Arthritis Research UK

Providing answers today and tomorrow

Programme: 'Care planning for people with musculoskeletal conditions'

Time and Date: **9:00-13:00; Thursday 20 June, 2013**
Venue: Unwin Room, Royal Institute of British Architects (RIBA), 66 Portland Place, London

NHS England's Mandate includes a commitment to ensure that 'everyone with a long-term condition … will be offered a personalised care plan ...' Building on the development of care planning and the 'Year of Care' programme in diabetes, there is current momentum to extend the care planning approach across long-term conditions, and to accelerate its implementation in the NHS. At this time, it is important to ensure that all health professionals involved in care planning should be alert to the presence of musculoskeletal conditions as a major comorbidity, and that the benefits of care planning can be fully realised by people with conditions such as osteoarthritis and inflammatory arthritis. This will workshop will consider and help to define the care planning process in relation to musculoskeletal conditions.

Session	Time
Introduction	
Welcome Chair: Alan Silman, Medical Director, Arthritis Research UK	**9:00**
Introduction Alan Silman, Medical Director, Arthritis Research UK Laura Boothman, Policy Manager, Arthritis Research UK	**9:05**
Care planning and the Year of Care Programme Sue Roberts, Chair, Year of Care Partnerships	**9:15**
An individual perspective on care planning Rob Hemmings	**9:30**
Discussion sessions	
1 The care planning consultation for people with musculoskeletal conditions Facilitated by: Jo Protheroe, Senior Lecturer in General Practice, NHS Manchester Activity: A care planning 'results and prompt sheet' for musculoskeletal conditions Feedback and wider discussion	**9:45**
Break	**10:20**
2 Musculoskeletal conditions, multi-morbidity and services Facilitated by: Tom Margham, Lead for Primary Care, Arthritis Research UK Activity: Accessing services following a care planning consultation Feedback and wider discussion	**10:35**
Implementing care planning - wider perspectives Chair: Alan Silman, Medical Director, Arthritis Research UK	
Care planning and long-term conditions – an NHS England/DH perspective Alison Austin, Personalisation and control lead, NHS England	**11:10**
A common narrative and 'ten principles' for care planning Laura Robinson, Policy and Communications Advisor, National Voices	**11:20**
Care planning across long-term conditions Nigel Mathers, Vice Chair, Royal College of General Practitioners	**11:30**
Discussion	**11:40**
Networking lunch	**12:00**
Close	**13:00**

Arthritis Research UK

Providing answers today and tomorrow

Care planning for people with musculoskeletal conditions

Chair: Professor Alan Silman, Medical Director, Arthritis Research UK

Thursday 20 June 2013

Musculoskeletal conditions: 3 groups approach

Common symptoms across musculoskeletal conditions include pain, joint stiffness, limitation in movement and fluctuation in severity over time.

1. Inflammatory conditions

Example: rheumatoid arthritis

Common features:

- **Age:** affects any age
- **Progression:** often rapid onset
- **Prevalence:** less common
- **Impact:** internal organs can be affected
- **Location of treatment:** urgent specialist treatment needed including drugs
- **Interventions:** treated by suppressing the immune system

2. Conditions of musculoskeletal pain

Example: osteoarthritis

Common features:

- **Age:** rare in the young
- **Progression:** gradual onset
- **Prevalence:** very common
- **Impact:** affects the joints and pain system
- **Location of main treatment:** treatment based in primary care
- **Interventions:** treated with physical activity and pain management

3. Osteoporosis and fragility fractures

- **Age:** affects mainly older people
- **Progression:** silent and gradual weakening of bone, sudden fracture
- **Prevalence:** very common
- **Impact:** hip, wrist and spinal bones are most common sites of fractures
- **Location of treatment:** prevention is based in primary and ambulatory care; fractures may require surgery
- **Interventions:** Medication to strengthen bones, falls prevention, fracture treatment

Programme

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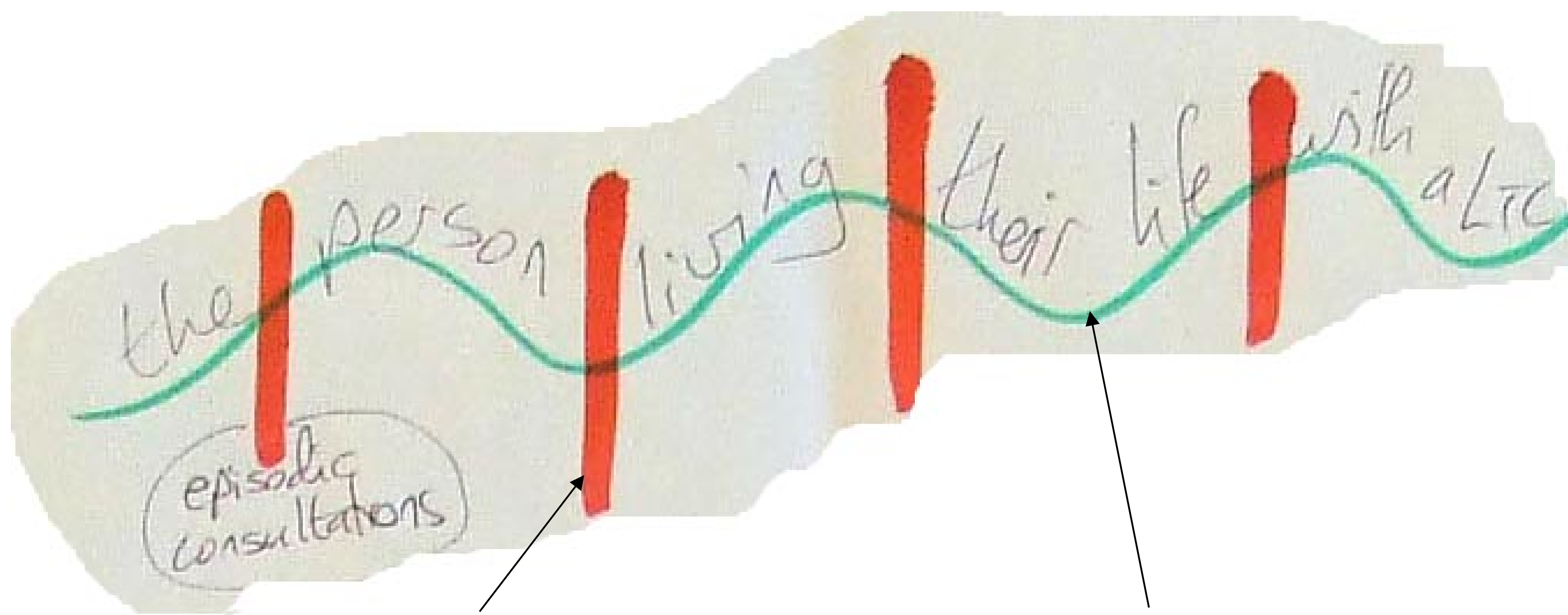
Care Planning and the Year of Care Programme

Care Planning for people with musculoskeletal conditions
June 20th 2013

Sue Roberts
Year of Care Partnerships

The *individual's* perspective



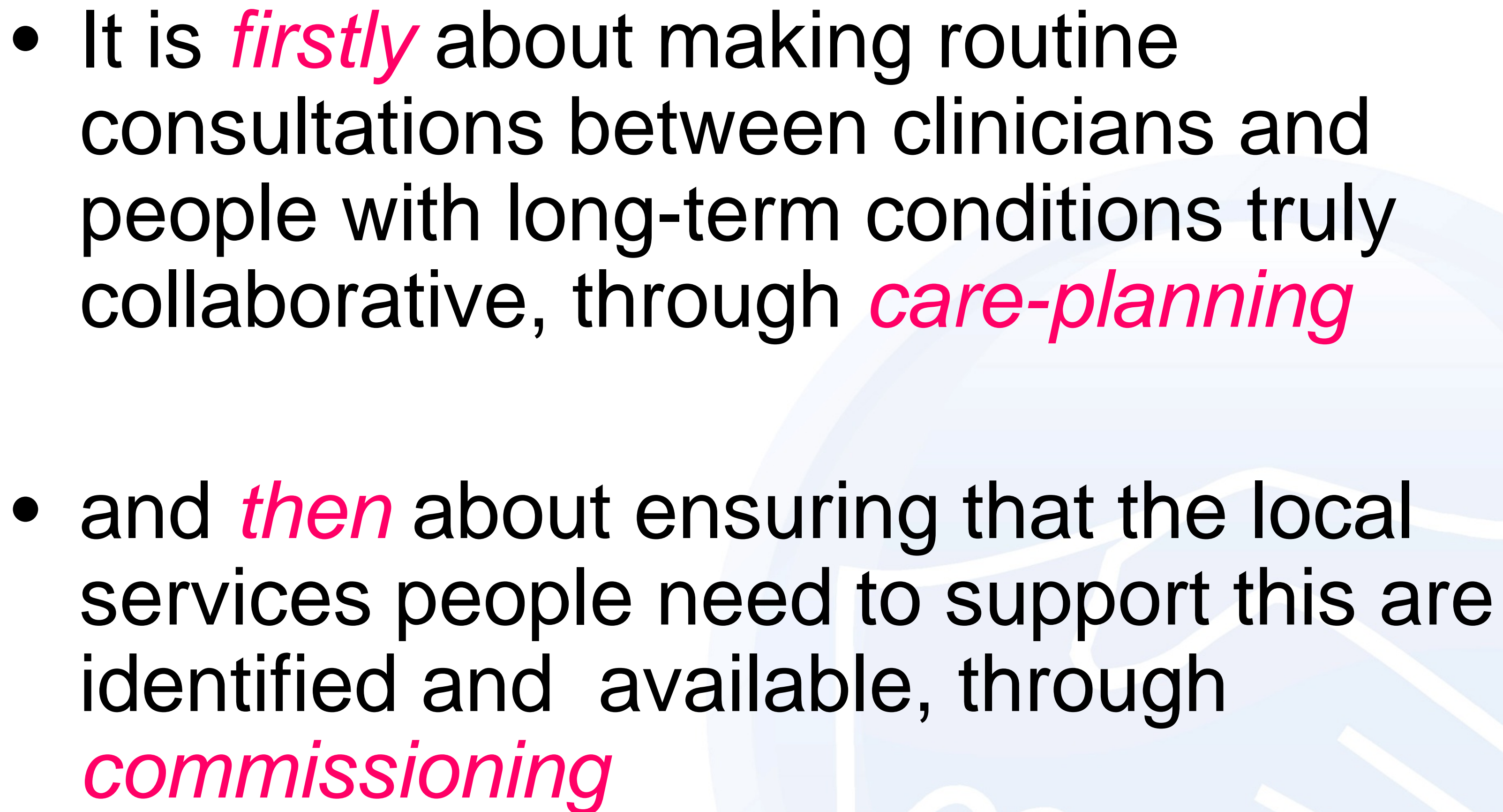
Hours with healthcare professional

= 4 hours in a year

Self-management

= 8756 hours in a year

The Key Aims of Year of Care



- It is *firstly* about making routine consultations between clinicians and people with long-term conditions truly collaborative, through *care-planning*

- and *then* about ensuring that the local services people need to support this are identified and available, through *commissioning*

The evidence base in *all* long term conditions

Engaged empowered patient

Partnership

Organised proactive system

= Better outcomes

In England : The Diabetes NSF

Internationally: The Chronic Care Model - Wagner

NORTH OF TYNE

NOTTINGHAM

BEXLEY

Rep National Training and
eam
1000 and quality assured trainers

Care plans versus Care planning

Medical Treatment Plan Template

________________ [Name of the medical centre / hospital / nursing home]

Address:

____

State: __________ City: ________ Zip code: ____________

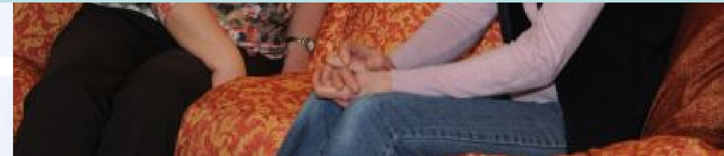
Contact number: ______________________ E-mail address: ____________________________

Date: __________________

Name of the patient: ___________________ [First name followed by last name]

Subject: ____ [Give the appropriate subject of the topic
E.g., The medical plan for the patient ________________ (mention the name of the patient)]

Having better Conversations



Treatment1 done by doctor: ____________________________ [Mention the full name of the doctor]

Date of treatmeny2: ____________________________

Treatment2 done by doctor: ____________________________ [Mention the full name of the doctor]

Period of patient care in the hospital: [From] ____________ [To] __________

Name of the nurse or nurses to take care of the patient: _________________

Patient admitted in department: _________________________

The given treatment plan for the patient is to be carried out as per the planned schedule. For any queries or complaints, you can contact ______________________ [give the name of the representative to be contacted] or call at the contact number ____________________ [mention the contact number of the representative]

__________________________ [Signature of the medical treatment planner]

More templates at - **Sampletemplates.org**

Care Planning Conversations

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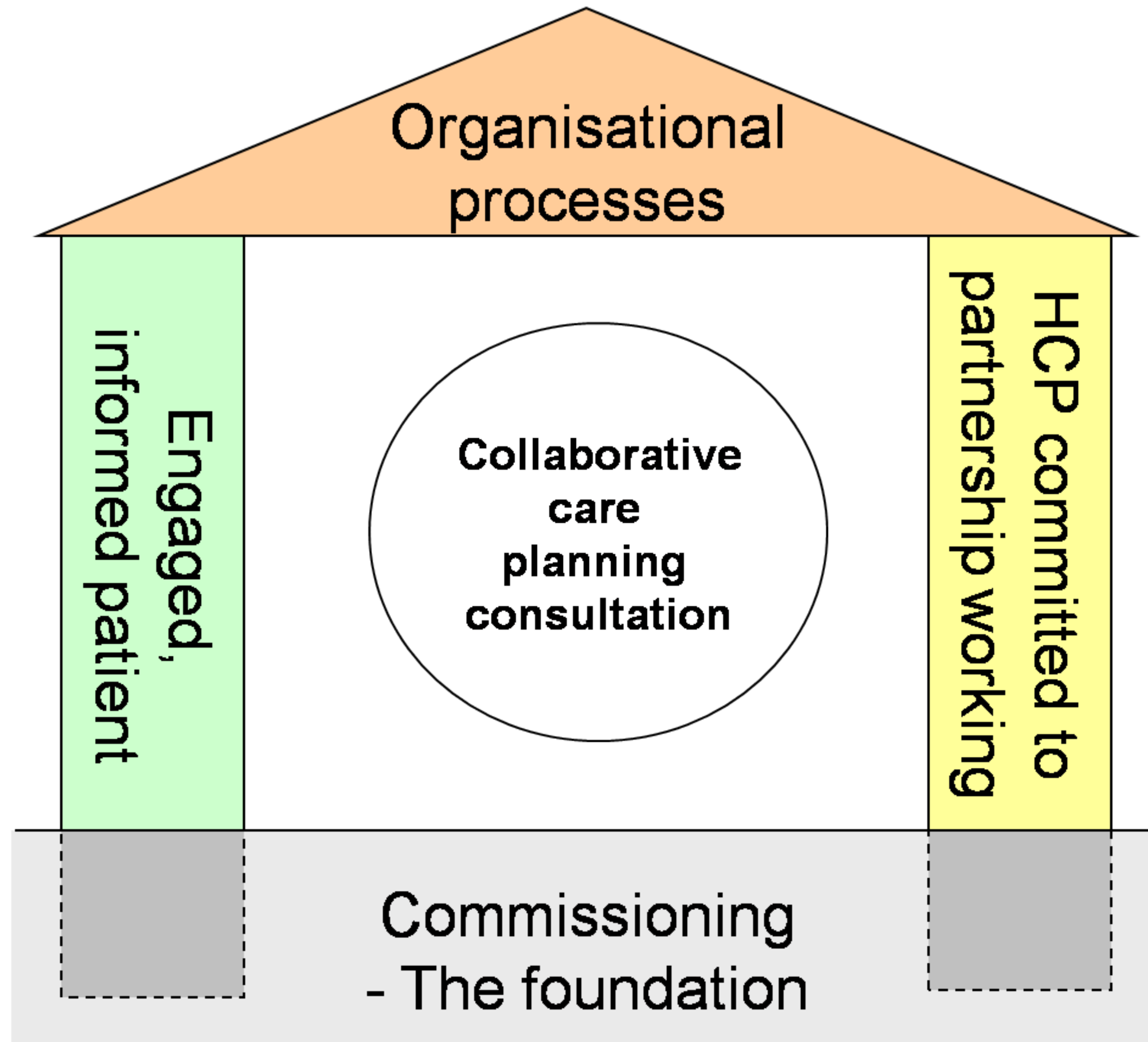
Delivering the care planning consultation

1st visit	Information gathering
Between visits	Information sharing
2nd visit	Consultation and joint decision making
	Agreed and shared goals and actions (care plan)

I got more information out of it than I ….did previously. Even though they were probably giving us the information, they were giving us it in a different way. [PWD12]

… Absolutely 100% better than it was, for me and for the patients.

