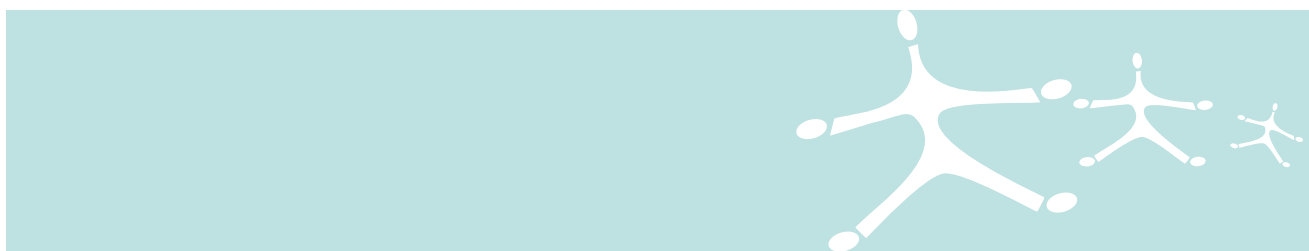


improving care for people with  
long term conditions

information sheet 1

# personalised care planning



*an 'at a glance' guide for healthcare professionals*

# personalised care planning

## improving care for people with long term conditions

### About this information sheet

This information sheet describes what personalised care planning is and what good care planning looks like as well as what it means for individuals and healthcare professionals.

### Who should read it?

Anyone involved in delivery of healthcare to someone with a long term condition, including doctors, nurses, allied health professionals, those delivering personal health budgets and health trainers.

### What is personalised care planning?

Personalised care planning empowers individuals, promotes independence and helps people to be more involved in decisions about their care. It centres on listening to individuals, finding out what matters to them and finding out what support they need.

Personalised care planning is essentially about addressing an individual's full range of needs, taking into account their health, personal, family, social, economic, educational, mental health, ethnic and cultural background and circumstances. It recognises that there are other issues, in addition to medical needs, that affect a person's total health and well-being. It is therefore a holistic process, treating the person "as a whole" with a strong focus on helping people, together with their carers, to achieve the outcomes they want for themselves. In doing this, it should open up more choices that are relevant for people with long term conditions. This is demonstrated well in the delivery of personal health budgets.

**70% of individuals with a long term condition say their care has improved as a result of personalised care planning.\***

### What does good personalised care planning look like?

Good care planning can make a huge difference to people's lives. It enables individuals with long term conditions to plan their care, have strategies in place to cope with exacerbations of their condition and have all the relevant information they need to make informed choices and decisions. Supporting people to self care means they have more confidence and control over their condition and understand how it affects their lives.

Individuals with long term conditions will be at different stages on their journey and their ability to take more control will depend to some extent on what stage of that journey they have reached. Someone who has just been diagnosed with a long term condition will have different needs to someone who understands and has accepted their condition, or someone requiring end of life support. Depending on the complexity of the person's need, a multidisciplinary team of staff may be involved in the care planning process.

As a minimum, a **care planning discussion** ought to focus on:

- agreeing the individual's goals (e.g. I want to lose weight, stop smoking, get out more, get a job);
- providing information (timely, relevant, ongoing, could be in the form of an Information Prescription);
- supporting individuals to self care, to take a more active role in their own health;

\*GP Patient Survey 2009/10

- agreeing on any treatments, medications, or other services such as access to support groups or structured education programmes such as the Expert Patient Programme;
- agreeing any actions;
- agreeing a review date.

**Successful personalised care planning needs to be developed with individuals, not done to them. It requires you to adopt a different role to the traditional “diagnoser and treater”. The healthcare professional’s role is to support individuals to acknowledge, understand and adapt to living with their condition.**

Please see **information sheet 2: Personalised care planning diagram**, which is designed to illustrate the care planning process. It also shows individuals at different stages of their journey, and the staff that might lead and be involved in the process. More examples can be found at [www.dh.gov.uk/longtermconditions](http://www.dh.gov.uk/longtermconditions)

## What is a care plan?

A care plan quite simply records the outcomes from a care planning discussion, including any actions agreed. It could be a written document, an electronic document or both. The person owns the care plan and can share it with carers and other family members if they wish.

