NHS

improving care for people with long term conditions

information sheet 2

personalised care planning diagram

an 'at a glance' guide for healthcare professionals

DH Department of Health

personalised care planning diagram

improving care for people with long term conditions

About this information sheet

The care planning diagram takes the reader through the different stages of an individual's journey when they have a long term condition, illustrated by real people case studies. The diagram includes information on the approaches and behaviours needed by a healthcare professional to deliver good personalised care. It can be used in conjunction with **information sheet 1: Personalised care planning**, or as a standalone document or wall chart.

A poster-size version of the diagram is also available at **www.dh.gov.uk/longtermconditions**

Who should read it?

Doctors, nurses, those delivering personal health budgets, allied health professionals and health trainers and anyone supporting individuals with long term conditions.

Personalised Care Planning for People with Long Term Conditions

People with long term conditions are at different stages on their journey, with different lives, different roles and different goals

People with long term conditions*

COPD, Dementia, Cancer, Asthma, Mental Health, Alzheimer's, Parkinson's, CHD, Stroke, Arthritis

*Not a complete list

Just diagnosed, Not yet diagnosed, Multiple conditions, Low confidence to self care, End of life, High confidence to self care

Married, Father, Unemployed, Carer, Widowed, Mother, In work, Live alone, I want to lose weight, I want to walk unaided, I want to live independently, I want to return to work, I want to stop smoking

Contact with Health/Social Care Professional/ Staff Member

Made via

For example:
- QOF Review
- Practice nurse appointment
- Social care worker
- Referral to community matron
- Referral to specialist nurse or consultant
- GP appointment
- Referral to specialist service

Offer Care Planning

Already has a care plan? Improve quality, aim for Gold Standard Vision*

*As described in commissioning personalised care planning: a guide for commissioners DH 2009

Lorna 78 years old

Lorna lives alone and wants to remain independent. She loves cooking and is a self taught chef. She's had diabetes since 50, was diagnosed with skin cancer at 74, has arthritis which causes problems with her knees and mobility and mild heart failure. She finds her failing health a hindrance to her life and this has caused her frequent hospital admissions which she loathed. She often feels lonely and isolated and wants to get out more, including attending her local bingo hall once a week with her neighbour.

Jack 55 years old

Jack has recently taken early retirement, is married and has a 13 year old daughter. He has been a heavy smoker for 40 years and was recently diagnosed with COPD. Jack is on the Quality and Outcomes Framework (QOF) register in his local GP practice, which means he will have regular reviews with his GP and nurse practitioner to monitor his condition. At his last review Jack was referred to a specialist respiratory team and was offered personalised care planning with the specialist respiratory nurse.

Workforce approaches and behaviours needed to deliver

"We don't **make assumptions** about what people want, we **listen to them**..."

"We see the care planning consultation as "**a meeting of two experts**", the individual and their clinician/ professional..."

"We focus on **wider, holistic needs** not just medical..."

"We don't "**do to**" people, we "**do with**" them..."

"We work **across agencies**, we have developed **protocols for sharing information**..."

"People with **complex needs** have a **named lead coordination of services**..."

We adopt the "common core principles to support self care": (www.skillsforhealth.org.uk)

- **Ensure individuals are able to make informed choices.** Support them to make decisions based upon their needs and preferences. Shift emphasis from "I know what is best" to listening to people's stories, what do they really want? What are their goals? **Communicate effectively** to enable people to assess their needs and develop and gain confidence to self care. Use communication and relationship skills that encourage and support people to work with you to identify strengths and abilities as well as areas for development. Finding solutions together, building on existing skills
- **Support and enable individuals to access appropriate information** to manage their self care needs – accredited, timely and relevant information. Continuous information throughout the person's "journey"
- **Support and enable individuals to develop skills in self care** – know what services are available in your area that you can offer to support self care such as Expert Patient Programme and how to access these. Offer your support, your knowledge and expertise for people to develop self care/self management skills
- **Support and enable individuals to use technology to support self care** – consider what equipment and devises are available and can support people to be independent, think about telehealth and telecare.
- **Advise individuals how to access support networks** and participate in planning, development and evaluation of services – people with LTCs really value speaking to others with the same condition, learning from their experience and feeling they are not alone. Know what is available and give people advice about them, promote people both receiving and giving support to others
- **Support and enable risk management** and risk taking to maximise independence and choice

The examples below illustrate how personalised care planning can proactively support people to be more in control, manage their condition better and get the most out of their lives. They show people at different stages of their journey, and the different professionals that might lead and be involved in the process. More examples, involving staff such as AHPs and mental health professionals can be found at ***www.dh.gov.uk/longtermconditions***

Lorna

Lorna is offered case management with a community matron, Andrea. At the initial home visit, they explore details about **Lorna's daily life, things she wants to do, can do for herself and what she finds difficult**. Andrea also **asks what Lorna has been doing to support her health** and **together they build up a picture** of Lorna's life, helping to complete the first contact needs assessment. Lorna says it **is a priority for her to live independently** but her family worry. Lorna thinks they may pressure her to move to residential care.