What needs to be in place?

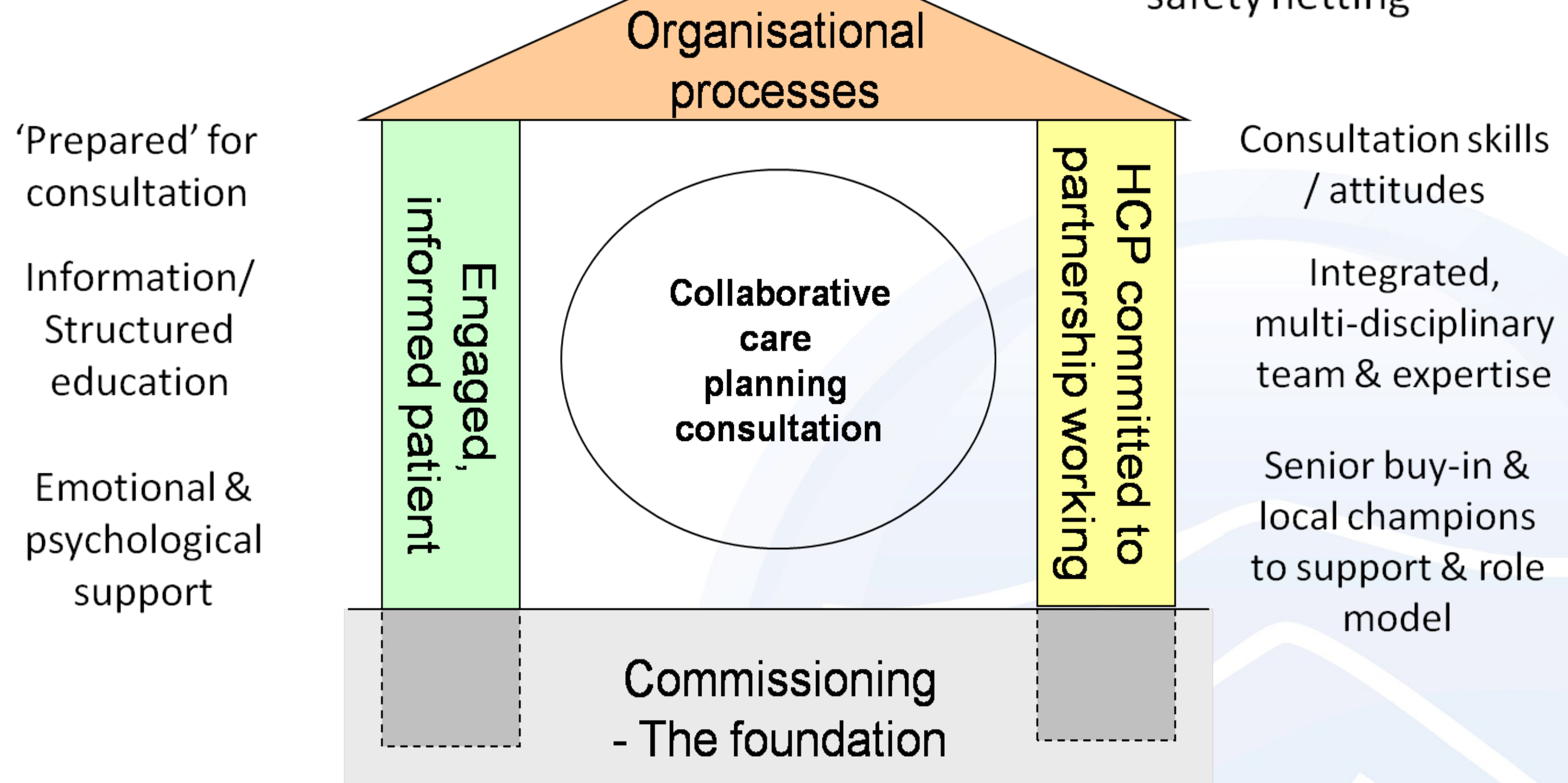


IT: clinical record of care planning

Test results / agenda setting prompts: beforehand

Know your population

Contact numbers and safety netting



Commissioning the menu (including Non Traditional Providers)

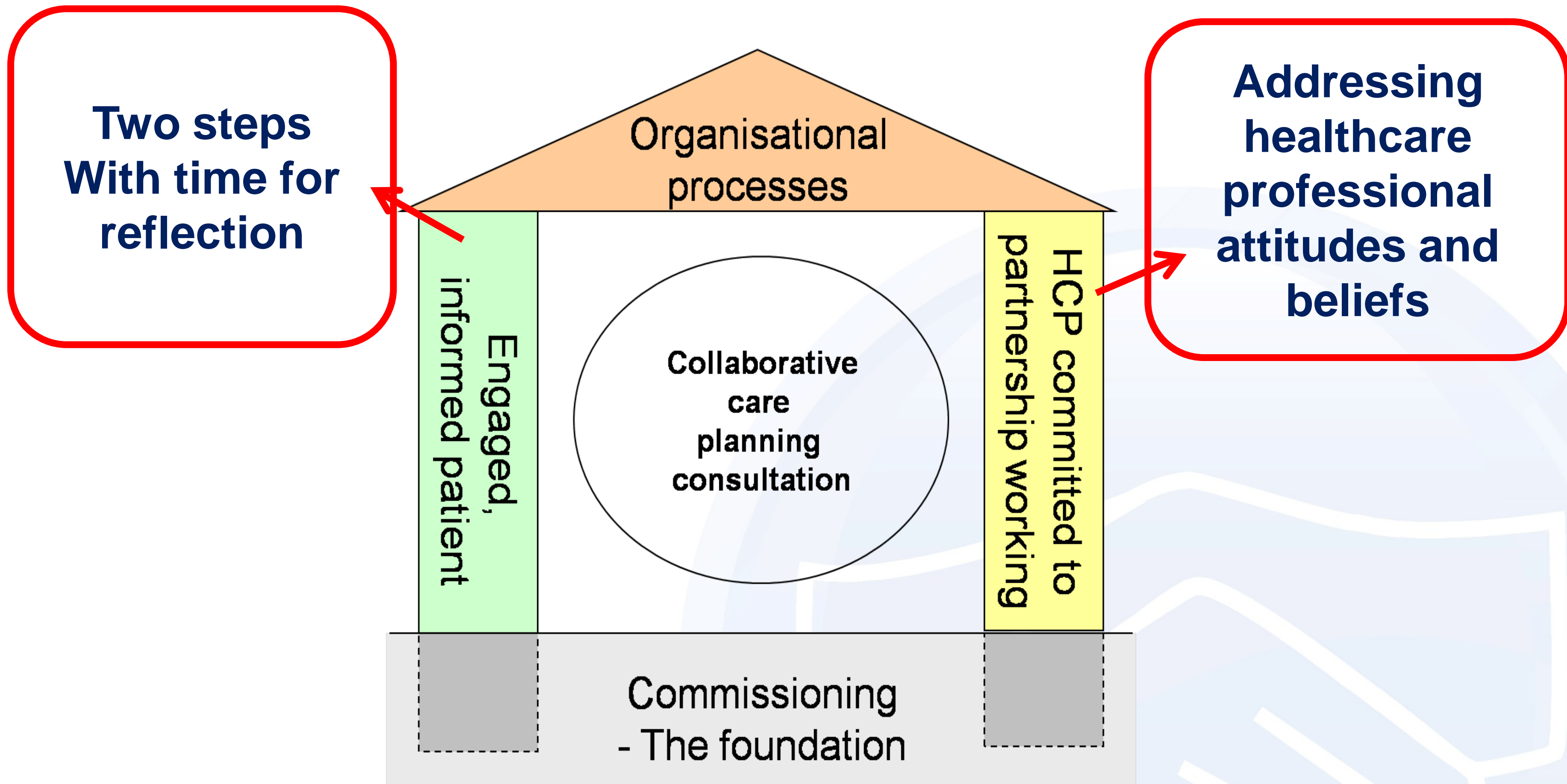
Commissioning care planning

Metrics and monitoring

How to achieve this?

A systematic and practical approach………

…………to culture change



Addressing attitudes, skills and infrastructure

Impact of care planning (YOC style) in diabetes

Improving experience and behaviour

Care planning as the norm for patients

'I feel more in charge both during the consultations and in managing my condition'

'I achieve a lot – I have become very conscious of what I eat and do more exercise. I started going to the gym to lose weight'

***'Each time I get a greater understanding of my condition and understand more about how I can go about maintaining and improving it'.* (P8)**

“

Improving satisfaction & effectiveness

‘I enjoy doing the clinic a lot more now… working with them rather than at them’

Care planning has made me look at patients differently. ……. I have to invest more time …. but it will get easier ….as people get more used to it.’

‘We have used the YoC as a template for other care packages.’

‘It’s absolutely 100% better for me and for the patients’

Better practice organisation and support for self management.

Productivity: Improving…….

'The new pathway is not only more patient centred but more efficient in time for both patients and health care professionals.'
(Practice team member)

Cost per patient
practice level
pre YOC: £21
post YOC: £21

COPD:
- **Admissions**

…………..reduced by 50%
- **A&E attendance**

…………..reduced by 68%

Tower Hamlets: People with Type 2 diabetes

92% of registered population taking part in care planning

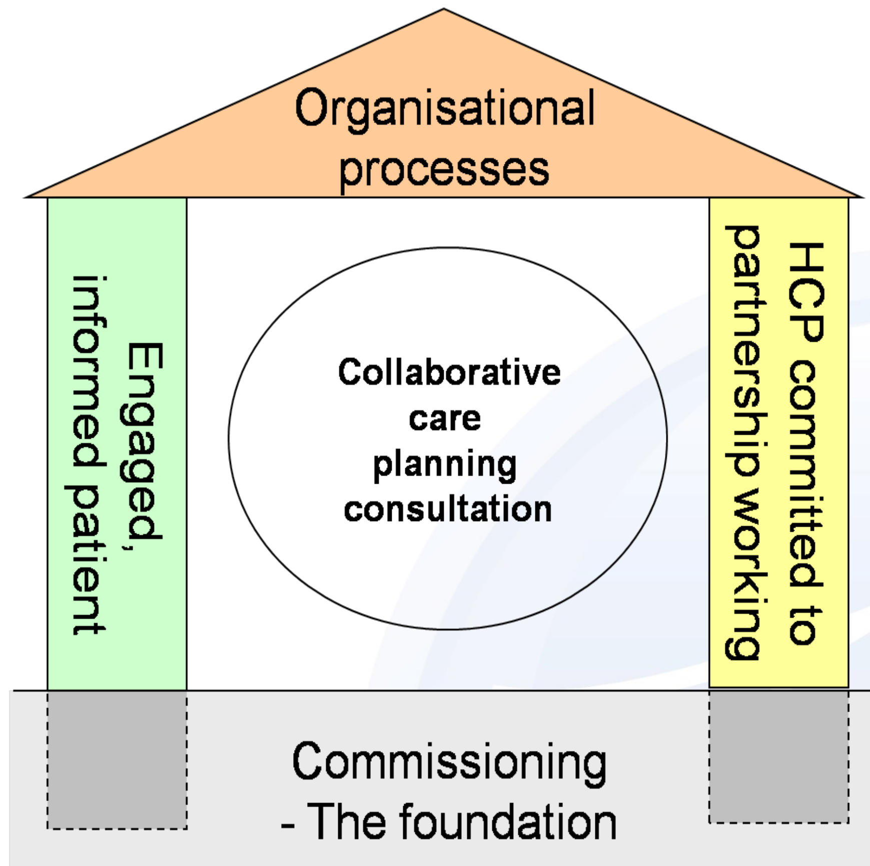
Patient perceived 'involvement in care' rose from 52-82%

% **all three BP, HbA1C and Cholesterol 'controlled'**

24 → 27 → 31 → 35

(current national average = 19%)

72% received all 9 processes in National Diabetes Audit: (Best in England : Average 49%)

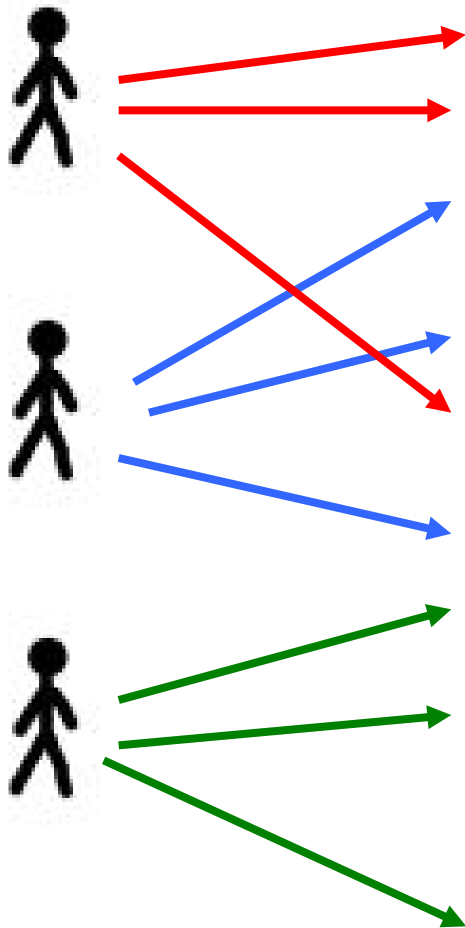


Commissioning the menu (including Non Traditional Providers)

Commissioning care planning

Metrics and monitoring

Commissioning perspective…. overview



MENU OF OPTIONS: Examples

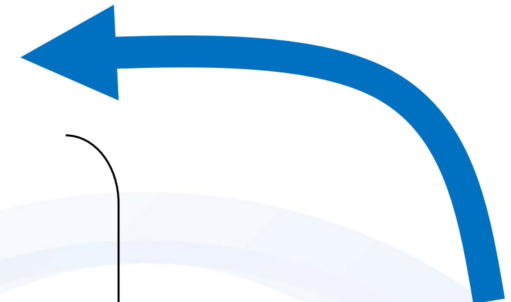
Support for Self management

- *Patient Education*
- *Weight management*
- *Health Trainers*
- *Smoking cessation*
- *Exercise programmes*
- *Health Coaching sessions*
- *Community support: Buddying / walking groups…*
- *Tele health / tele care*
- *Arts for Health*

