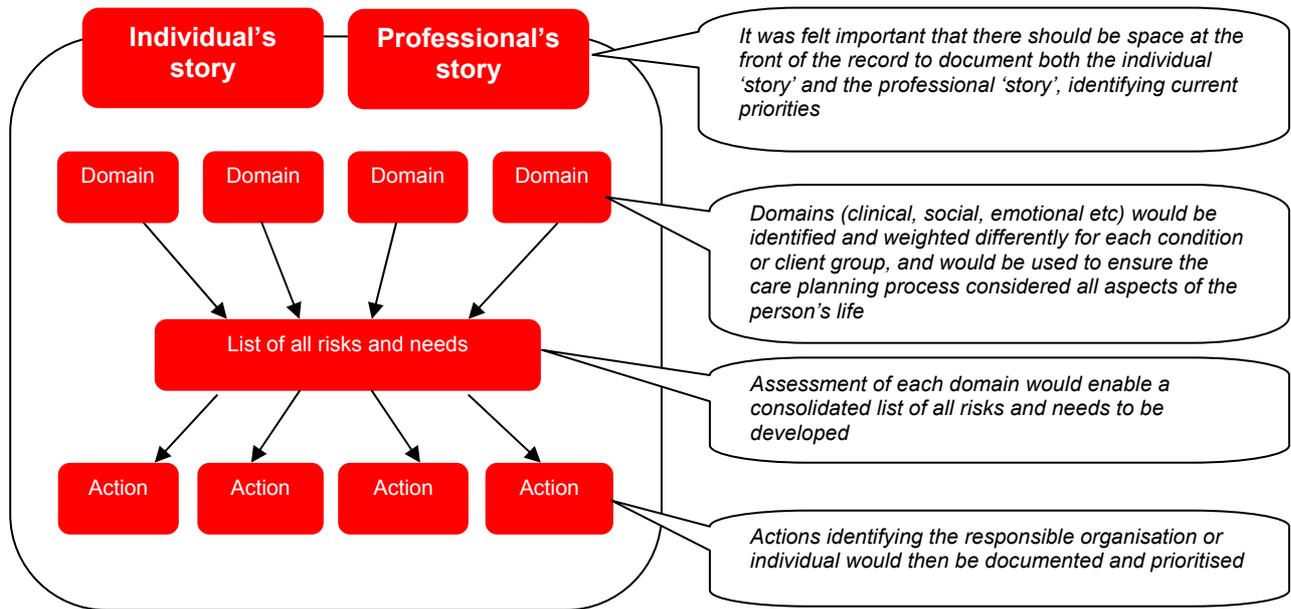


Figure 3: Care planning vision model

5.0 Barriers to the implementation of good care planning

Stakeholders reached the view that there are barriers preventing good care planning being successfully implemented, some of which apply generally to care planning and some of which relate more specifically to particular long-term conditions.

Perceptions of “care planning” can vary across organisations and disciplines and it was suggested that some activities that may get called care planning do not actually fulfil some of the core requirements, particularly those concerning putting the person at the centre. Without a clear and common understanding of what care planning should involve it is not possible to achieve successful implementation.

It was felt that in many places where care planning does exist it tends to address discrete stages in the condition rather than taking a comprehensive or holistic approach to the conditions experienced. This will restrict the extent to which the intended benefits of care planning can be realised. It was felt to be particularly important to establish not just whether care plans exist for patients but how the plans were developed and who was involved in their development.

5.1 Training, skills and experience

Staff with responsibility for developing care plans have often not been provided with sufficient opportunities to acquire the skills required to lead the process in a way which helps the individual reach decisions and results in a mutually-owned approach to care. Likewise, among individuals, the understanding of what care planning is or could be was reported as variable, which is perhaps not surprising in circumstances where practitioners’ skills and knowledge is inadequate. Allied to this, participants in the workshop commented that some individuals may be resistant to the introduction of care planning into their established care routines and that this viewpoint should be respected.

5.2 Use of appropriate language

The language used both in the discussions that take place in care planning and in the documentation itself can often be insufficiently person-centred with the result that the overall process is conveyed as being service-led and clinically-focussed. Linked with this was the view that care plans are sometimes wrongly confused with person-held records and are simply seen as a means to store information for different professionals to interpret rather than for the individual concerned.