People with low level or moderate needs may not want a written document; they may prefer to record anything agreed in their patient notes. They may decline a care plan, or not be happy with the term “care plan” as it may imply the need to be “cared for” when they have full and active lives. This is why in some areas it is called a “health plan” or “self management plan”.

For those with complex health and social care needs a care plan is likely to be a more detailed written document, which may also be called a support plan. It is important that people with complex health and social care needs have:

- a lead coordinator such as a community matron or specialist nurse;
- a contingency plan for crisis episodes or exacerbations of their condition;
- action plans to attain their goals;
- a detailed medication plan and date for review.

The most important thing is that the discussion has taken place, that outcomes are recorded in an agreed format and that people know they have a plan to manage their condition.

## What are the benefits of a care plan?

The overarching aim of care planning and agreeing a care plan is to improve the quality of care and outcomes for people with a long term condition by engaging them more in decisions about their care and to take control of their own health. This process is the central thread of long term conditions management. Planning care in this way is more proactive and meets people’s full range of needs.

For example, overcoming anxiety and depression that was previously undiagnosed means a person can have better health outcomes and be less likely to need repeated GP appointments or emergency admissions. Similarly, crisis planning and knowing whom to contact can reduce unplanned admissions; self managing can slow progression of disease. This benefits individuals and NHS staff and organisations through improved quality of care, increased job satisfaction and efficiency savings.

People with one long term condition are two to three times more likely to develop depression than the rest of the general population. People with three or more conditions are seven times more likely to have depression.\* Therefore routine assessment or screening for depression as part of care planning can help reduce those inequalities and support people with long term conditions to have a better quality of life and better social and working lives.

## How do multiple care plans feed into an overarching care plan?

A person may have one or several treatment/management plans. For example, they may have been referred to a physiotherapist for a special assessment to agree a self care plan; they may also have agreed a health plan with, for example, a weight loss clinic.

These documents should feed into an overarching care plan, providing additional information about aspects of their overall care package to be shared with the people who are involved in contributing towards that person's care.

It is recommended that it become common practice for all healthcare staff who have contact with a person to refer to their overarching care plan to check that the care they are agreeing supports that person's stated goals.



\*NICE 2009: Depression in adults with a chronic physical health problem

## The role of the healthcare professional in care planning

Supporting people to manage their health and their condition better by taking them through a process of discussion, shared decision making and ongoing support as part of the care planning approach enables healthcare professionals to work in a more inclusive way – **working with** people rather than **doing to** them.

Good communication skills are crucial for optimising a care planning discussion and supporting individuals to self care. It is vital that healthcare professionals have the right skills, approaches and behaviours to deliver high quality personalised services for individuals with long term conditions. For more information about relevant training for professionals go to [www.dh.gov.uk/longtermconditions](http://www.dh.gov.uk/longtermconditions)

## Preparing for a care planning discussion

The following questions may prompt healthcare professionals to think about how they interact with individuals:

Do I **communicate** effectively?

Do I **listen**?

Do I **support** individuals to make **informed choices**?

Do I **support individuals** to access appropriate information?

Do I **support individuals** to **develop skills in self care**?

Do I discuss **risk**?

Do I put aside my own **health beliefs**?

Do I view the individual in **front of me** as having **expert knowledge** in addition to mine?

Do I see the **individual as a whole** – not just concentrate on the individual's medical condition?

Am I **supporting** this individual to **take control**?

Do I ensure that those with complex needs are **receiving coordinated care**?

Do I strive to **work across agencies** and promote **safe information sharing**?

Do I ask individuals what they feel they need to **better self manage**?

Do I ask individuals if they have any ideas as to the **services they would like to be included in their plan**?