Specific problem solving

Personal Health Budget

Coordinating clinical / social input



Macro-level commissioning by the CCG on behalf of the whole LTC population

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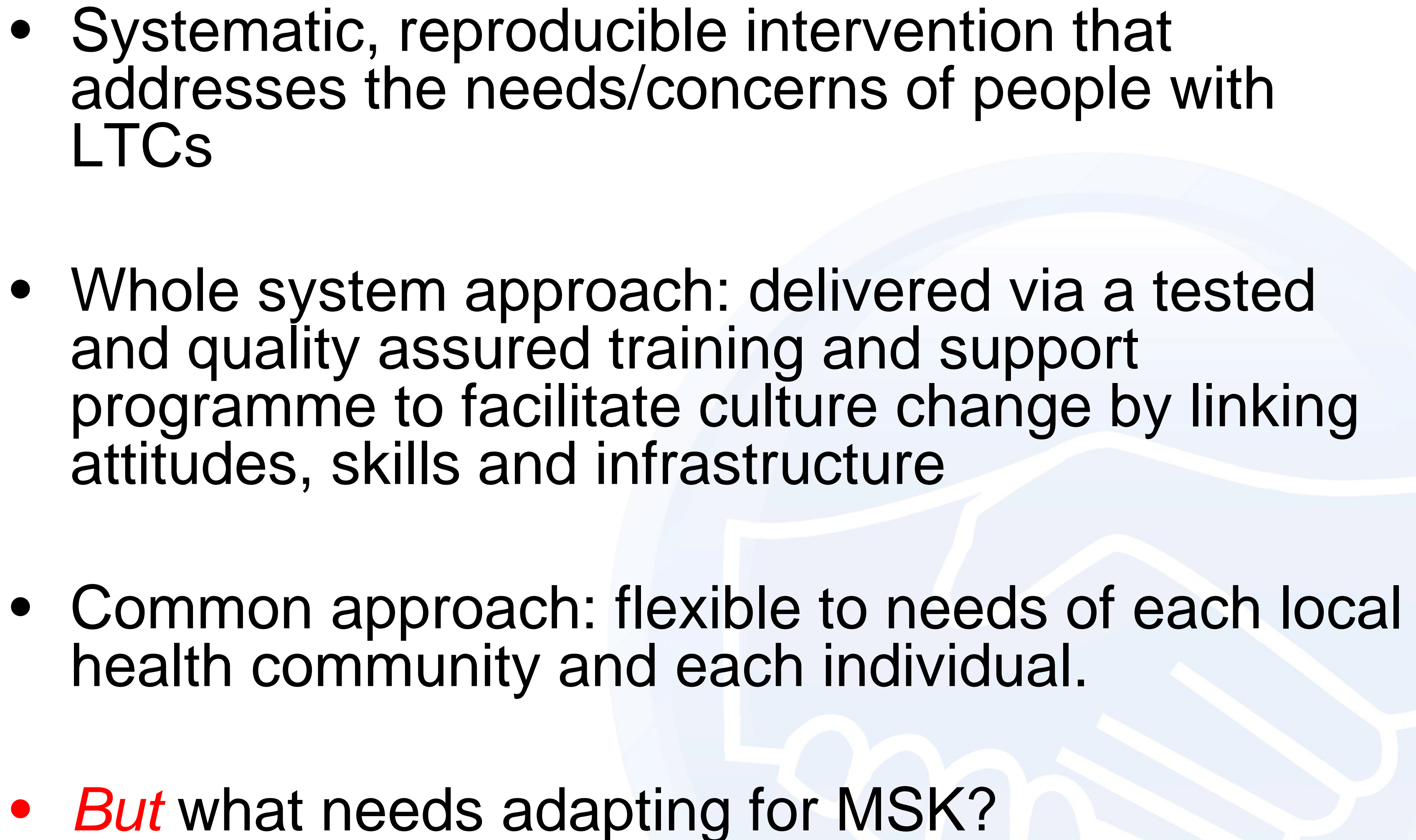
A Delivery System: Key points



- Systematic, reproducible intervention that addresses the needs/concerns of people with LTCs
- Whole system approach: delivered via a tested and quality assured training and support programme to facilitate culture change by linking attitudes, skills and infrastructure
- Common approach: flexible to needs of each local health community and each individual.
- *But* what needs adapting for MSK?

What are the current commitments to care planning for musculoskeletal conditions?

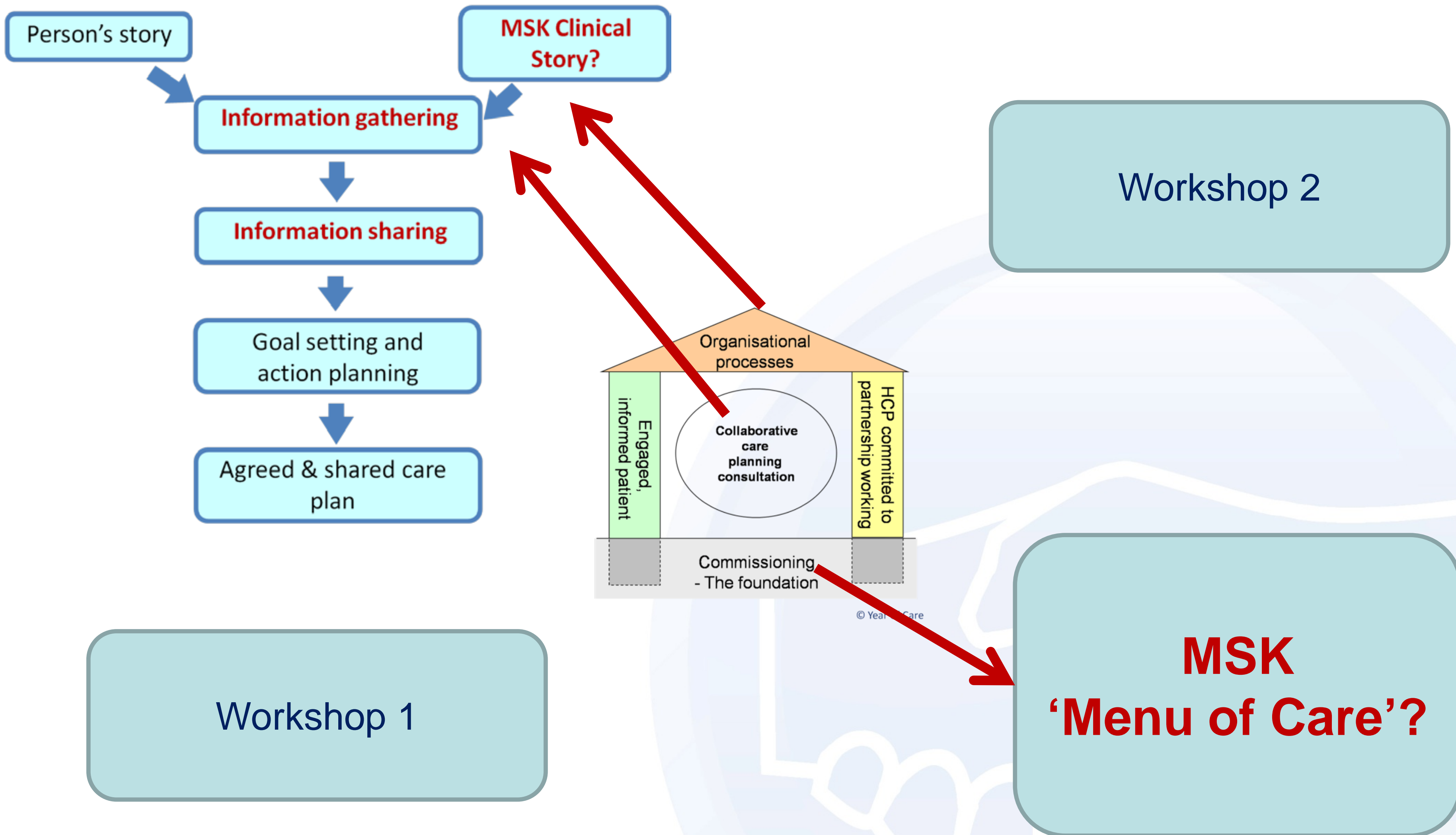
Treatment plans

or

'Having better Conversations'?

review to: assess disease activity; check for the development of comorbidities or complications; assess the need for surgery; organise cross referral within the multidisciplinary team; assess the affect the disease is having on a person's life."

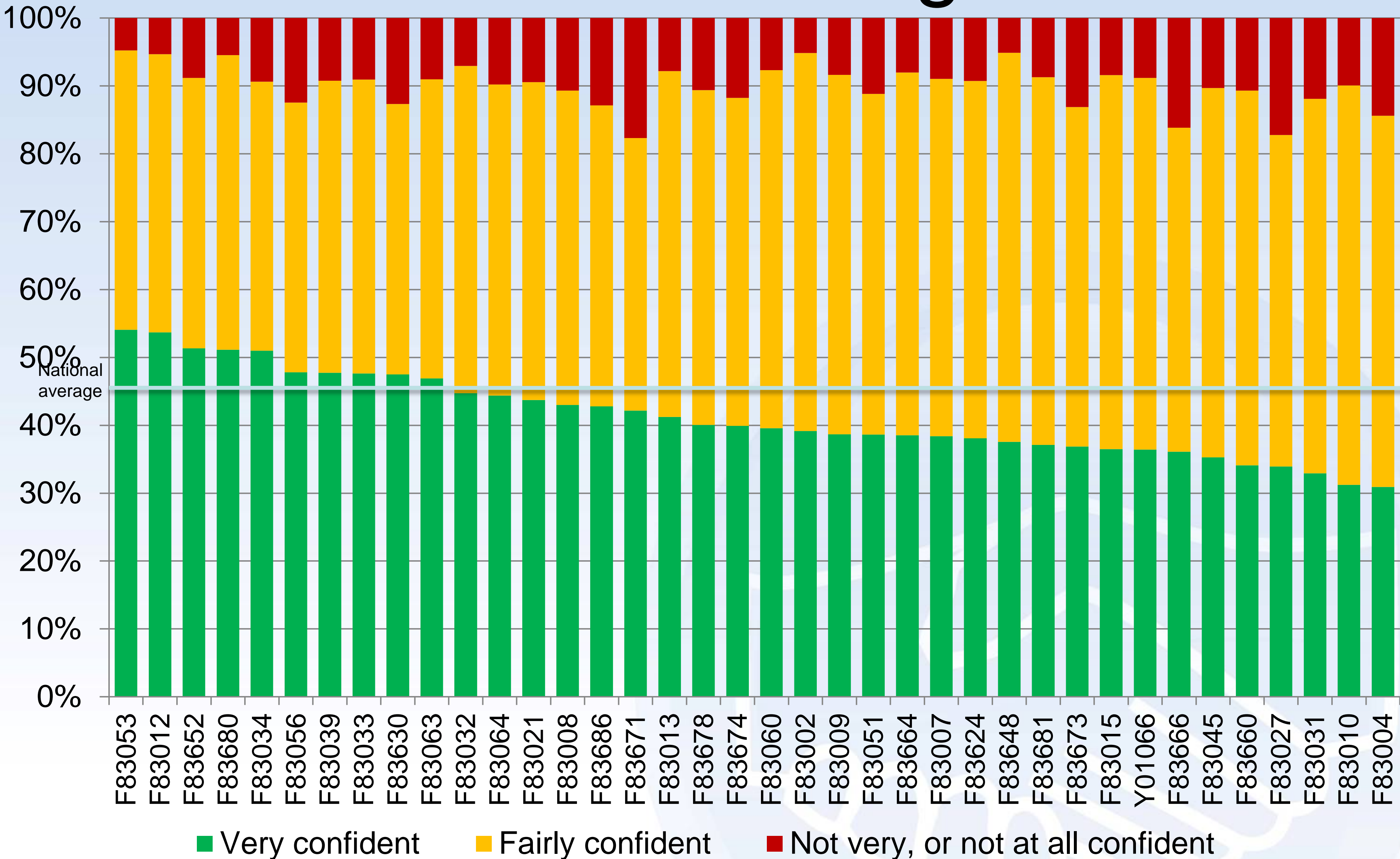
Questions for MSK community



Over to you!