5.3 Developing effective ways to work across boundaries

The challenges of persuading people to work across professional, organisational, sectoral and geographical boundaries, including sharing information where appropriate, can diminish the realisation of some of the benefits of care planning. While this is also linked to the language issues reported above, where terminology employed by particular professions excludes others, another important aspect is the challenge of reaching agreement between the individual and different practitioners and agencies on what information should be shared and with whom. Holding information on paper also creates a barrier to the transfer of information between organisations.

5.4 Incentives

Participants in the workshop strongly felt that there is a lack of incentives available to professionals and organisations to implement good care planning, partly because the benefits described in section 4.0 may not be immediately realisable by professionals or their own organisations. It was also felt that there might be a misperception that care planning might be overly administrative and with too great an emphasis on non-clinical aspects, which might act as a perverse incentive for those focussing on the clinical domain.

5.5 Unpredictable course of conditions

It was felt that there are particular features of some neurological conditions that may have a less predictable course than a generic approach to planning might foresee (with some conditions going into remission, for example). This presents a challenge for care planning to be sufficiently flexible to allow easy exit and re-entry as required by the individual.

5.6 Time pressures

Many practitioners face growing caseloads with which a large amount of bureaucracy is associated. It was felt that this was particularly the case in social care but also in other professions, and that this often prevented sufficient time or attention being given to care planning.

6.0 Critical success factors

Stakeholders identified a number of factors which it is essential to achieve in order to implement care planning successfully. These factors centre on the elements and principles which should accompany good care planning. A suggested approach to achieving these within the wider context of initiating care planning within an organisation from a low or non-existent base is set out in section 7.0. Examples of how this has been achieved in health communities across the country are contained within Appendix 1.

6.1 Key elements and principles.

There are a number of key stages in the process of care planning, which would be present in almost all manifestations of care planning:

- entry into the system;
- assessment;
- development of care plan;
- implementation of care plan;
- review; and
- exit and/or re-entry or recall into the system.

These stages can be linked together into the following care planning model:

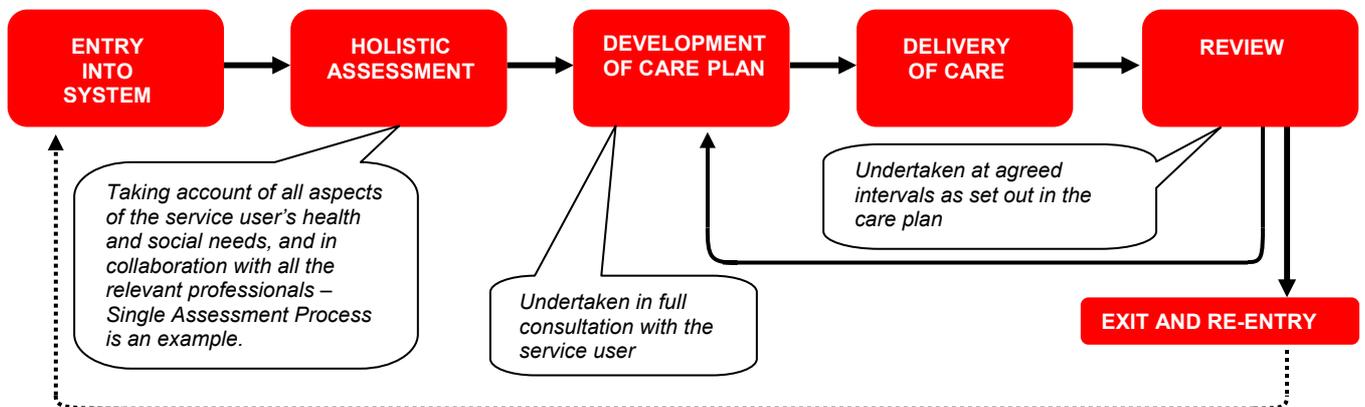


Figure 4: Care planning stages model

Within each of these stages there are both elements and key principles, validated by the workshop participants, adherence to which it is believed is necessary in order for care planning to be successful. The table below contains all the elements and principles which have been identified. There are also a number of over-arching elements and principles which apply to the whole process rather than to specific elements.

