Piloting the introduction of personal health plans for people with long term conditions

An outline of work to develop personal health plans for patients with long term conditions, empowering them to take greater ownership of their healthcare.

INTRODUCTION
NHS East of England is the strategic health authority for the East of England and is responsible for health strategy in Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk. Around 1.6 million people in the region have long term conditions.

Public consultations run by the SHA to establish the major health concerns of people in the East of England showed that long term conditions were a priority area for action. Results clearly indicated they wanted more control over their care and lives.

Personalised care planning gives patients more choice by providing information on a range of options for managing their condition, including a greater focus on self care. They are encouraged to discuss their wider health and wellbeing needs with healthcare professionals, and choose services that meet their individual needs, rather than practitioners simply recommending services that match their long term condition (Morton and Morgan, 2009).

THE PERSONAL HEALTH PLAN
In July 2008 NHS East of England set up a group to oversee the development of personalised care planning in the region.

Workshop sessions were held for people with long term conditions, their carers, health and social care professionals and representatives from third sector organisations. These sessions aimed to help shape the development of a tool to support implementation of personalised care planning.

During these sessions patients indicated that they preferred the title “personal health plan” to “personal care plan”. They felt the latter implied that something was being “done to” them rather than that they were working in partnership. The concept of the personal health plan developed in NHS East of England does, however, follow the principles of person centred care planning outlined in the first article in this series (Morton and Morgan, 2009).

The principles surrounding the health plan are that patients own them and they decide with whom they choose to share the information. It can be used to prepare for a hospital appointment with a specialist team, or an appointment with a GP or practice nurse. The health plan is essentially a tool to empower people with long term conditions and to change the focus of consultations between patients and healthcare professionals to a more equal partnership. It is designed to be flexible and patients can choose which sections they feel are most beneficial to support management of their condition(s). Some patients may choose not to have a health plan and that is their decision.

The language, style and content of the tool were developed and tested during workshop sessions in 2008. A range of opinions were sought on a draft of the health plan in November 2008. Although the concept was well supported, there were different opinions on what it should include. It was decided that the best way to proceed was by carrying out pilots using the tool, involving people with long term conditions, carers and healthcare professionals.

PILOT STUDY DESIGN
In March 2009, NHS East of England launched a three month, 15 site pilot of the personal health plan to help patients with long term conditions to take greater ownership of their condition and to agree the actions they needed to improve their quality of life. Patients should be supported by a healthcare professional, often a nurse, to help them on this journey of empowerment.

Nurses in a variety of roles – including community matrons, specialist nurses and practice nurses – are critical to the success of this concept. Pilot sites included GP practices, a carers’ organisation, a prison, a neuro-rehabilitation team and community services. Among the 15 pilot sites was NHS South West Essex Community Services. The pilot study aimed to test the language, layout and content of the personal health plan.

Implementing these health plans involves practitioners working in new ways with patients with long term conditions, such as co-production (engaging people across the system to work together to make change happen) and in equal partnership. Another dimension of the pilot was therefore to discover how using the plan changed the way practitioners work with patients and to learn what skills and training they need to deliver personalised health planning.
INITIAL FEEDBACK

An event was held with representatives from the pilot sites in June to understand the learning from the pilot work. This was an extremely informative day with lots of valuable discussion on how to further develop the personal health plan. Key learning included:

- The plan is optional and people with long-term conditions can choose if they would like to have one;
- It must be flexible and patients can choose which sections they wish to complete;
- The way the concept of personal health planning is explained to patients is particularly important in ensuring positive engagement in the process;
- Nurses and other healthcare professionals highlighted that they would like further information to enable them to better explain personal health planning to their patients;
- The health plan appears to be particularly beneficial if introduced at the time of diagnosing a long-term condition;
- It is a flexible tool and can be completed over the course of a few consultations.

Patients, in conjunction with their healthcare professional, were free to decide how to use the health plan. Some found it helpful to complete the tool in several sessions, particularly if patients needed support filling it in, or wanted time to think about the questions.

One GP practice opened on a Saturday in order to provide longer appointments for patients to work on their plan, while community matrons in South West Essex introduced the tool during routine visits to patients’ homes.

Many healthcare professionals found it challenging to create extra time to work with patients to complete the plan initially, but became keen to use it when they saw the benefits later in the pilot. NHS South West Essex Community Services created extra time by prioritising caseload and workforce management.

Some practitioners found people who had just been diagnosed were keenest to develop their plan and understand their condition. Others, such as NHS South West Essex Community Services, only offered the plan to those with experience of how their condition affected their life.

The South West Essex pilot found some patients became emotional when discussing how their condition affected their life. They said this was because they felt they had the time and space to be listened to. As a means of further supporting implementation, interview and active-listening training for HCAs and associate practitioners is planned, although it is recognised there are elements of the health plan that will require support from registered nurses or other healthcare professionals.

NHS South West Essex (both the PCT and the community services branch) is running a joint commissioning and provider pilot to use health plans to identify gaps in service provision. These could be providing a home visiting optician, home counselling or something as individual as a Wii Fit for someone unable to exercise outside their home.

NHS South West Essex has also set up a multi-agency steering group so a range of health and social care staff can share knowledge of personalised health planning. The aim is that all services will work with the same written personal health plans.

IMPLICATIONS FOR NURSES

Nurses are pivotal to making personalised health planning a success. They have a key role liaising with other organisations, including social care and the third sector, and in helping people with long-term conditions to understand the benefits of engaging in the process.

The process of implementation gives everyone involved in a patient’s care a broader view, allowing them to see an individual person, not a condition. This is because it focuses on patients’ wider needs, not just their medical ones, and involves two way communication between the healthcare professional and patient.

Fundamental to the initiative is the fact that patients own their personal health plans and choose with whom they share the information. For example, they may decide to take the plan to hospital to help them express their needs if they feel they have difficulty in communicating these. It also helps them to communicate how their condition is affecting them, what support they need during an exacerbation and what medication they take.

People with long-term conditions benefit most when they have enough time to understand the health planning process and can talk freely about all of their needs.

CONCLUSION

Initial results from the pilot study are encouraging and the Department of Health (2009) has highlighted the work in NHS East of England as an example of good practice.

Work will be undertaken to refine the personal health plan’s content based on feedback from pilot sites. To support fuller implementation of the health plan across the SHA, a toolkit is being developed to support nurses and other healthcare professionals. This will include a competency framework outlining the skills needed to support the different stages of the personalisation process.

Another exciting initiative being developed in the near future is the piloting of an electronic version of the health plan with colleagues from NHS Connecting for Health. In addition, some of the pilot sites, including NHS South West Essex Community Services and NHS Norfolk, are examining how personalised health planning can be the first step towards offering a personal health budget to people with long-term conditions.

REFERENCES


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