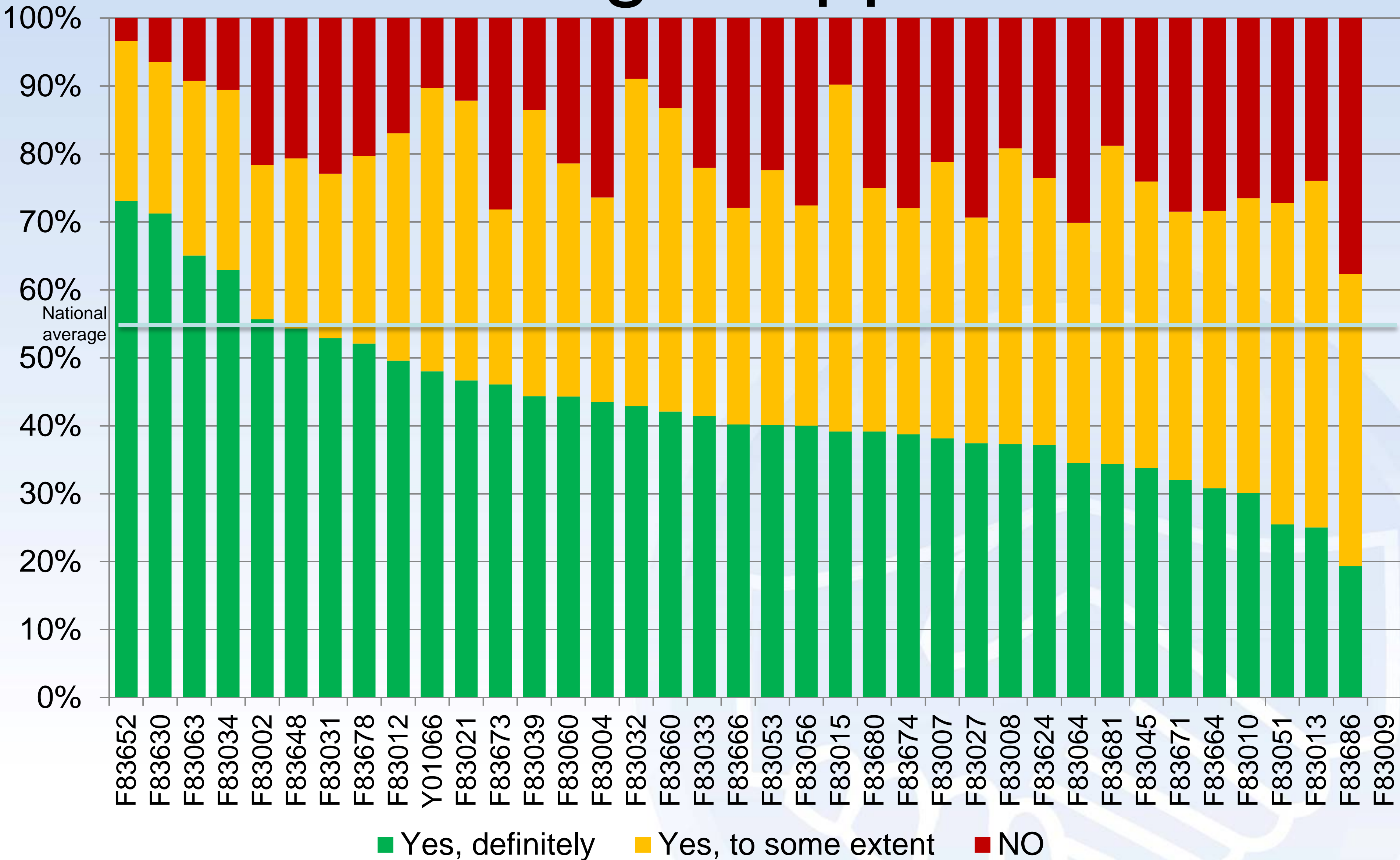
www.diabetes.nhs.uk/yearofcare

Confidence to manage health

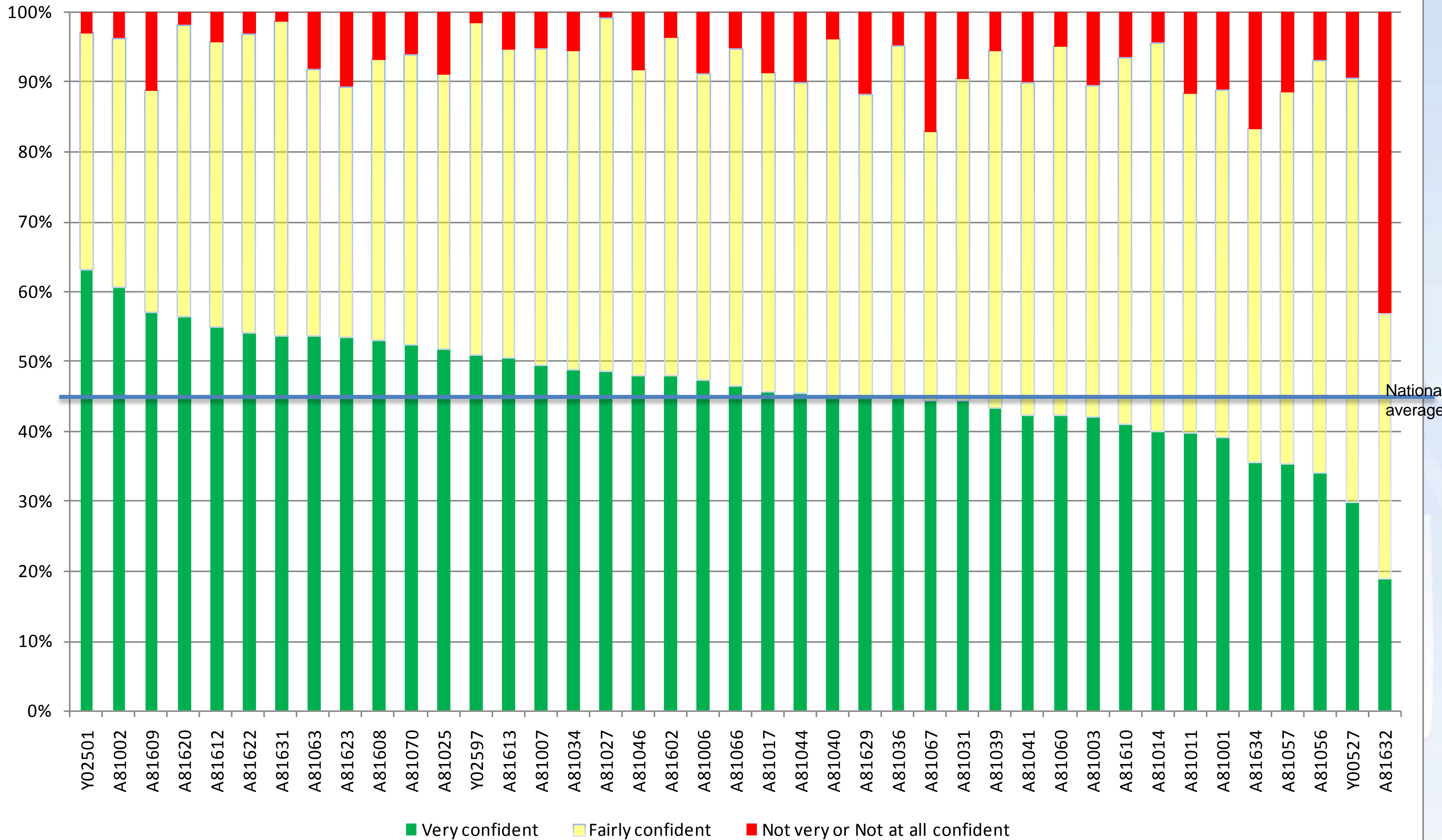


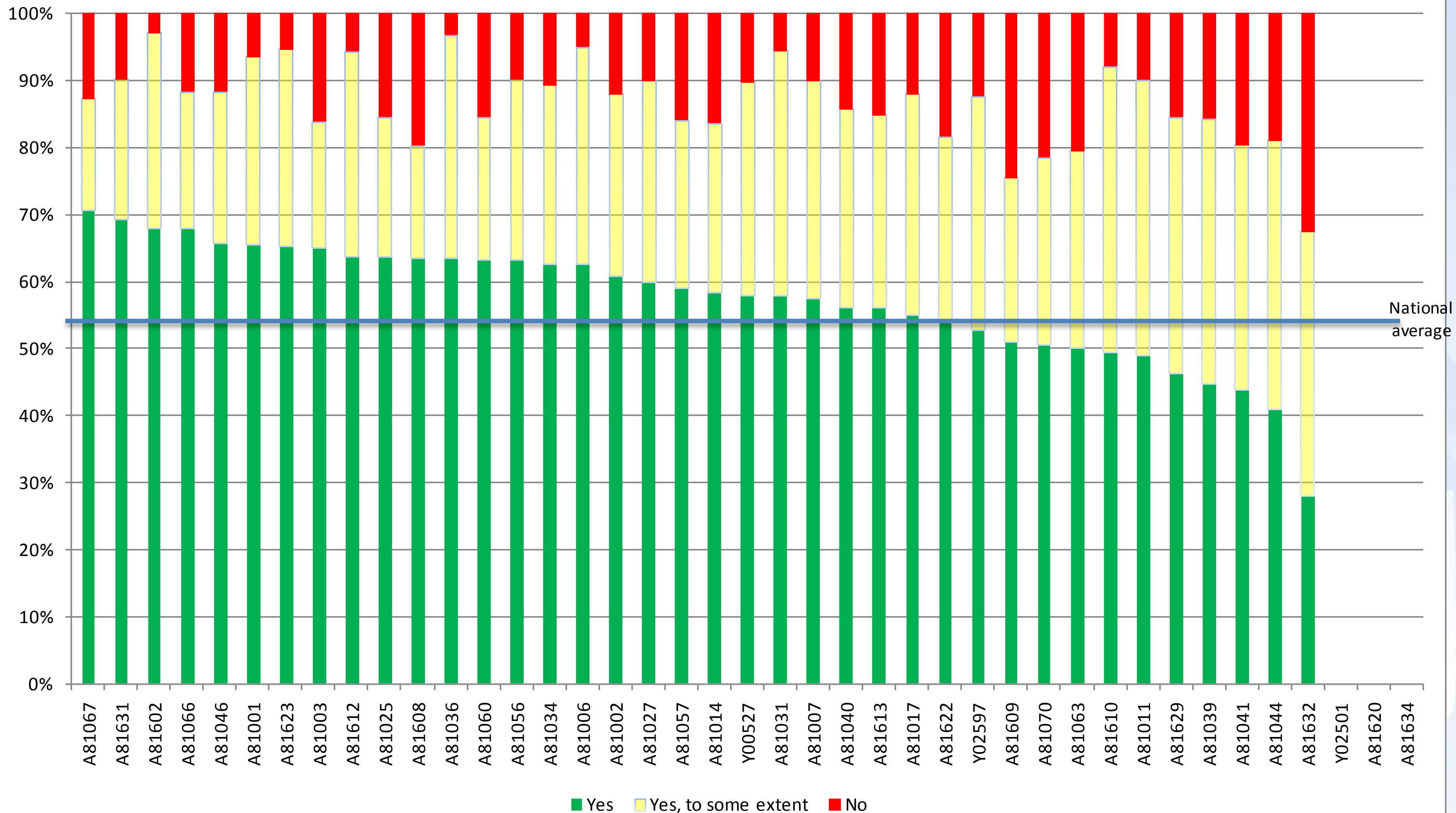
Q33: How confident are you that you can manage your own health?

Enough support



Q32: In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? Please think about all services and organisations, not just health services


How confident are you that you can manage your own health?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
National average
Y02501
A81002
A81609
A81620
A81612
A81622
A81631
A81063
A81623
A81608
A81070
A81025
Y02597
A81613
A81007
A81034
A81027
A81046
A81602
A81006
A81066
A81017
A81044
A81040
A81629
A81036
A81067
A81031
A81039
A81041
A81060
A81003
A81610
A81014
A81011
A81001
A81634
A81057
A81056
Y00527
A81632
Very confident
Fairly confident
Not very or Not at all confident


In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
National average
A81067
A81631
A81602
A81066
A81046
A81001
A81623
A81003
A81612
A81025
A81608
A81036
A81060
A81056
A81034
A81006
A81002
A81027
A81057
A81014
Y00527
A81031
A81007
A81040
A81613
A81017
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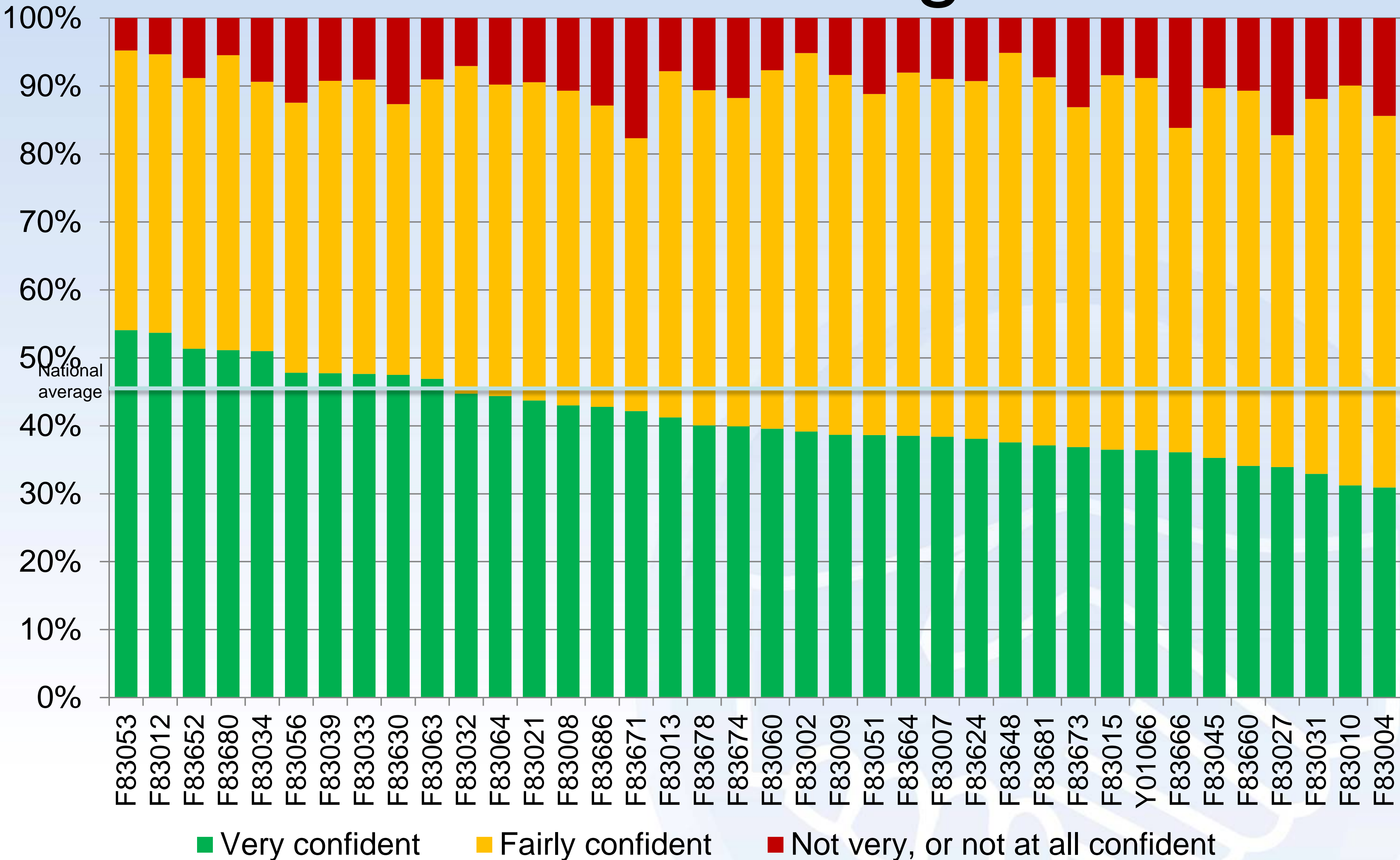
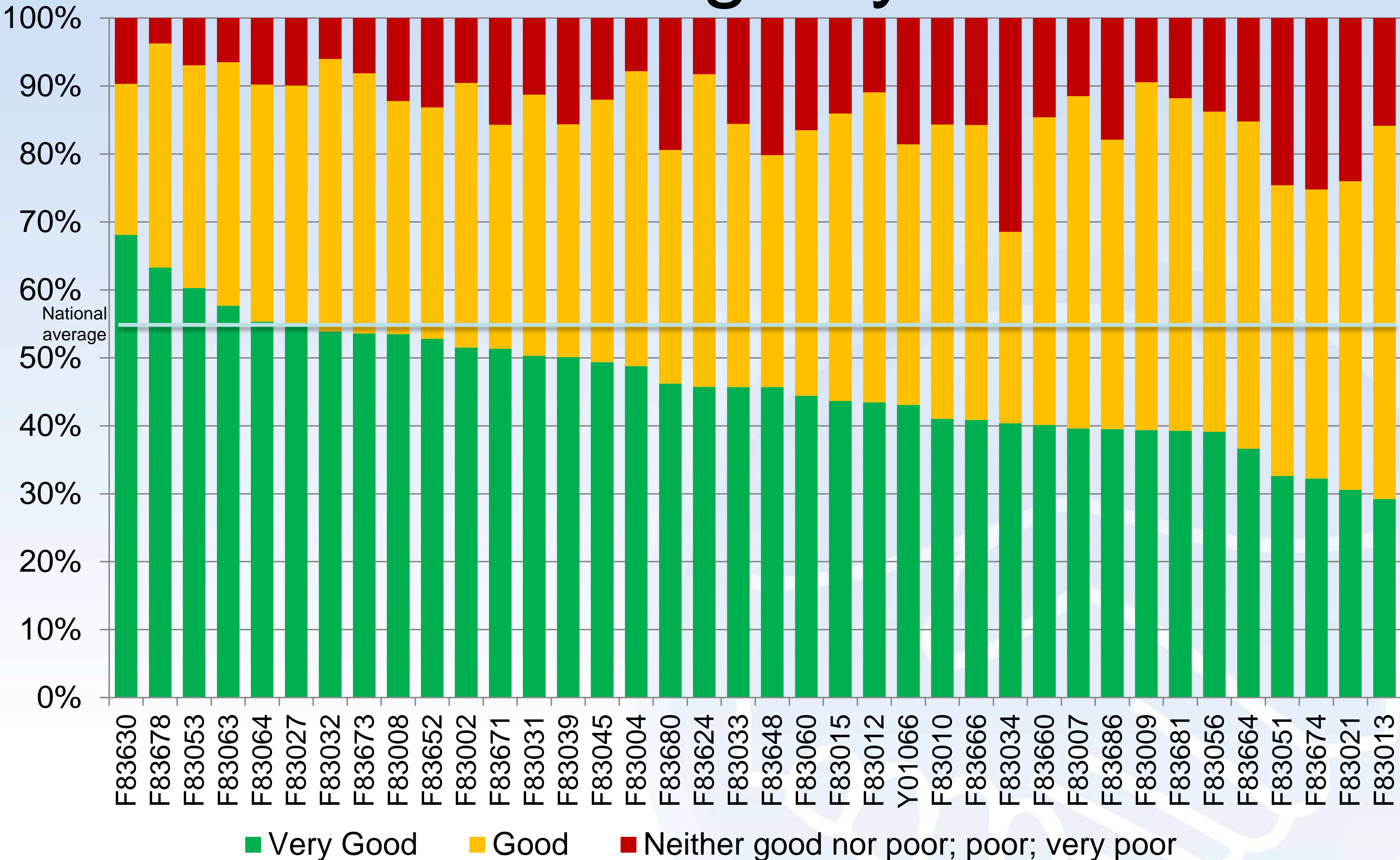
Y02597
A81609
A81070
A81063
A81610
A81011
A81629
A81039
A81041
A81044
A81632
Y02501
A81620
A81634
Yes
Yes, to some extent
No

Confidence to manage health



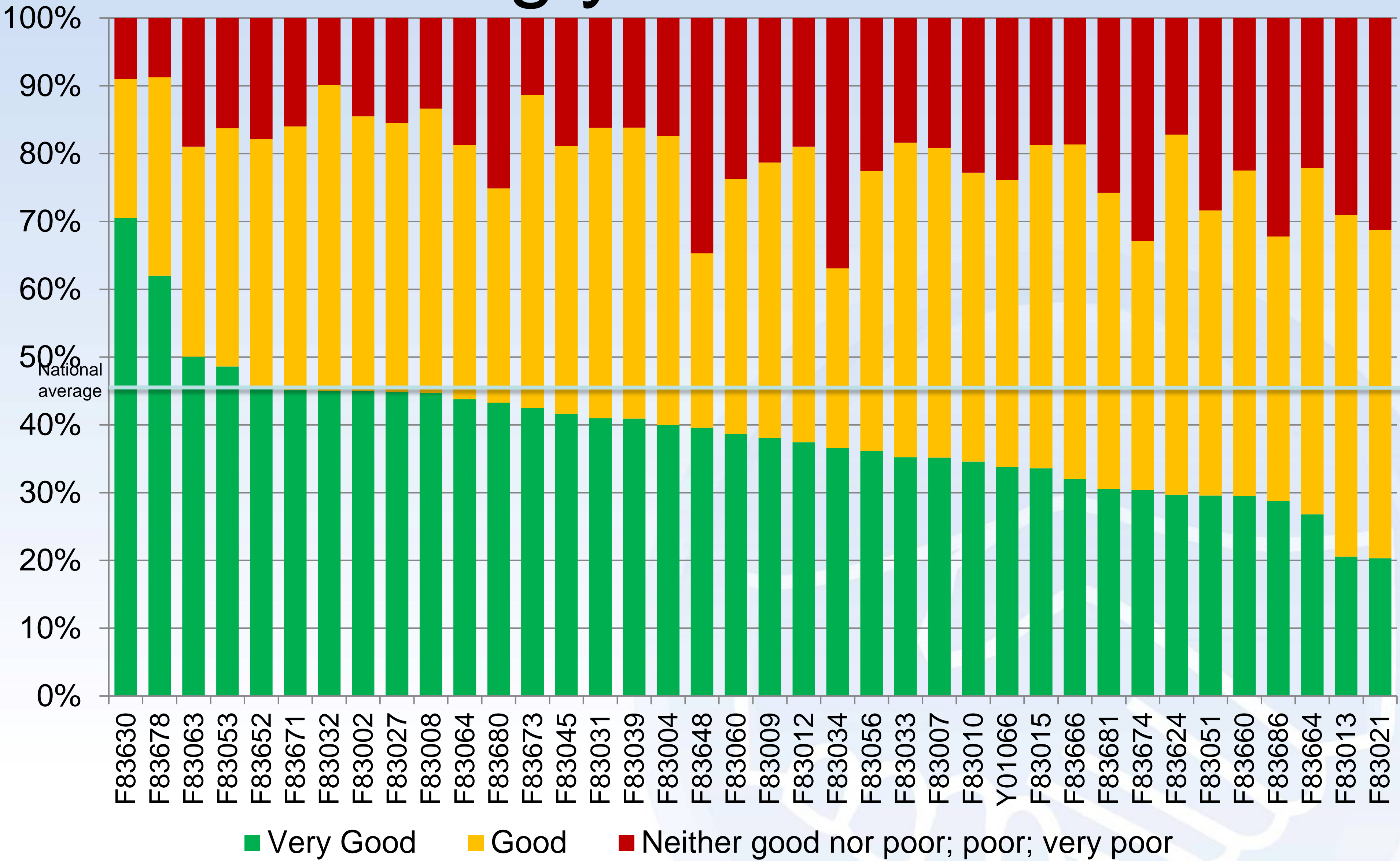
Q33: How confident are you that you can manage your own health?