	Elements / tasks	Principles
Entry	<ul style="list-style-type: none"> • Identification of person in potential need • Acquire relevant contact details 	<ul style="list-style-type: none"> • Information should ideally be recorded once to avoid duplication, and shared as appropriate
Assessment	<ul style="list-style-type: none"> • Identification of key worker / single contact • Person and professional agree what the assessment and care planning process is meant to achieve (outcomes) • Holistic identification of needs and risks, including those of carers where appropriate 	<ul style="list-style-type: none"> • Assessment should begin with the person’s “story” (what’s new, what’s good, what’s tough etc.) issues, evidence, experience) and the professional’s “story” (issues, evidence and experience). • Holistic approach to assessment – covering all domains (clinical, social, psychological, lifestyle)
Develop care plan	<ul style="list-style-type: none"> • Prioritisation of issues by care planner and person • Development of action plans for the service and the person • Identification of any equipment required 	<ul style="list-style-type: none"> • Care planner / co-ordinator requires adequate training and experience (including the capacity to discuss risk) • Care planner / co-ordinator requires access to up to date evidence and information including a directory of potential resources • Care plan to be designed with and for the person and shared with carers / family if appropriate • Care plan should address how to live with the condition (social as well as medical) • Care plan must be flexible to meet a wide range of needs and conditions • Clarity required between holistic and specific care to be provided • Care plan to be held by the individual and accessible by both them and the professionals.
Implement care plan		<ul style="list-style-type: none"> • Work as a team to provide care, not as a series of unconnected individuals • Services and support should follow the care plan
Review	<ul style="list-style-type: none"> • Review and update action plans at agreed time periods • Care plan should be reviewed and if necessary continued or modified at agreed intervals, changes documented 	
Exit/ re-entry	<ul style="list-style-type: none"> • Discharge to self-care where appropriate, with clear routes back to more intensive professional interventions • End of life plan (where appropriate). 	
Over-arching elements and principles	<ul style="list-style-type: none"> • Process should be evaluated by organisations to identify areas for improvement • Process and decisions taken should be recorded and documented 	<ul style="list-style-type: none"> • Empowering professionals • Process led / endorsed from the top and aligned with wider targets for staff and organisation • Process joins up working and information-sharing across professional and organisational boundaries • Individual feels like and is seen as a whole person – not just a patient or service user • Process is transparent for all those involved • Process should provide emotional support to the individual (and their carer, where appropriate). • Process is ongoing, not a one-off event

Figure 5: Key elements and principles of care planning

7.0 Conclusion: making care planning a reality

The purpose of this project has been to identify the common themes in good care planning for people with long-term conditions. In doing this, we have established that there are a number of benefits to be realised from good care planning, but many barriers hindering successful implementation.

This final section explores how organisations can work towards overcoming barriers such as those outlined above and successfully implement care planning. A number of stages have been identified in the process of achieving this, as shown in figure 6:

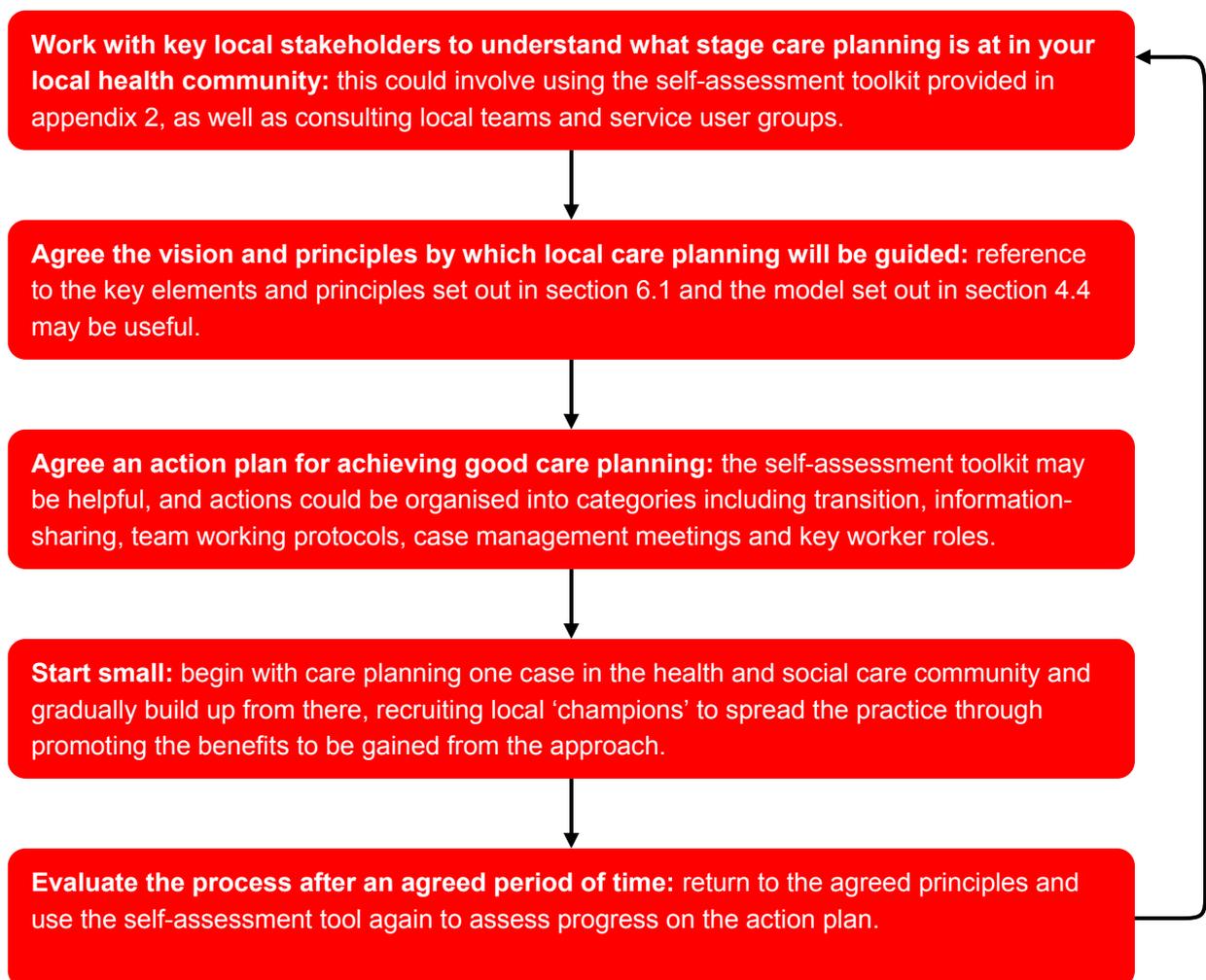


Figure 6: Staged process for achieving successful care planning implementation

Appendix 1 comprises a number of case studies illustrating how care planning approaches have been successfully implemented in a number of different contexts. Appendix 2 is a self-assessment toolkit for use by organisations wishing to assess their care planning arrangements against elements and principles which should be common to most approaches to care planning.

8.0 Appendix 1: case studies

The main focus of this report has been on the ideal approaches to care planning, representing what might be regarded as a 'gold standard'. It may be useful however to disseminate real-life examples of where care planning is actually being implemented with some degree of success, if only to demonstrate that successful implementation can be more than just an aspiration.

Case study 1: Shared Care Plan, Hounslow

The vision

Under the Single Assessment Process (SAP), there is a need to share an integrated Health and Social Care Plan of the outcome of the assessment, subject to consent, with the individual, their carer(s) and the Care Team involved.

The format of Hounslow's "Shared Care Plan" has been designed to link in with person centred care, the single assessment process and now long term conditions. It is being used when a holistic assessment has taken place (in Hounslow, the FACE Overview assessment is being used).

The idea of the "Shared Care Plan" is that the information is owned by the assessed individual and is the foundation of the person held record. With the individual's consent, it should be made available to those who have contributed to the assessment, and those providing services. It can then be supported by more detailed information for those that require it.

Whenever possible, the assessed individual (with capacity) will play a key role with their care coordinator in managing his or her own care. They should be encouraged to actively participate, with their doctors, nurses, social workers, therapists, pharmacists and others (including the voluntary and independent sector) – all working together to achieve the best possible outcome(s).