## Preparing others too

As well as thinking about how to approach a care planning discussion, preparing the individual for the appointment is also beneficial, for example with prompts about questions to ask, by sending them copies of letters to other clinicians about them or sharing test results with an explanation of what they mean. Encouraging individuals to get the most out of a discussion and to really have an expectation that they can ask what they want and that they are equal partners in the discussion is core to personalised care planning.

## How do you know you are being effective?

How do individuals feed back? Are there any patient feedback surveys in the area? Are individuals achieving the outcomes they want for themselves?

**The essence of care planning is about healthcare staff truly engaging with individuals, encouraging their input and views about their care and finding out what could really make a difference to support their health and well-being.**

## Further information for healthcare professionals

### Health needs assessment tool

A health needs assessment (HNA) tool developed by NHS Kirklees helps healthcare professionals to identify the needs of the individual and target resources more effectively, offering more personalised support to individuals with long term conditions. For more information on the HNA tool in Kirklees, please visit [www.kirklees.nhs.uk/your-health/helping-yourself-to-better-health/self-care-toolkit/overview-of-self-care-options/health-needs-assessment/](http://www.kirklees.nhs.uk/your-health/helping-yourself-to-better-health/self-care-toolkit/overview-of-self-care-options/health-needs-assessment/)

### Well-being Star™

The Well-being Star™ for long term conditions is another free tool that can support healthcare professionals in their care planning discussions. The tool works by encouraging the person to consider a range of factors that impact on their quality of life. These are not restricted to health, but cover a broader range of issues including lifestyle, looking after themselves, managing symptoms, work/volunteering/other activities, money, where they live, family/friends and feeling positive.

The PDF version of the tool is free to download and use within your organisation. To register please go to [www.outcomesstar.org.uk](http://www.outcomesstar.org.uk)



## Personalised Care Planning and Information Prescription e-learning toolkits\*

NHS Employers has produced two e-learning packages to help develop the skills and knowledge needed to produce personalised care plans and Information Prescriptions.

[www.nhsemployers.org/PlanningYourWorkforce/LongTermConditions/Pages/LongTermConditions.aspx](http://www.nhsemployers.org/PlanningYourWorkforce/LongTermConditions/Pages/LongTermConditions.aspx)

### Supporting Self Care e-learning toolkit\*

This is designed for healthcare staff supporting people with long term conditions.

[www.e-lfh.org.uk/projects/supportingselfcare/index.html](http://www.e-lfh.org.uk/projects/supportingselfcare/index.html)

### End of Life Care for All e-learning toolkit\*

Enhances the training and education of all those involved in delivering end of life care.

[www.e-lfh.org.uk/projects/e-elca/index.html](http://www.e-lfh.org.uk/projects/e-elca/index.html)

More information on personal health budgets can be found at:

[www.personalhealthbudgets.dh.gov.uk](http://www.personalhealthbudgets.dh.gov.uk)

Publications and other resources on long term conditions management are available at:

[www.dh.gov.uk/longtermconditions](http://www.dh.gov.uk/longtermconditions)

\*Please note you will need to register with the site provider to access these toolkits

The series of information sheets is available to download at [www.dh.gov.uk/longtermconditions](http://www.dh.gov.uk/longtermconditions) and covers the following topics:

**Information sheet 1:** Personalised care planning

**Information sheet 2:** Personalised care planning diagram

**Information sheet 3:** Care coordination

**Information sheet 4:** Assessment of need and managing risk

**Information sheet 5:** What motivates people to self care

**Information sheet 6:** Goal setting and action planning as part of personalised care planning

**Information sheet 7:** How information supports personalised care planning and self care

**Information sheet 8:** End of life care and personalised care planning

Look out for further information sheets covering other relevant topics.

Your feedback is extremely important to us. Please send your comments/suggestions for this information sheet, or good examples of personalised care planning and supported self care within your area, to

[longtermconditions@dh.gsi.gov.uk](mailto:longtermconditions@dh.gsi.gov.uk)