Listening to you



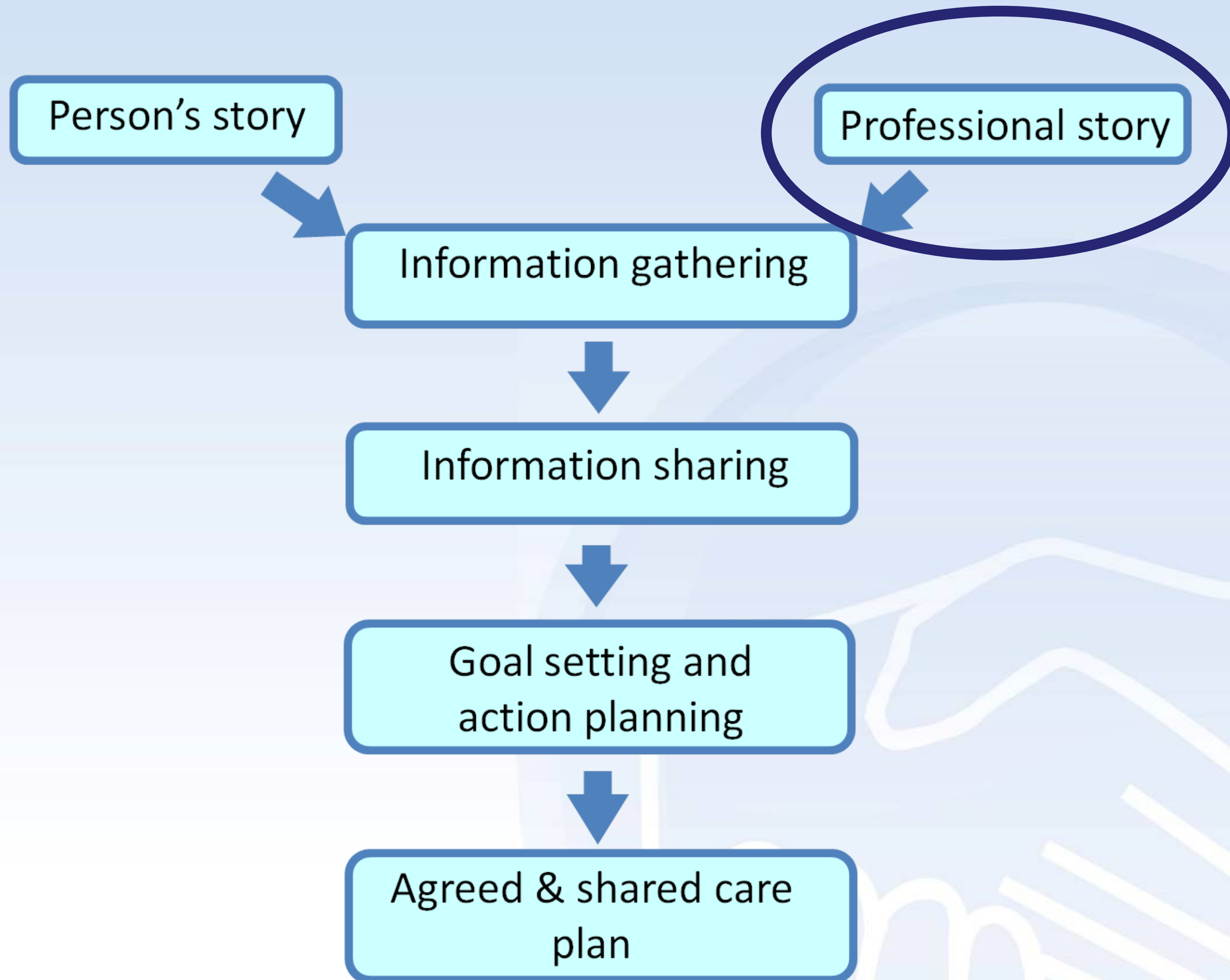
Q21b: Last time you saw or spoke to a GP from your GP surgery, how good was that GP at…listening to you

Involving you in decisions



Q21d: Last time you saw or spoke to a GP from your GP surgery, how good was that GP at…Involving you in decisions about your care

Care Planning Conversations



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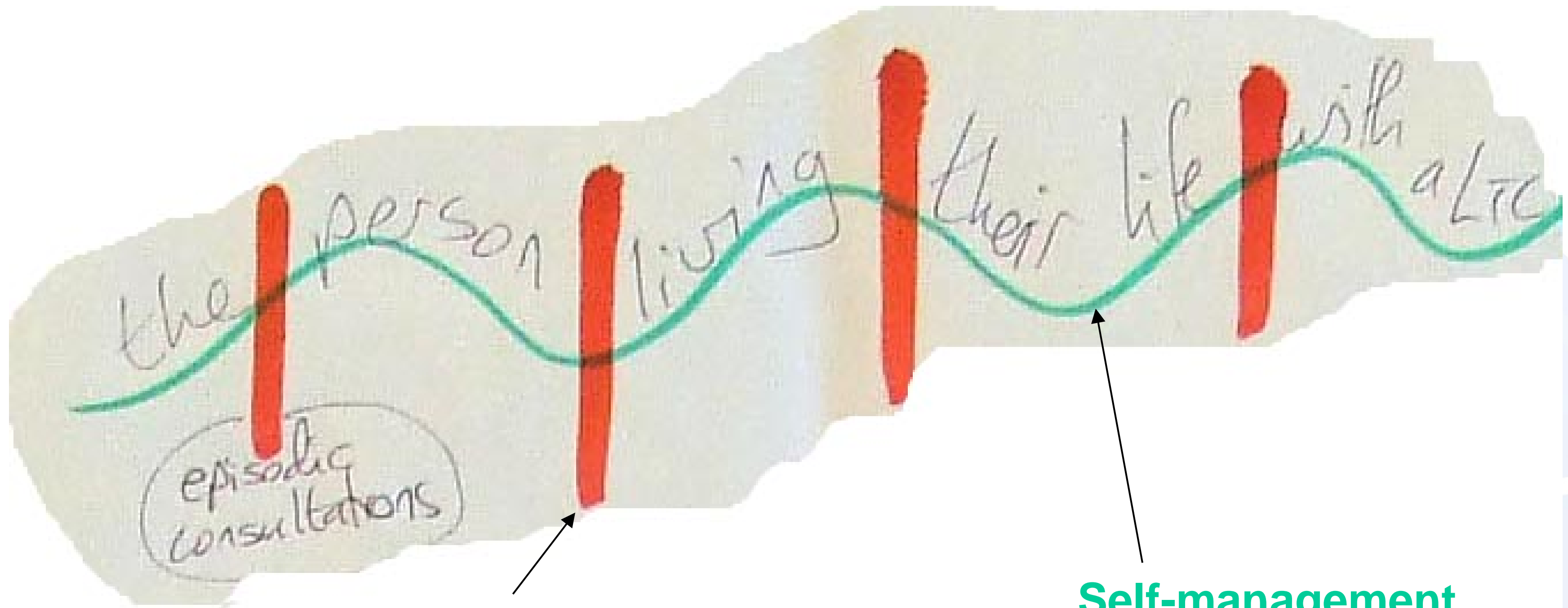
The *individual's* perspective



Hours with healthcare professional

= 4 hours in a year

Self-management

= 8756 hours in a year

IT: clinical record of care planning

Know your population

Test results / agenda setting prompts: beforehand

Organisational processes

Contact numbers and safety netting

Prepared for consultation

Information / education

Emotional and psychological support

Engaged, informed patient

Collaborative care planning consultation

HCP committed to partnership working

Consultation skills / attitudes

Integrated, multi-disciplinary team and expertise

Senior buy-in and local champions

Commissioning - The foundation

Identify needs map resources

Commission care planning

Establish and publicise menu of care

Quality assure and monitor

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Productivity: Improving…….

'The new pathway is not only more patient centred but more efficient in time for both patients and health care professionals.'
(Practice team member)

Cost per patient
practice level
pre YOC: £21
post YOC: £21

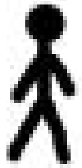
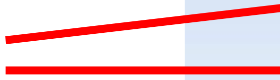
COPD:
- **Admissions**

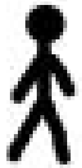
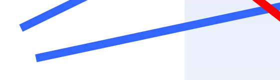
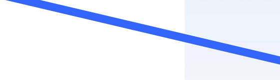
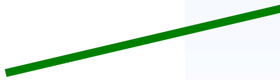
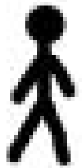
…………..reduced by 50%
- **A&E attendance**

…………..reduced by 68%

Kirklees: *Improvement programme : saved £225K*

Care planning: the golden gate!

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Arthritis Research UK

Providing answers today and tomorrow

An individual perspective on care planning

Rob Hemmings

Video clip: http://www.diabetes.nhs.uk/vid.php?o=596

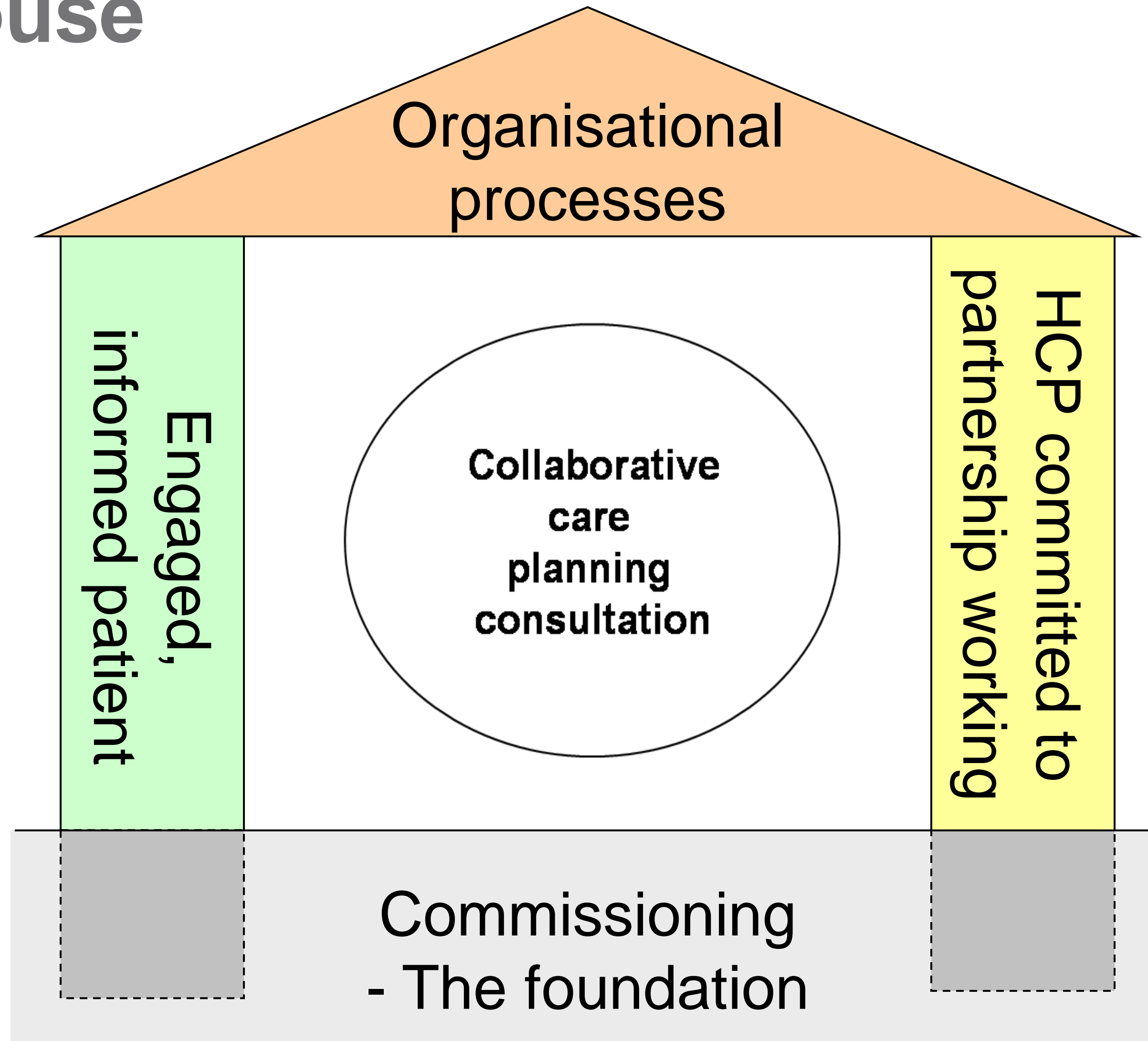
Arthritis Research UK

Providing answers today and tomorrow

The care planning consultation for people with musculoskeletal conditions

Jo Protheroe
Senior Lecturer, Keele University & Senior Lecturer in General Practice, NHS Manchester

The care planning consultation: centre of the house



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Care planning: a systematic approach

First contact

Information gathering

Between contacts

Information sharing / reflection

Second contact
Care planning consultation

Agenda Setting / shared decision making

Agreed and shared goals and actions (care plan)

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What information is gathered? - Diabetes

Your Results

Measurements that affect your future risk of health problems
Diabetes Control: Your HbA1c is an overall measure of glucose control over the past 8-10 weeks. A level of between 6.5 and 7% or 48-53 mmol/mol is associated with the lowest risk of complications.
Blood Pressure (BP): A target blood pressure of below 130/80 lowers the risk of complications (a target of below 125/75 is used if you have kidney disease)
Cholesterol and Blood Fats: Lowering your cholesterol can reduce the risk of heart attacks and strokes. Treatment to lower cholesterol is recommended in diabetes for all people over 40 years. For other people, treatment depends on your overall risk. The target cholesterol is less than 4
Smoking: Smoking causes problems with your health in many ways but is particularly damaging in people with diabetes.
Weight: Being overweight increases the risk of many medical conditions including heart disease, arthritis and premature death. It can also make your diabetes and blood pressure more difficult to control.
Mood: How you feel could make a big difference to your diabetes. What are your answers to these questions: • During the last month, have you been bothered by feeling down, depressed or hopeless? • During the last month have you had little interest or pleasure in doing things?

Your annual screening checks
Kidney Tests: Your kidneys are tested by looking at a blood test (eGFR) and an early morning urine test (ACR). Ideally the higher the eGFR the better. Normally eGFR should be over 90. The ACR is better if under 3.0
Eyes: Your eye check looks for any changes to tiny blood vessels at the back of your eye. This may be done at a different time to the other checks
Feet: Your feet check detects if you have problems with circulation or the feeling (sensation) in your feet

Last results	Recent Results	Questions, thoughts, ideas

Goal Setting	Date:

What do you want to work on?
What do you want to achieve?
How important is it to you? Not important 1 2 3 4 5 6 7 8 9 10 Important

Action Plan

What exactly are you going to do?
What might stop you and what can you do about it?
How confident do you feel? Not confident 1 2 3 4 5 6 7 8 9 10 Confident

© Year of Care 22.03.10

Diabetes Results and (Care) Plan

Diabetes Planning Appointment

Name: ....