Designing the care planning document

The original idea for the "Shared Care Plan" came from a self-management tool that has been developed as part of the 'Pursuing Perfection Project' in Whatcom County, Washington, USA¹⁵. The "Shared Care Plan" has now been placed on the Institute for Healthcare Improvement web site¹⁶.

The original process of developing the tool incorporated a review of other SAP care plans already in use. Managers, practitioners/clinicians and the people they work with in Hounslow were involved in the development of the original care plan and again with Version 2.

Version 1, 'My Shared Care Plan', was placed on the Centre for Policy on Ageing website¹⁷.

¹⁵ <http://www.patientpowered.org/>

¹⁶ <http://qualityhealthcare.org./qhc>

¹⁷ http://www.cpa.org.uk/sap/sap_careplanning_list.html

Version 1.2 (also on the Centre for Policy website) is made up of five separate documents. The documents that must be completed are the integrated Health and Social Care Plan and the Care Team. The other documents should be used as appropriate, in line with best practice and service requirements. Other service plans can follow as necessary.

1. Health and Social Care Plan

- This integrated document contains the conclusions on risks and needs from the Overview assessment.
- It also includes the abilities, strengths and preferences of the individual and state how they might be able to be fulfilled.
- Basic Personal Information should sit on top of this document so that it does not have to be taken again.
- Information about the Care Team providing services should always be attached.
- To be shared with the individual, their carer(s) and the care team involved from health and social care.

2. Care Team

3. Timetable of Care

When there is a need for complex care arrangements – optional.

4. Contact List (including emergency numbers)

Contact list for the assessed person and their carer(s) – optional.

5. Service Plan (Criteria and Charges for Non-NHS Services)

Social Services requirement only: not necessary to share with the care Team. No need for NHS staff to complete.

The Health and Social Care Plan also is being used in the NHS Care Record Service SAP Interim Solution in London.

Implementation

The shared care plan is now being used across adult services in social services, and work is being undertaken with district nurses, community health services, the acute Trust and mental health services to roll out the process to the health sector. The fact that both health and social services have been involved in developing the care planning process supports the implementation of the process across the system(s).

Evaluation

It is planned that the process and the shared care plan document will be reviewed and revised on an ongoing basis, particularly in relation to changes in the SAP and new ways of managing long-term conditions. An evaluation of the process is not yet being undertaken as it is felt that there needs to be a period of “bedding down” to give staff and service users a chance to get used to the new documentation before focusing on operational issues. Initial feedback from clinicians/practitioners is that the new shared care plan has enabled care to become much more person centred.

Case study 2: Nottingham City PCT integrated rehabilitation and intermediate care service**The vision**

In this PCT primary care and social services rehabilitation and intermediate care service operate as a jointly-funded integrated service and have done for some years now. The aim is to provide a service which is advantageous to both staff and service users (older people in need of intermediate care and adults of all ages in need of rehabilitation services), achieved through good communication and co-ordination between nurses, social workers, occupational therapists, physiotherapists and support workers.

Implementation

The team operates as a single multidisciplinary unit, with specialist professional lead roles for certain staff which oversees continuing professional development and issues such as changes in the regulation of each profession within the team.

The process that is implemented and documented is effectively the care planning process in all but name (the use of language is important because of the range of professions which make up the team). So at the end of the Single Assessment Process documentation there is a summary which forms the care plan and which will have been developed as part of the holistic approach to identifying the person's risks and needs. The summary includes identified needs, difficulties, risks, the options discussed (covering resources, interventions, services, meetings, managing identified needs) and recommendations for any ongoing referrals.

Mainstreaming

The service provided is subject to ongoing development – for example the team is keen for the paper version of the Single Assessment Process which they are using to be replaced by an electronic version, and are waiting for it to be developed. Also, there is continuing work to bring patients and service users to the centre of the service, with efforts to involve them in the planning of services. At the moment there is good representation from people who have had strokes, but not yet from other patient and service user groups. As part of their response to the Long-Term Conditions NSF they are working towards offering reviews as a standard part of the service, but this is dependent on having sufficient resources.

Success factors

For the head of the team, success has been evident from the staff within the team, who prefer to work in a more co-ordinated way which is less defined by professional boundaries and more focussed on the needs of the people accessing their services. There has also been good feedback from the people themselves via patient questionnaires.