Andrea asks Lorna to explain how she feels before she reaches a crisis such as a hypoglycaemic episode or a flare up of her arthritis and **what are her own warning signs**, which Lorna describes in detail. Together they agree that a telephone number for when she feels like this will really help so that either Andrea or one of her colleagues can talk on the phone and if necessary visit her. The various medications Lorna takes cause confusion so Andrea describes Lorna's medication in detail and together they devise a simple system for correct dosage at correct times with clearly marked, colour-coded containers. They discuss **the different options that might support Lorna to stay at home**, including monitoring devices. Andrea arranges to visit when her daughter (who is her main carer) is there so that she can be involved in the discussion to support Lorna.

Follow up continues with a **joint needs assessment**, which suggests Lorna is eligible for social care support. She arranges a visit from a social care worker (Claire) who is part of a multidisciplinary team in the GP practice. Claire completes an assessment of Lorna's social care needs following which she is allocated an individual budget. The emphasis through the care planning discussions on what Lorna wants to do and her goals make it easier for Lorna to plan her support the way she wants and achieve her desired outcomes.

Lorna takes a cash individual budget and employs her neighbour to assist with her personal care needs and also to support her to get to the bingo hall once a week. She also purchases a laptop to enable her to do her shopping on-line and also keep in touch with family members who live in various parts of the country. Lorna feels sure these activities will make **her feel less isolated** even though she will be doing this from home. Lorna's daughter (her main unpaid carer) is also offered an assessment in her own right and is allocated an individual budget which she uses to go on two weekend breaks.

Lorna's agreed care plan is called **care/support plan** to accommodate the different terminology used by health and social care professionals, **breaking down language barriers**. The plan records her goals for remaining independent, feeling less isolated, staying out of hospital, being able to control her diabetes and continuing to cook and enjoy her food. From a social care perspective, the plan has to be "signed off" by a team manager agreeing that it meets Lorna's assessed needs and keeps her safe, healthy and well. The plan is a written document and is printed off and put in a yellow folder with all her other important information such as the medication she is taking and her doctors appointments. Lorna wants her daughter to have full access to the plan and **feels more confident and reassured about the coordination of her services, contingency plans for when she has a crisis, that she is getting more out of her life and has more independence and control**.

Jack

At their first meeting the specialist nurse Kate, finds out about Jack and his general health and well being: **how much he understands his condition, how it affects his life, what he wants to do, whether he has any worries or fears, and how his health makes him feel**. They explore what he is already doing to support his own health and the main areas he wishes to discuss.

Jack tried many times to give up smoking but found it too difficult. He worries about his health, and feels very low which makes everything harder for him, in particular giving up smoking and getting out more. He lacks energy and feels apathetic and this is impacting upon his relationship with his wife and daughter. **Jack is relieved to be able to tell someone that he is feeling depressed** and has very little motivation to take basic care of himself, let alone attempt something as challenging as stopping smoking.

Kate helps him to think about his immediate future and what he would like to do. Jack says he wants to be more active, to get out more, to get back into playing golf but has little motivation. He doesn't want to take anti-depressants in addition to his other medication. Together they **explore other options**, which could include Cognitive Behavioural Therapy, which has had recent extra funding from the local PCT. Jack thinks this might help him so he is referred.

Before his next consultation, **Jack is sent a leaflet inviting him to consider questions he might want to ask** or issues to think about beforehand. This reflective phase of the care planning process helps him prepare for the meeting, **making him feel valued and equal**. Jack already feels much more positive and says he wants to consider stopping smoking. His specialist nurse tells him about the services available including smoking cessation clinics, which he decides to try. Jack is still struggling to accept he has COPD but **in partnership with Kate and drawing from her expert knowledge in the condition he is able to access information and develop his own knowledge and understanding on managing it better**, including changing his inhaler and reducing his steroids. Kate's approach is that Jack is an expert on living with his condition and they work in partnership. Jack is offered information about local peer support groups, including a trusted on-line social network site linked to NHS Choices (although he is not IT literate, his daughter is able to help him).

Within 6 months Jack is feeling much better. His mood has lifted, he is able to get out more, even playing golf twice a week. He has managed to stop smoking over the last two months – a significant achievement, boosting his confidence. Jack's **current and future goals are recorded in his care plan** which he keeps. His treatment plan and medications are included in the back of the care plan. Having the **discussion and a formal record helps him to focus on what he wants to do**.

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/**

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**

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**

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

Supporting Self Care e-learning toolkit*

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

More information on personal health budgets can be found at: **www.personalhealthbudgets.dh.gov.uk**

Publications and other resources on long term conditions management are available at: **www.dh.gov.uk/longtermconditions**

The series of information sheets is available to download at 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**

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