Your Appointment: ....

Please bring this to your appointment as it will be used to record what you decide to do to manage your diabetes over the next year and what you would like to discuss at your review.

These are some of the things which people ask about. Circle any which are most relevant to you?	
Medical check-ups	Your mood
Taking medication	Eating the right amount
Avoiding sugary foods	Giving up smoking
Monitoring glucose levels	Alcohol within limits
Healthier eating	Foot care
Pregnancy & Conception	Regular physical activity
	Sexual Health

What aspects of your diabetes would you like to discuss?

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What information is gathered? - COPD

My Lung tests	Latest Results	Questions, thoughts, Ideas
FEV1-The FEV1 (% predicted) (Forced Expiratory volume) is the amount of air you can blow out in one second. This test measures how strong your lungs. It is measured as a number, and then compared to the usual level for people of your height and gender with normal lungs.	My FEV1 as a % predicted is	
Oxygen saturation levels-The oxygen level in my blood is measured with a pulse oximeter, which is usually a probe placed on the finger. It shows how well your lungs are working to get oxygen into the body. Healthy lungs will usually get results of 95-100%	My oxygen saturation levels are:	
How does this affect me?		
Mood: How you feel could make a big difference to your health • During the last month, have you been bothered by feeling down, depressed or hopeless? • During the last month have you had little interest or plea things?	*Your thoughts:*	
Breathing You will know how your breathing affects you day-to-day, bu ways of looking at this that help understand how this is cha year, including ways of scoring your breathing and how m have had chest infections or been in hospital for your breath 12 months.		
MRC Score (1-not a problem to 5-very limited by breathing)		
CAT Score (0-40) the impact of your breathing on your qua		
In the last 12 months, I have had ... chest infections In the last 12 months, I have been in hospital for my breathi		
Other measures		
Weight: Being overweight increases the risk of many medi including heart disease, arthritis and premature death. It can your blood pressure more difficult to control. Being underwe increase the risk of health problems. Your weight in Kg is		
Smoking: Smoking causes problems with your health in m		
Blood Pressure (BP): A target blood pressure of below 14		

Personal Plan	Date:
What issues are most important to you?	
What exactly are you going to do?	
How confident do you feel about doing this? **Not confident 1 2 3 4 5 6 7 8 9 10 Confident**	

What my Key worker will organise for me

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COPD Care Planning Results Sheet

This leaflet includes some of your test results and other information to help you think about how things are going, what you would like to discuss at your appointment with your key worker to decide how to manage your COPD over the next 12 months.

These are some of the things which people ask about. Circle any which are most relevant to you?	
Medical check-ups	Your mood
Taking medication	Giving up smoking
Mobility	Alcohol within limits
Healthier eating	Tiredness
Appetite	Sexual Health
Wheezing	Activity
Breathlessness	Stamina
Help for your carer	Help with your social needs

Arthritis Research UK

Activity: A care planning ‘results and prompt sheet’ for musculoskeletal conditions

- Working with the person next to you, please discuss what a ‘results and prompt sheet’ for people with musculoskeletal conditions might include
- What results and health information could it contain?
- What factors should be included as prompts?

Musculoskeletal Conditions
Care Planning Results and Prompt Sheet

This leaflet includes some of your test results and other information to help you think about how things are going, what you would like to discuss at your appointment to manage your musculoskeletal condition over the next 12 months.

These are some of the things which people ask about. Circle those that are most relevant to you
[Add areas here – e.g. physical activity, mood]

Musculoskeletal measurements and results	Latest Result	Questions, thoughts, Ideas
[Suggest measure]		
[Suggest measure]		
[Suggest measure]		
[Suggest measure]		
[Suggest measure]		
[Suggest measure]		
Other non-specific measures to be included:		
[Suggest measure] e.g. **Smoking:** Smoking causes problems with your health in many ways.		
[Suggest measure]		
[Suggest measure]		

Arthritis Research UK

Feedback and discussion questions

- What results and information should be included (which are generic to all LTCs)?
- Does the two-step process, developed in diabetes, fit for care planning for musculoskeletal conditions?
- How would the information gathering and sharing work in practice?
- Where would the care planning information gathering and the consultation itself take place for people with musculoskeletal conditions (primary care/secondary care?)

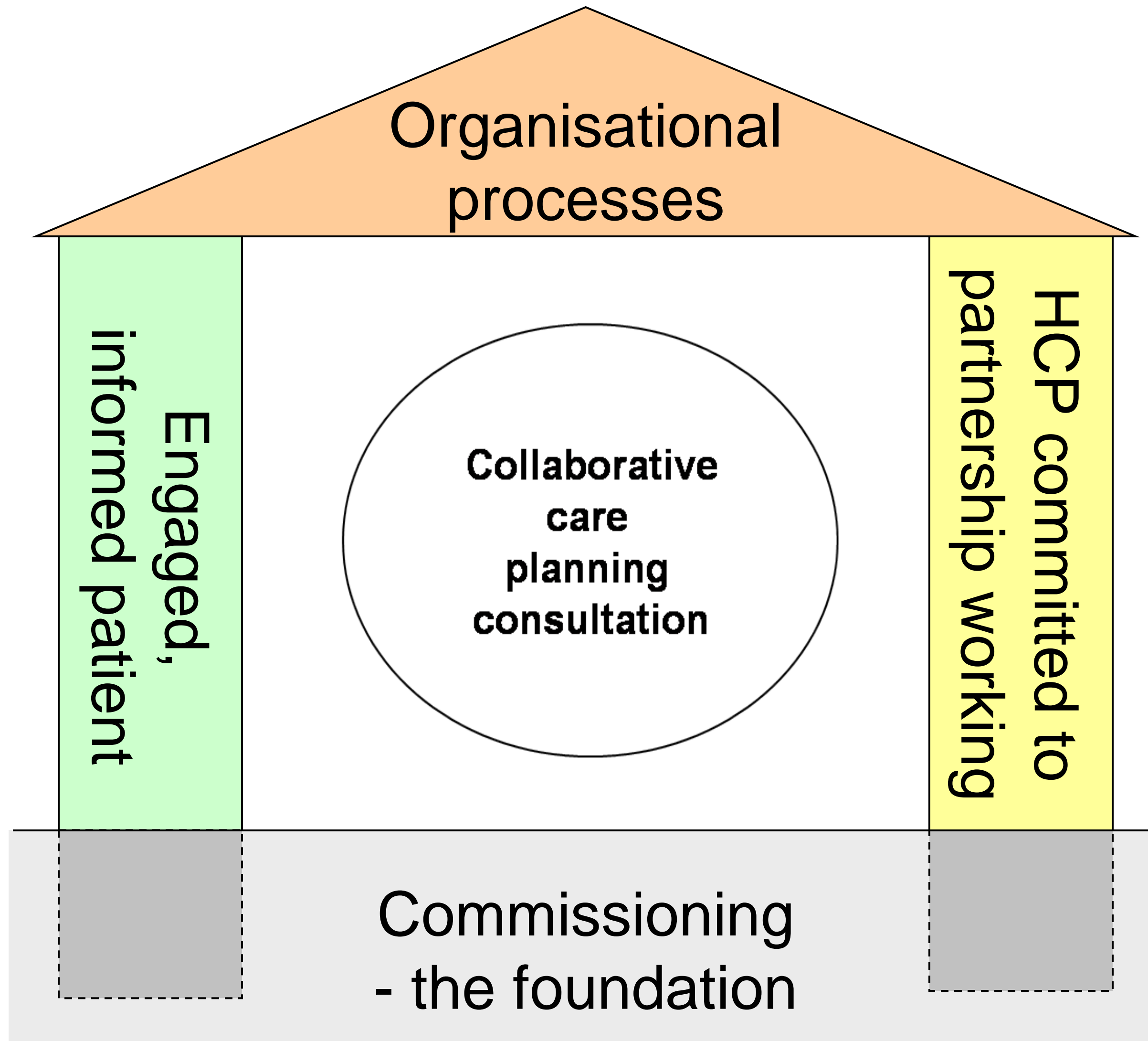
Arthritis Research UK

Providing answers today and tomorrow

Musculoskeletal conditions, multi-morbidity and services

Tom Margham
Lead for Primary Care, Arthritis Research UK

Commissioning services : the 'foundation'

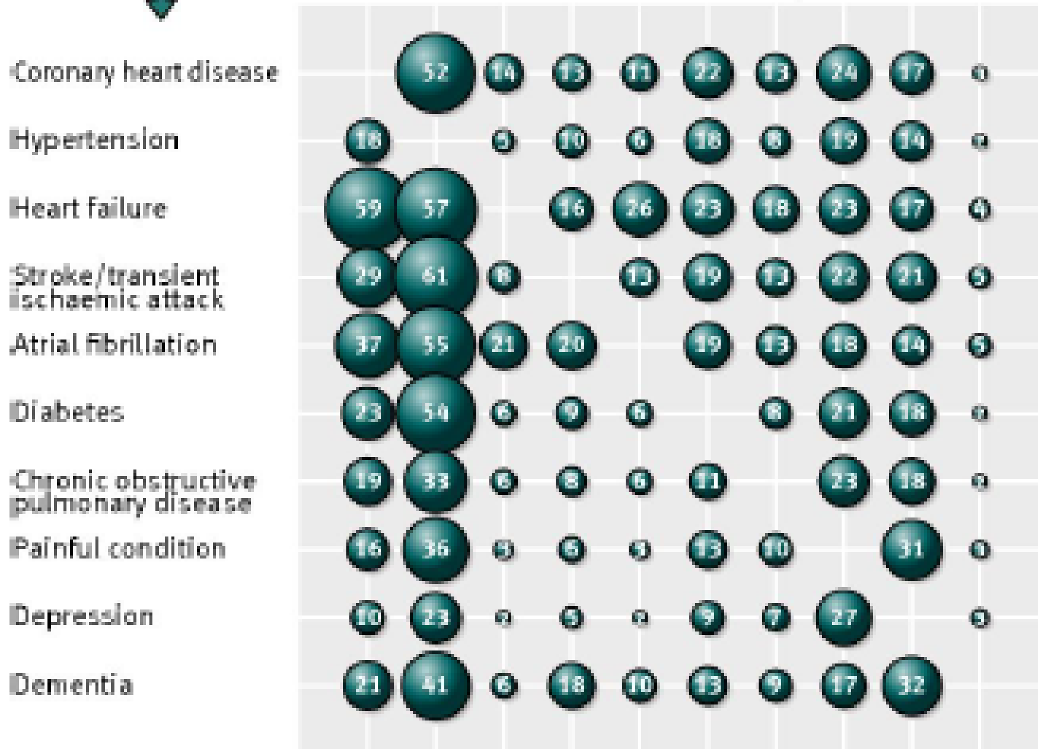


© Year of Care

Multi-morbidity

Percentage of patients with the row condition who also have the column condition

Coronary heart disease
Hypertension
Heart failure
Stroke/transient ischaemic attack
Atrial fibrillation
Diabetes
Chronic obstructive pulmonary disease
Painful condition
Depression
Dementia

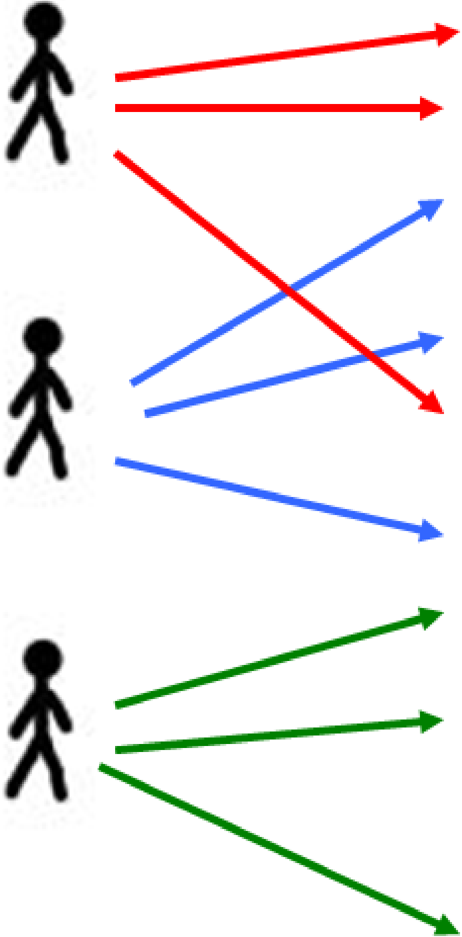


Bruce Guthrie et al. Adapting clinical guidelines to take account of multimorbidity
BMJ 2012;345:e6341

Activity: Accessing services following a care planning consultation

- Each pair has a card with a scenario of a person with a musculoskeletal condition (Mrs Jones, Mr Smith)
- Discuss the services (or types of service) you may need.
- Feedback to the group
  - Which services are generic?
  - Which are specific to MSK?

Menus of options: examples



Relatively 'independent'	'Frail': multiple morbidities
Support for Self management • *Patient Education* • *Weight management* • *Health Trainers* • *Smoking cessation* • *Exercise programmes* • *Health Coaching* • *Community support: Buddying / walking groups…* • *Tele health / tele care* • *Arts for Health* Specific problem solving Personal Health Budget **Coordinating** clinical / social input	• Case management package • Community MDT assessment • Sheltered re/housing • Home care package • Reablement service • Non traditional provider / charity input e.g. Age UK / clubs / buddying • 'Staying steady group' • Specific problem solving • Technology - telecare / alarms • Residential care • Advanced planning • End of Life care

© Year of Care

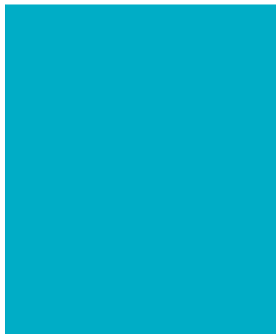
Wider discussion questions - services

- Feedback to the group – which services are generic? Which are specific?
- How should people's access to services be co-ordinated?
- How can we identify the people who most need care planning?
- What musculoskeletal specific knowledge (training and information) is needed so that musculoskeletal conditions are included in all care planning for all LTCs?