It appears that the success of the care planning that is taking place is linked to the success of the integrated team, the structure of which has been transformed to a greater extent than may initially be thought practical elsewhere. However, where such multidisciplinary integration can be achieved, it is clearly beneficial in helping to foster a holistic approach to care, within which care planning is a part, as a joined-up team is better equipped to provide a joined-up service.

The team does report some difficulty in making the care plan meaningful for the person – while care is taken with all the documentation to ensure that the language is not discipline-specific, it is much harder to ensure that it is also person-centred.

Benefits

The benefits to running the service in this way include patients and service users receiving a service which is not divided by boundaries which to them may be meaningless (for example the boundaries between clinical and social care). The head of the team also reports greater staff satisfaction in this approach to the delivery of care, with much better communication potentially avoiding duplication as well as preventing people falling between the gaps in services.

Case study 3: General practice in Hexham, Northumberland, for people living with diabetes**The vision**

A general practice in Northumberland is piloting a new approach to care planning to promote person-centred care and to ensure that decision making and action planning are genuinely shared between patients with diabetes and the practitioner.

Implementation

The involvement of the patient in the annual review process is aided by patients receiving their test results by post before their review, so that they have time to consider the implications of their results and think about any questions they may have for the practitioner. The patient is also provided with a sheet to write down any questions or issues that they would like to discuss at their review.

The practitioners are being trained to elicit the patient's agenda and support joint decision-making by explaining the risks and benefits of different options in ways that are accessible to the patient. Patients are encouraged to take ownership of the care process and to proactively self manage their condition. Ultimately the patient and practitioner agree a plan of care for the forthcoming year focussing on action planning and goal setting. Information (eg. blood tests, weight etc) is collected, processed and sent to the patient by a Health Care Assistant. The practitioner therefore can concentrate their time in the consultation to achieving the goals listed above. Implementing the process therefore required the addition of some HCA support, but practitioner time was neutral (and more effectively used).

The care plan documentation incorporates a space for the patient to document their 'story' i.e. their concerns and experiences and their current priorities, and for the professional to document their views on the process and the current situation for the patient. On the front page of the care plan the key action points for the patient during the year are documented clearly.

Evaluation

The pilot is aiming to test the feasibility of implementing the approach on a wider basis. Enabling full implementation of the process has involved service reorganisation, which has demonstrated that the success of the scheme has been dependent on the fact that it is part of both individual practitioners' priorities, and organisational priorities. Therefore, the enthusiasm of the practice has supported the success of the pilot.

Whilst the care planning process now takes longer (slight increase in HCA time), it is anticipated that it will result in less frequent contacts with the patient. In addition staff find the process very rewarding because it enables a more satisfying relationship with the patient.

The pilot is using patient satisfaction questionnaires to evaluate the patient experience of the process, and the practice has received positive feedback from these questionnaires. It is likely that this positive feedback is also contributing to the motivation of staff.

The next stage of the evaluation is to test the sustainability of the approach.

Case study 4: Colchester Neuro-rehabilitation team

The vision

The Colchester neuro-rehabilitation team has operated on a multidisciplinary basis for the last ten years, providing a holistic rehabilitation service for people with neurological conditions. The team comprises physiotherapists, occupational therapists, specialist nurses, psychologists, rehabilitation assistance and social workers. Close links are also maintained with the wheelchair clinic, speech and language therapist, orthotics and dietician. There is no 'team leader', but a culture of co-operation and mutual respect across the team. Contributors to the multidisciplinary service are managerially accountable to their respective heads of discipline but are co-related and clinically accountable to the consultant clinical neuro-psychologist.

Operation

The team operates through a clear set of processes which centre on the progress of the individual through the system. Each new referral is discussed at the team's weekly meeting, at which the results of the single core assessment are shared, needs identified and an agreement reached on which team members should be involved in their care. The single core assessment reflects elements of the single assessment process but was developed locally and covers details including medical history, domestic circumstances, benefits received, mobility, communication and cognitive ability and domestic and care needs.

Once a referral has been accepted, a process of person-centred goal-planning will take place, at which the individual will be consulted on their physical, mental and social ambitions, and these will be discussed along with their carers and all the professionals involved. In some cases the professionals may need to intervene to suggest that some ambitions may not be realistic. A standard one-page form has been developed on which the goals and progress against them are recorded.

