Examining how personalised care planning can help patients with long term conditions

All patients with long term conditions are to be offered a personalised care plan by 2010. This article details how this approach can benefit both patients and staff.
are unaware of their treatment options and do not have a plan for managing their condition (Opinion Leader Research, 2006).

PERSONALISED CARE PLANNING

Personalised care planning aims to put people on an equal footing with health and social care professionals, moving away from “doing to” to “doing with”. A care planning consultation should feel like the “meeting of two experts” – the patient/client and their clinical carer.

It focuses on a discussion with individual patients about goals to support their health and wellbeing, such as returning to work, stopping smoking, improving diet or living independently. The discussion should also focus on supporting them to self care, and finding out what impacts on their health and wellbeing, such as poor housing and emotional and psychological needs.

Choice should be stimulated through personalised care planning, which embraces three key components. These are people having:

- Power to shape their pathway through services and keep control over their lives;
- Preferences to choose how, when and what treatments or services they receive;
- Personalised services organised around their lifestyles.

Care planning should be proportionate to need. For example, for those with a range of complex needs, it is led and coordinated by one professional, such as a community matron or specialist nurse. It follows a health and social care assessment of need, takes more time and is more detailed. There is a strong emphasis on coordinating services and contingency planning.

For those with less complex needs, the planning process must include information about how their condition impacts on their life and support for self care so that each patient can make the best decisions and decide how best to manage their condition.

Providing patients with information such as test results or prompting them to think about questions to ask before the care planning consultation takes place also helps them to reflect and prepare so they get the most out of the discussion. It also establishes an equal relationship with their healthcare professional.

THE CARE PLAN

The care plan records the outcome of the discussion between the patient and healthcare professional, and lists any actions agreed. The patient owns the plan, can receive a printed copy and chooses who has access to it. The level of detail will depend on the complexity of the long term condition.

For example, a care plan for an older person with heart disease, diabetes and arthritis will be detailed and would include information about medication, contingency or emergency planning for exacerbations, and health and wellbeing goals.

At the other end of the spectrum, for someone young and fit with moderate asthma, the care plan could include advice on how to use inhalers, details of websites such as NHS Direct that provide information on self care, a goal to quit smoking and a referral to a smoking cessation service.

BENEFITS

Many benefits can be gained from personalised care planning. International evidence shows best outcomes are achieved when there are: systematic proactive services; people engaged in their own care; and healthcare professionals and people with long term conditions working in partnership (Wagner et al, 1996). The Diabetes Year of Care programme (tinyurl.com/diabetes-year) and the Co-Creating Health initiative (tinyurl.com/co-creating-health) are two national service transformation programmes informed by this philosophy.

People who feel more confident to manage their own health tend to feel more confident in their everyday lives and so have a higher quality of life. They also tend to have improved clinical outcomes (Newman et al, 2004). Supporting people to self care through care planning can reduce GP visits by 40% for high risk groups (Fries and McShane, 1998) and hospital admissions by 50% (Montgomery et al, 1994).

Nurses should see people taking more active involvement in their health and wellbeing, which should lead to less reliance on services. An overall improvement in the management of long term conditions should free up nurses’ time, allowing them to focus on proactive and preventive approaches.

Another benefit is improved job satisfaction. Community matrons, for example, say they find proactively managing patients with complex needs, using holistic assessment and care planning techniques, hugely rewarding, according to anecdotal evidence. A patient with COPD in Kirklees said: “Without the support from my community matron to stop smoking, I wouldn’t be alive now” (from a DH case study).

DELIVERY

Supporting people with long term conditions requires healthcare professionals to adopt a different role to the traditional “diagnoser and treater”. They must support patients in acknowledging, understanding and adapting to their condition. This is essential since, by definition, long term conditions are incurable and their effects are permanent and variable.

Healthcare professionals are the “experts” in understanding disease. However, patients will know best whether proposed treatments or support fit into their lives. While they may value help deciding what will work for them, they must make the final decision if the plan is to be effective.

Nurses should consider how they interact and engage with patients. Are they listening to what they want, providing information and supporting them to self care?

Guidelines to help nurses develop skills to support patients include Common Care Principles to Support Self Care (Skills for Care, Skills for Health, 2008). Practitioners keen to gain further skills may be interested in learning techniques such as motivational interviewing or cognitive behavioural approaches, which are effective for motivating people to change behaviours.

Linked to the care planning commitment is Your Health, Your Way, formerly known as the Patients’ Prospectus (DH, 2008c). This aims to raise public awareness of what services they should expect to be offered to support self care.

Your Health, Your Way should begin to drive demand for services such as the Expert Patients Programme and peer support networks, or equipment such as blood pressure monitoring devices or handrails.

Online practical tools

An information booklet for healthcare professionals was recently published, alongside a range of online practical tools and resources. Further national tools are currently being developed, including e-learning modules for care planning and information prescriptions (DH, 2008d).

Delivering personalised care, listening to patients, and putting them at the centre of their care requires a cultural shift from “doing to” patients to “doing with” them. Nurses may feel familiar with the concept of care planning, but true personalisation takes this to a new, more dynamic level. The care plan itself can be also a vehicle for patients to hold important information, a significant step in shifting the locus of control.
Finally, no amount of good intentions will change practitioner behaviour if the working environment is not supportive. If the timing of appointments is wrong, if patients do not have the information or understanding to take part, if working practices are geared to ticking boxes and if commissioners measure the number of care plans rather than involvement in the new process, then things are unlikely to change.

**CONCLUSION**

The DH has responded to feedback from patients and the public by developing health policy that is more patient centred. Personalised care planning is among the latest of these policies. It is initially being offered to people with long term conditions because they will benefit most, but the principles should apply to all those receiving health and social care services.

Successful personalised care planning will ensure those with long term conditions receive care tailored to their needs, preferences and lifestyles. It will promote support for self care and information to support choice.

Nurses have a huge role to play in delivery, using and developing skills to make a difference to the thousands of patients with long term conditions with whom they come into contact each day. However, the scale of cultural change required across the NHS workforce should not be underestimated.

Nurses will benefit from this policy by being able to address the wider needs of those with long term conditions, which should lead to better outcomes and patient satisfaction.

Part 2 of this series, published next week, looks at how a GP practice is piloting nurse-led personalised care.

**REFERENCES**

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