NHS England

NHS England, personalisation and Long Term Conditions

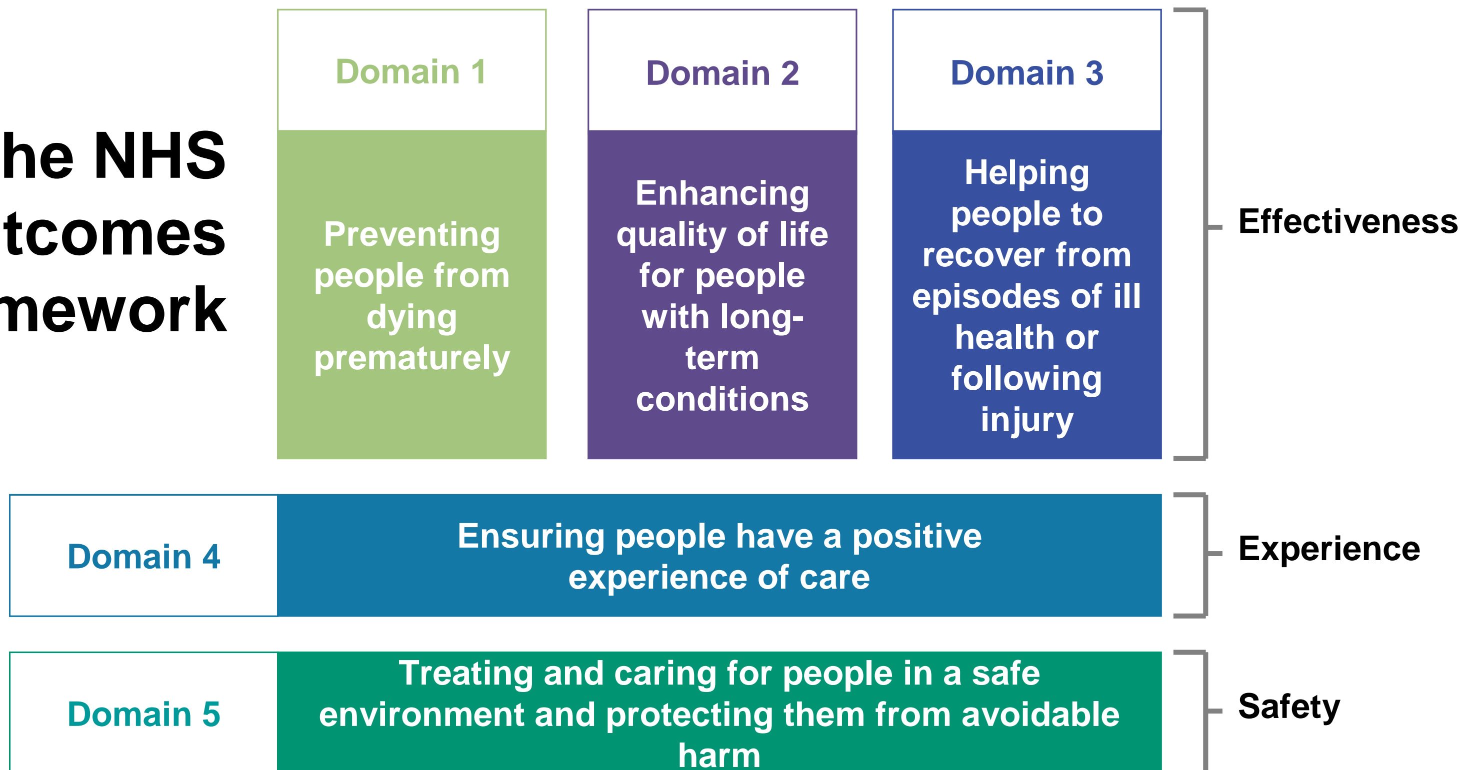
Alison Austin



THE NHS CONSTITUTION
the NHS belongs to us all

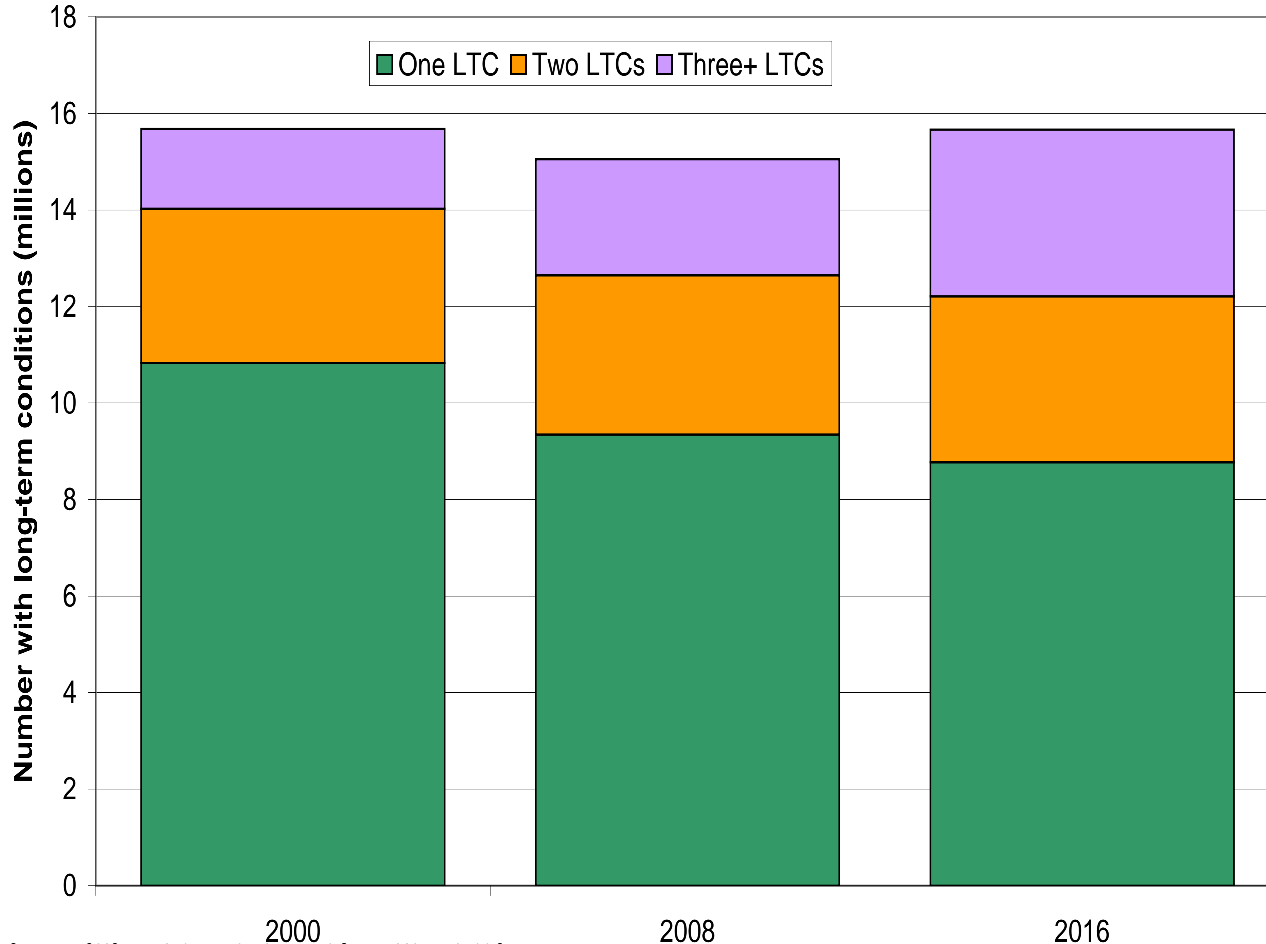
Our focus – delivering improved outcomes

NHS England



One disease vs. rise of multiple Long term conditions

NHS England



What business are we really in?

- 15m with LTCs
- Massive rise in population with a co-morbidity
- Most GP sessions LTCs
- 77% bed days
- 70% spend
- Mostly self manage, 5800 waking hours pa

Source: Department of Health analysis of ONS projections and GHS

Traditional NHS models will need to be radically rethought.

- Acute focused, episodic single disease models will not work,
- We need active patients, self-managing multiple long term conditions and supporting each other,
- We will need proactive, personalised care planning to support & manage multiple morbidities,
- We need to increase outcomes/outputs within the environment of no increases in NHS funding

3 key priorities for NHS England

- Enhancing the lives of people living with Long Term Conditions - care planning is key.

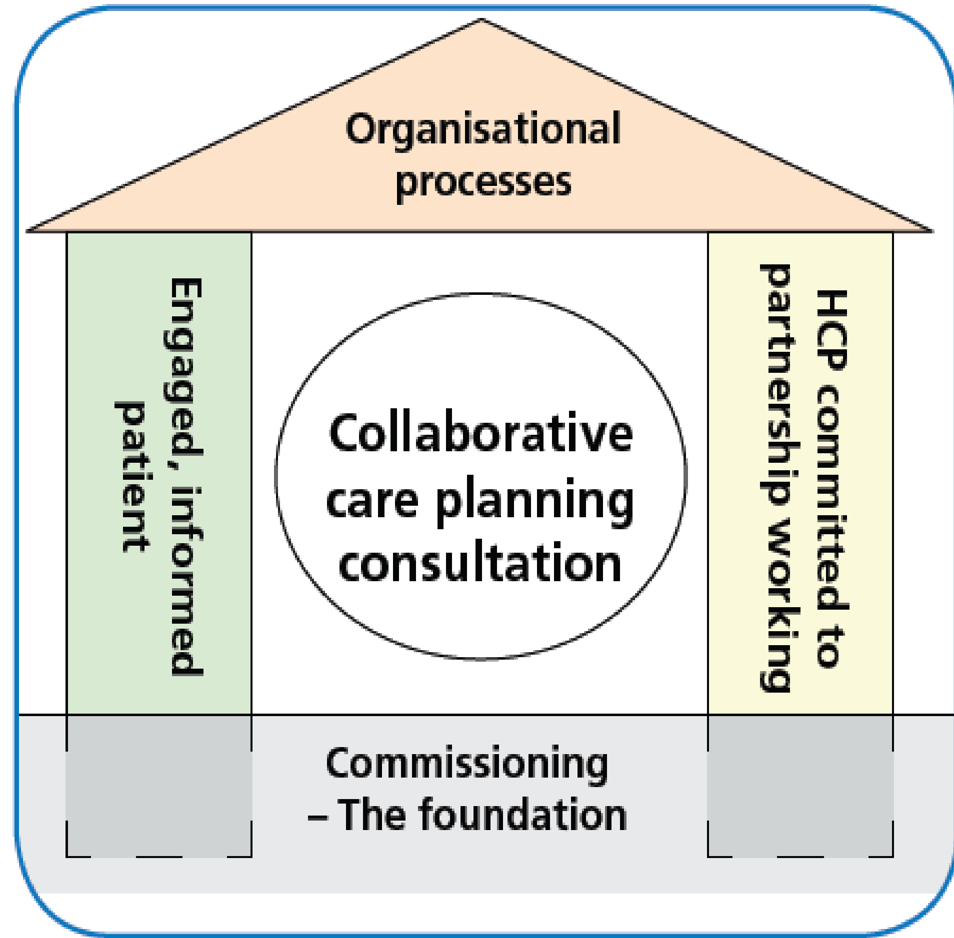
- Integration – a holistic, personal approach to providing care

- Patient Participation - People as ACTIVE PARTNERS in control of their care

Enhancing the life of people living with LTCs

The House of Care

At the highest level, enhancing the quality of life for people with long term conditions will be dependent on the system providing person centred, coordinated care



The National Collaboration on Integrated Care and Support

- On May 14, 2013, a partnership of 13 national organisations and bodies publicly committed to a shared vision of integrated care and support to help ensure better outcomes for service users and the system
- The collaborative is seeking to achieve this aim by creating the conditions nationally for person-centred, coordinated care to flourish locally

in association with:

The NHS Mandate – objective on patient participation in care

The NHS Mandate Objective:

- "To ensure the NHS becomes **dramatically better at involving patients**… empowering them to manage and make decisions about their own care and treatment."
- "by **2015**… more people **managing own health**… everyone with LTCs including MH, offered a **personalised care plan**… patients who could benefit have the **option to hold a personal health budget… information** to make fully informed decisions."
- Shared decision making, self-management, PHBs, information and personalised care planning all linked

Patient Participation – better outcomes, particularly high needs

Information as a supported service

- Targeted information and support. Risk stratification, health literacy and activation key to lifestyle change. Built into professional models.

Shared decision making (literature focused on PDAs)

- Stronger on experience of care than outcomes, some reduction in use of services (surgery)
- Information and decision aids necessary, not sufficient

Personalised care planning and Personal Health Budgets

- Cost effective, improve QoL, best for high needs with support

Self Care and Self Management Support

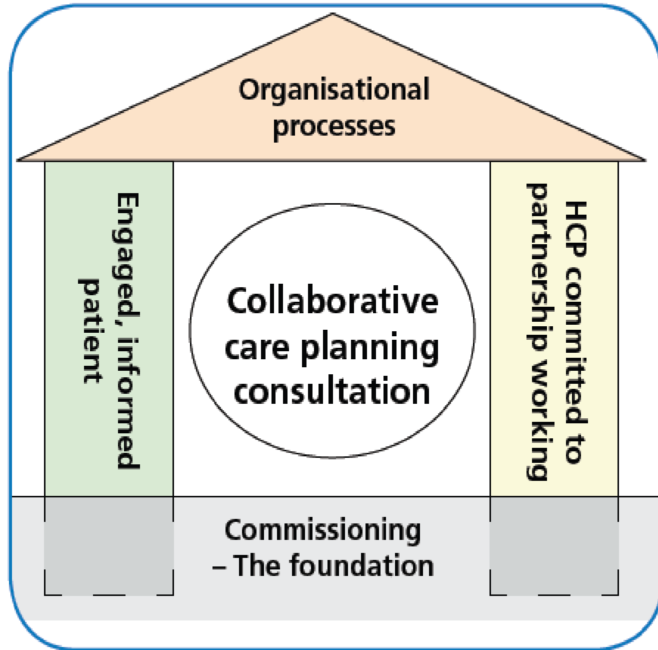
- Impact of behaviours, QoL, symptoms and resources.

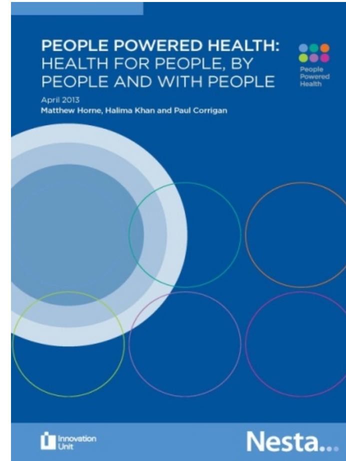
The challenges

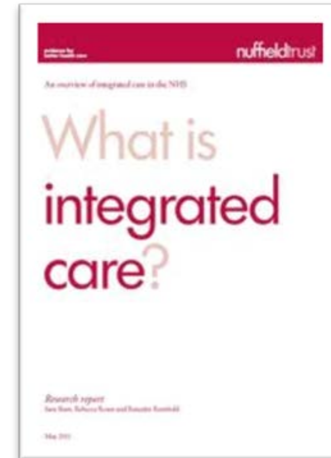
NHS England

- Making sure people get the right information, advice and support
- Justifying using public money differently
- Freeing up money in the system
- Changing the culture in the NHS
- Scaling up, mainstream without losing anything

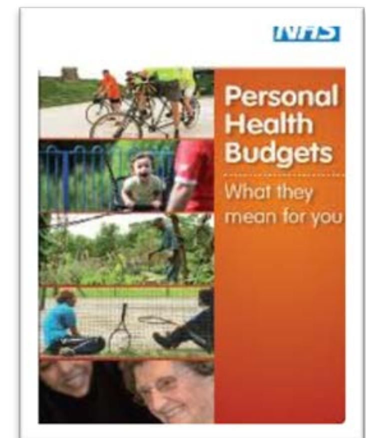
The Shared Vision – building on the important work of others



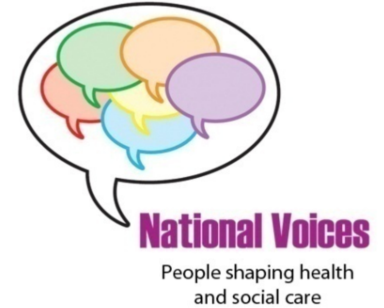




… PiF and many more…



SOURCE: adapted from NESTA slide

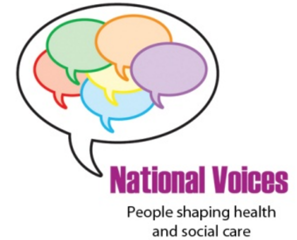


A Common Narrative and Principles for Care and Support Planning

Laura Robinson
Policy and Communications Advisor

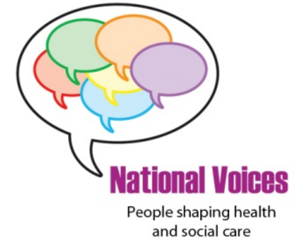
www.nationalvoices.org.uk @NVTweeting

National Voices' work



- The Health and Social Care Act 2012
- Narrative for Coordinated Care
- The Care Bill
- Principles of Care and Support Planning

Narrative of Coordinated Care



- Launched in May 2013
- From the perspective of the person who uses care and support services
- Sets out what people would experience if care works well
- Includes a series of statements on care planning

Generic 'I' statements

Care planning

I work with my team to agree a care and support plan.

I know what is in my care and support plan. I know what to do if things change or go wrong.

I have as much control of planning my care and support as I want.

I can decide the kind of support I need and how to receive it.

My care plan is clearly entered on my record.

I have regular reviews of my care and treatment, and of my care and support plan.

I have regular, comprehensive reviews of my medicines.

When something is planned, it happens.

I can plan ahead and stay in control in emergencies.

I have systems in place to get help at an early stage to avoid a crisis.

Principles of care and support planning

National Voices
People shaping health and social care

Principles of care and support planning

What is care and support planning – and why do we need it?

- People with long term conditions and disabilities, and their carers, should be supported to live the lives they want to lead, and receive the treatment and care they identify and need.
- Care and support planning recognises a person's strengths and abilities and enables them to work with a professional to develop a single, coordinated plan to achieve the goals they agree together.
- The process might happen slightly differently in different care settings but these principles are designed to give people and professionals a shared understanding of what these discussions should include.