In consultation with the individual (and their carer, where appropriate), the team will then identify all the needs the person will have in order to reach the agreed goals. At this stage the person's carers will usually receive training to continue the required rehabilitation procedures on a day to day basis, a transfer of responsibilities which fits well with the direct payments system as the carer who will be in receipt of the direct payment will then have day to day responsibility for all aspects of the person's ongoing rehabilitation.

Review

Each person's rehab plan will be reviewed every three months to assess their progress on achieving their agreed goals. Where the individual has achieved their goals, more demanding goals can be set or they will be placed on a "maintenance service", meaning that they will no longer require such close contact with the service but will be checked on at agreed intervals and will be able to access more intensive services again should they go into remission. As part of the maintenance service, an "SOS service" is available, whereby the individual can call for more assistance if it is required.

Ongoing developments

The service has now been operating successfully for ten years, and it would appear that this provides a good model for other neurological teams to emulate. More recently, the team has worked to develop links with a local inpatient stroke unit, in order to improve patients' experience on discharge, as it had been identified that the condition of stroke patients leaving hospital can deteriorate rapidly without a coherent and responsive approach to their outpatient care. This system has now been successfully implemented.

Success factors

Overall, the spokesperson for the team argued that the key to the success of the service was the pooling of resources across health disciplines and social care, and that the culture of understanding, knowledge-sharing and respect between the different professions was also crucial to achieving that success.

9.0 Appendix 2: self-assessment toolkit

It is intended that this self-assessment toolkit can be used as part of the staged care planning development process outlined in section 7.0.

	Key element or principle	Achieved?	Agreed actions
		<i>Yes/no/partly</i>	
Entry	Is there provision to identify people in potential need?		
	Is there a system to record contact details in other information in a single place?		
	Is there a system to decide how information is shared, when and with whom?		
Assessment	Is a key worker identified for each individual?		
	Do the professional and the individual begin by agreeing intended outcomes of the process?		
	Are needs and risks identified holistically, including those of carers where appropriate?		
	Does the assessment bring together the experience and knowledge of both the professional and the individual?		
	Does the assessment cover all domains (clinical, social, psychological, lifestyle)?		
Development of care plan	Are the issues prioritised by the care planner and the individual?		
	Are action plans developed for the service and the individual?		
	Are equipment requirements or other needs identified?		
	Do all professionals undertaking care planning have adequate, relevant training and experience?		
	Do all professionals undertaking care planning have access to up to date evidence and information including a directory of potential resources?		
	Are the care plans designed with and for the individual, and shared with carers if appropriate?		
	Are the care plans flexible enough to meet a wide range of needs and conditions?		
	Do the care plans draw a distinction between the holistic and specific care to be provided?		
	Are the care plans held by individuals and accessible to them and to professionals?		

	Key element or principle	Achieved?	Agreed actions
		Yes/no/partly	
	Do the care plans address how to live with the condition (social as well as medical issues)?		
Implementation	Do the professionals from different organisations, individuals and carers work as a single team?		
	Can it be demonstrated that services and support received by the individual follow the care plan?		
Review	Are action plans reviewed and updated at agreed time periods		
	Are care plans reviewed and, if necessary, continued or modified, at agreed intervals, and changes documented?		
Exit/re-entry	Is there provision for discharge to total self-care to take place where appropriate, with clear, well-documented routes back into the system?		
	Are end of life plans developed as part of the care planning process where appropriate?		
Over-arching elements and principles	Has the care planning process been evaluated to identify areas for improvement?		
	Is the process, and all decisions taken, documented?		
	Does the care planning process empower professionals?		
	Is the care planning process led/endorsed from strategic levels and aligned with wider targets for staff and organisation?		
	Does the process improve joined-up working and information-sharing across professional and organisational boundaries?		
	Can it be demonstrated that individuals feel they are seen as a whole person and not just a patient or service user?		
	Is the process transparent for all those involved?		
	Can it be demonstrated that the process provides emotional support to the individual (and their carer, where appropriate)?		
	Can care planning be demonstrated to be an ongoing process and not a one-off event?		

Figure 7: Care planning self-assessment toolkit