Overarching principle	
Care and support planning should be offered to everyone who could benefit; anyone with a long term condition or disability and/or their carers.	
Preparation	
1. Starts from the point of view of the person	The person should be actively supported to consider in advance how they want to live their life, what they have to offer and the support they have and need.
2. Gathers necessary information and makes it available upfront	The care coordinator should help bring together the necessary information from other professionals working with the person, including medical information and any treatment, care and support options.
3. Builds in time to reflect and discuss options	The person must have sufficient time to consider the information received and discuss options with family, friends and/or carers.
Discussion	
4. Takes a partnership approach	Both the person and the professionals working with them have expertise. Both bring important information to explore and discuss together.
5. Identifies meaningful personal goals	The person and their care coordinator should discuss and identify manageable goals that the person wants to achieve.
6. Focuses on prevention	The person and their care coordinator should consider which information or support could enable the person to continue living as well as they can and prevent new needs from developing.
7. Develops a coordinated package of care and/or support	The person and their care coordinator should consider the broad range of options to help the person achieve their goals – including community services and wider support - and how this can be coordinated.
8. Builds in support to help people better manage their own care	Discussions should identify ways to help the person feel confident about managing their care and support in between contact with professionals and should clarify who to get in touch with if circumstances change.
Recording	
9. Discussions are recorded and outputs owned by the person	Discussions should be recorded, made available in the person's preferred format and shared with whoever the person wishes to share it with.
Follow up and review	
10. Agrees next steps and a date for review and follow up	Care and support planning is an ongoing process. The person and their care coordinator should agree a date for the plan to be reviewed.

I am a person who uses health, care or support services and would like to find out more about how care and support planning could benefit me

I am a professional and would like to know more about using care and support planning in my work and how it could benefit the people I work with

Coproduced with National Voices' members, partners, professionals, patients and service users

- Coproduced with National Voices' members, partners, professionals and people who use care and support services
- Aim: Create a common understanding amongst people who can benefit and across professional silos
- Draft Principles now published for views:

  www.nationalvoices.org.uk

Online tool

National Voices
People shaping health and social care

The Benefits of Care and Support Planning

The Benefits

For a person with a long term condition or disability, care planning can help:

- improve understanding of your condition or disability
- reduce severity of existing systems or help prevent your condition or symptoms from worsening
- support you to remain independent and promote greater confidence and control over your care
- builds on your strengths, and support you in achieving wider goals, such as returning to work
- you play a role in self care and get recognition and support from professionals in this role

For a carer, support planning can help:

- provide advice, information and recognition
- identify practical or emotional support which might be useful, including community services
- coordinate the support you receive with that of the person you care for more effectively

How to get started

How you start the care and support planning process might vary, depending on your personal situation. The first step is to speak to a professional you are in contact with.

This could include:

- Your GP
- Your social worker
- Your Specialist Nurse
- Your hospital consultant

You might want to print off the Principles document and share this with them to help with this discussion. You could also tell them about the online version at www.nationalvoices.ork.uk/PrinciplesofCSP.

There are also certain situations, such leaving hospital or moving from children to adult services, when effective care planning may be particularly important. Click here to find out more about this.

Click here to read our Q&A on care and support planning.

Care planning in Diabetes – Barbara's story

'I understand what's going on now, and what I can do to help myself.
I feel more in control of things'

Care planning in COPD: David's story

'I'm being looked after now…but I'm also looking after myself'

Care planning for older people: Jane and Jim's story

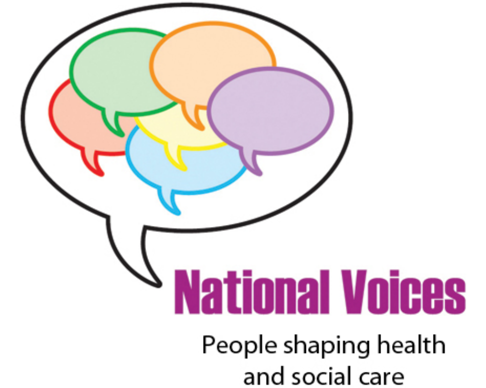
'The best thing was being able to do the process together'

Care planning in mental health: Sahib's story

'I'm doing things that I never dreamed I'd be able to do…I'm still learning'

Click here to view some example care and support plans

- Provides:
  - more information on each of the Principles
  - Case studies of Care and Support Planning in practice
  - Links to additional resources and example templates etc
- Other ways of disseminating the content?



Thank you for listening

Share your views on the Principles of Care and Support planning:

www.nationalvoices.org.uk/principles-care-support-planning

Laura.robinson@nationalvoices.org.uk @LauraRobinson5

The University Of Sheffield.

Royal College of General Practitioners

2011 THE AWARDS AWARD WINNER
UNIVERSITY OF THE YEAR

‘A Coalition of the Willing and Determined’

Professor Nigel Mathers

Vice-Chair, Royal College of General Practitioners
Professor of Primary Medical Care, University of Sheffield

Arthritis Research UK
June 2013

Original RCGP Care Planning Programme:

The Vision:

*A **joint strategic approach** to health improvement based on the concerted **implementation of care planning** in general practice, within the context of multimorbidity, and **in partnership** with a range of **disease specific organisations;** covering, for example, cardiovascular conditions, respiratory and musculo-skeletal conditions and cancer as well as **other organisations** eg Kings Fund.*

The RCGP Care Planning Programme

Aims:

- To embed care planning into the ‘core business’ of General Practice
- To incorporate the development of care planning skills into the GP training curriculum and facilitate other educational initiatives for established GPs.

The RCGP Care Planning Programme

Objectives:

1. Build communities of Practice ('Natural Laboratories')
    - Leadership facilitation
    - Active Championing ("diffusion of innovation")
    - Primary Healthcare Team involvement
    - Service redesign/delivery models

2. Develop a central reference (evaluation) group
    - Learning and training resources (GP curriculum)
    - Improvement research (evaluation)
    - Development of IT/Metrics
    - Communication strategy

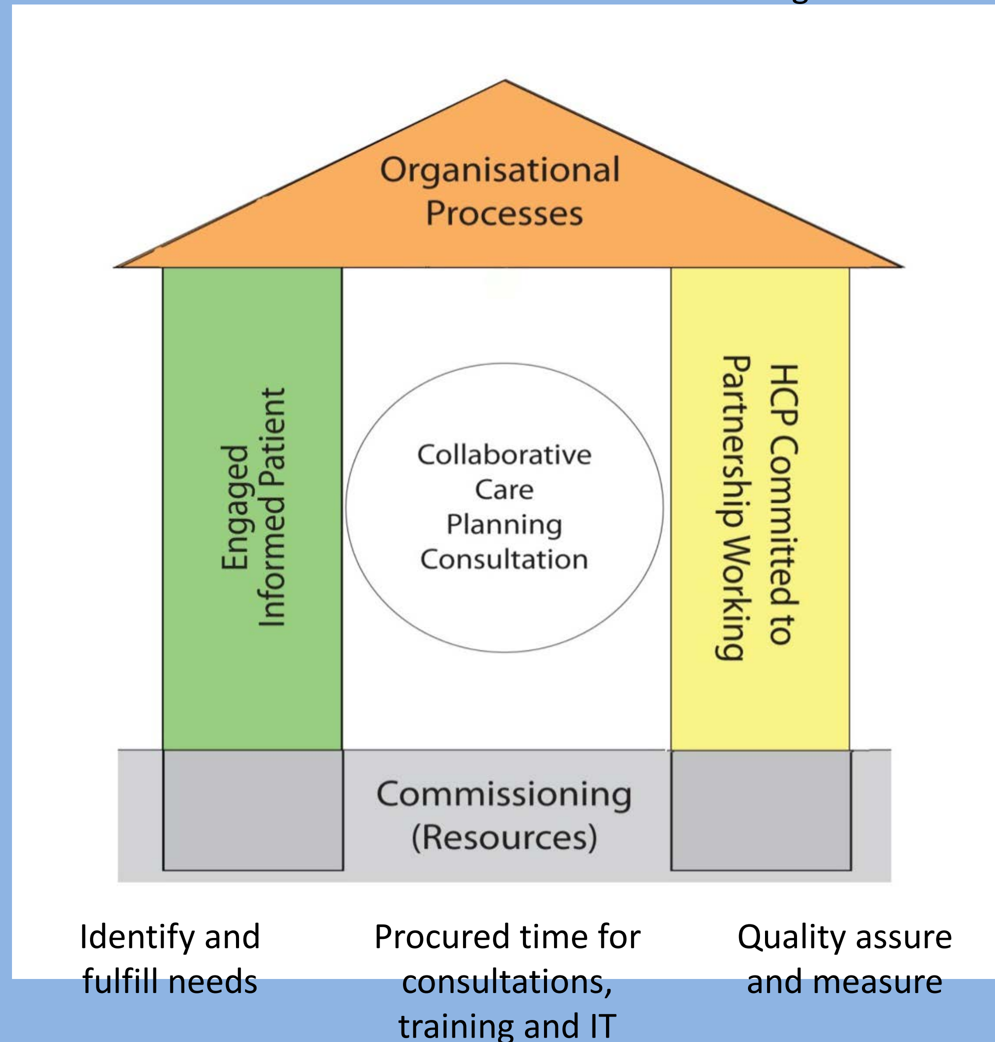
‘The House’

IT: Clinical record of care planning
& able to feed data into commissioning

‘Prepared’ for consultation

Information/ structured education

Emotional & psychological support

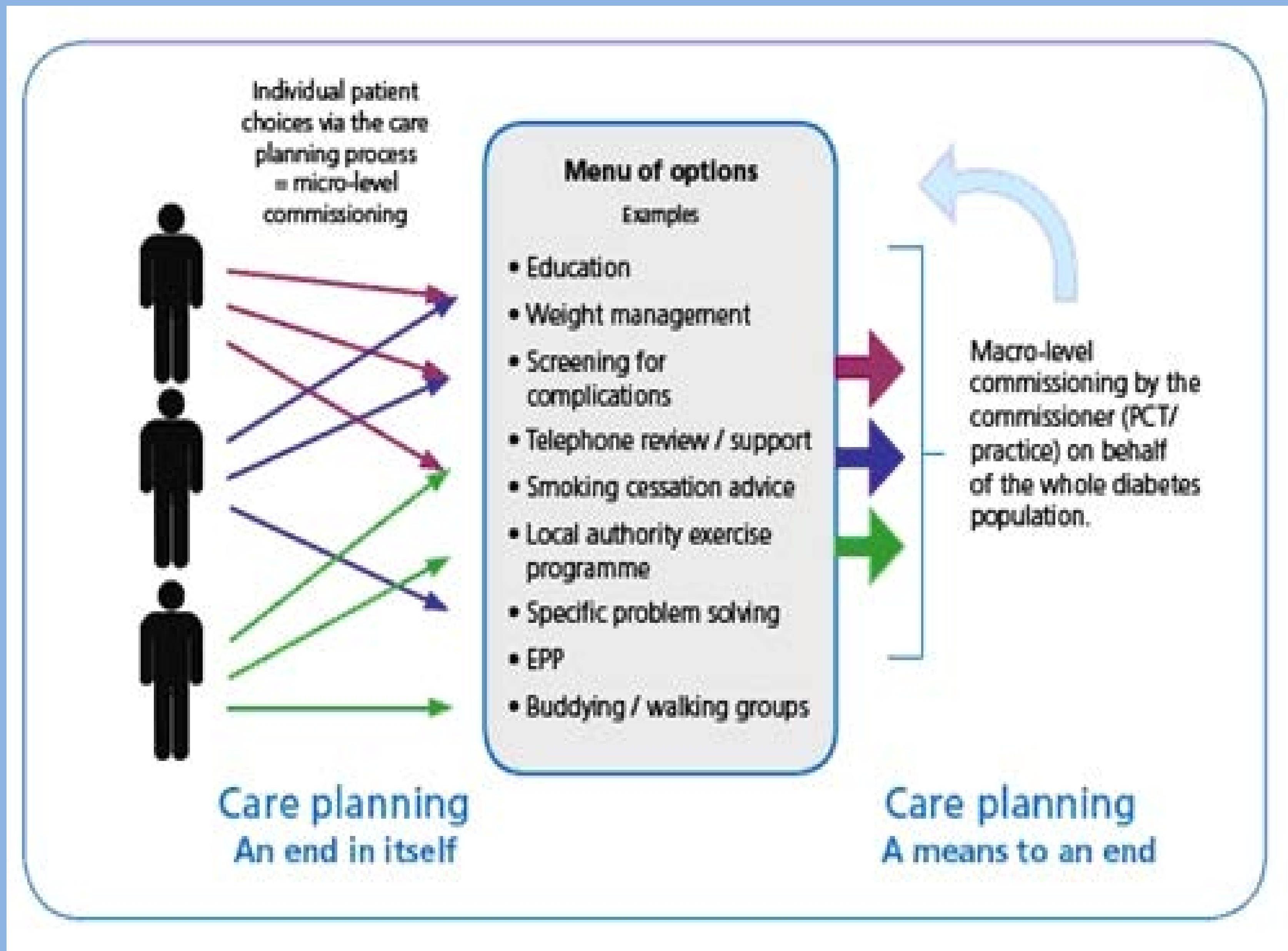


Consultation skills/attitude

Integrated, multi-disciplinary team & expertise

Senior buy-in & local champions to support & role model

A Coalition of the Willing and Determined



RCGP Care Planning Programme

Communities of Practice – Tasks

- Redesign the condition-specific pathway
- Contribute to evaluation
- Collect feedback and use agreed metrics
- Develop local systems of project management
- Medical ‘musts’ in multimorbidity
- Determine resource use within/between Practices
- Use agreed IT
- Participate in learning sets
- Develop and share local commissioning mechanisms

RCGP Care Planning Consortium:

- British Heart Foundation
- British Lung Foundation
- Macmillan Cancer Support
- Arthritis Research UK
- King's Fund
- Health Foundation
- Primary Care Rheumatology Society
- Diabetes UK
- RCGP

A Coalition of the Determined:

- RCGP/RCP
- NHS Bodies
  - NHS IQ
  - NHSE
- Voluntary organisations
  - Nesta [‘People Powered Health’]
  - The Richmond Group of Charities
- Patient organisations
  - National Voices
- ‘Think Tanks’
  - The Health Foundation
  - The Kings Fund

Values

- A holistic and integrated approach to care
- Transformation of health care professional relationships towards partnership
- Promotion of People Powered Health,Care Planning, Shared Decision Making and Community Engagement

Core Principles of Co-operation

- Each organization contributes according to their interests and capacity and is supported according to their needs’

- This is an ‘alignment of objectives, not individual ownership

Outputs [1]

- Act as an expert reference group
- ‘Pool’ and publish the learning
- Develop a common strategic approach

Outputs [2]

- Support and ‘operationalise’ the Delivery System
- Develop and support high quality training
- Identify and develop evaluation methodologies

Linked Work streams needed to Implement the 'Delivery System'

A: Communities of Care Planning Practice

This involves **developing communities of practice** in which care planning is the norm for people with LTCs.

Elements include developing a **leadership group** of primary care and community professionals to share learning , work with Colleges and HEE on a **workforce strategy for LTCs** including developing training curricula and quality assurance

Set up: including developing a **'Quality assured'** cohort of trainers / design facilitators to use the 'House of Care' model to work with

- Practitioners to introduce care planning as routine
- CCGs to support system wide redesign and ensure local support for practitioners to enable this to happen

Led by RCGP working with the YOC programme

B:Developing Healthy Communities

This recognises that people living with long-term conditions face significant challenges, but they also have **strengths and abilities** including the capacity to manage their own health, given the right support..

This work stream will establish **communities of practice centred on coproduction and peer support** , designed to address specific issues which have been identified as difficult and strengthen the practical, evidence and financial base introduced in PPH .

Led by NESTA

C: QI, metrics, standards , and incentives

Work with NICE /other standard setting bodies to ensure the lessons from work streams (A) and (B) are incorporated into guidelines and Standards.

Develop /evaluate methods for collecting appropriate metrics across the whole LTC 'landscape' – linking with work stream (B)

Work with the NHSE to ensure lessons from work streams influence the nature of national incentives / GP contract.

Develop specific tools and resources to *'make it easier for delivery teams to do the right thing'* using appropriate quality improvement methodologies.

Close links with NHSIQ

B: Innovation and Evaluation

This group will develop a comprehensive programme of work based round the Evaluation of Complex interventions.

Using communities of practices (and smaller units/ practices /teams) developed in work stream (A) as the 'laboratories' .

Use wide variety of robust methodologies - including economic evaluation.

Generate hypotheses to be designed into delivery by Work stream (A) for further testing .

Led by an academic consortium based around an academic primary care institution/s

Critical tasks

- Agree the narrative
- Agree the governance / and overall funds
- Develop a Trainer Programme
- Develop a redesign team
- To scope the communities of practice
- Map other work streams onto this.

It is time for change!

Thank You