Collaborative Care and Support Planning in End of Life Care

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With more people living with long-term conditions, proactive collaborative care and support planning (CC&SP) is gaining momentum as a core part of what it means to be a GP. It is a reflective process which encourages patients to say what they feel is important to them and enables people with long term conditions and their carers to work in partnership with health and social care professionals, to use their own assets, goals and priorities to design their care.

Implementing CC&SP
The RCGP’s Clinical Innovation and Research Centre has recently launched Stepping Forward: Commissioning principles for collaborative care and support planning to support commissioners and practice staff to implement this new approach. Here, we take a look at some of the building blocks for delivering CC&SP and examine how they positively influence the way we deliver end of life care.

Engage people with lived experience, and their carers, in service design
Tuckett describes the consultation as a ‘meeting of experts’. It is crucial to remember that people with experience of living with LTCs, and their carers, are the experts in their care. They can provide a strong narrative as to why change is needed, and they can give invaluable support to commissioners when conducting the needs assessment, identifying gaps in services. One of my patients, who required intravenous antibiotics for six weeks, was a carer for her frail, elderly husband. She was unable to stay as an inpatient and travelling 60 miles a day to the hospital outpatients was out of the question. We reconfigured and developed a home intravenous antibiotic service in order to accommodate an unmet need which she was able to identify when planning her care. This, in turn, highlighted the issue for other people in our community with similar difficulties.

Train the workforce
Workforce development for CC&SP, including training, is a strategic commissioning responsibility. Commissioners must ensure that sufficient training is available before practices embark on implementing CC&SP to avoid false starts. Training is needed for all practice team members, not just GPs. Practice managers and reception staff, for instance, will need to understand the care planning process and the administrative processes needed to make it happen. Proactive planning on this scale is a huge paradigm shift for many in primary care and the whole team needs to adapt to this way of thinking.

Identify participants
There is no ‘silver bullet’ for identifying which patients would benefit most from CC&SP. Commissioners and delivery partners need to work together to agree a systematic methodology for identifying people for CC&SP, that works for their context. Generally speaking, it can be useful to think of the number of long term conditions a patient has, as an indicator for the level of CC&SP they will need. I use a number of different mechanisms to identify people at my practice;

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some clinical software systems have an Electronic Frailty Index, we also have admission data from a service called RAIDR as well as the old-fashioned GP sixth-sense, which should never be overlooked! These data sources can give an indication of those with complex needs, recurrent A&E attendances or admissions which may indicate that a more co-ordinated, cohesive, multi-agency plan is needed to better support their needs.

Promote multi-disciplinary team working
We need to use the resources of the whole primary health care team and distribute workload equitably across a multidisciplinary team working together across health and social care. CC&SP does not, and should not, have to be done by the GP alone. Teams will need to make changes to build in the longer consultation time needed for the ‘discussion’ phase. The challenge we are facing in our practice, like many others, is managing the acute demand but also investing ‘up-stream’ with longer appointments for long-term condition patients and those with complex needs.

Actively work with the third sector and health and social care
The third sector is an essential partner for providing CC&SP to the population. Third sector organisations can bring specialist skills, knowledge and capacity, along with an alternative view of the needs and gaps in provision that may exist for your population. Third sector organisations can take a significant role in engaging and empowering patients before they enter the care planning process. At our practice, we have recently run a falls prevention programme, partnering with Age Concern (UK) as well as the local district council. It is amazing to discover what help and resources are already available and engaging with other organisations and introducing your patients to them can provide access to a great deal of expertise and effectively reduce the practice workload.

With an increasing number of more elderly and frail and an escalation of long term conditions, the need for collaborative care planning and support is ever greater if we are to meet the challenges ahead. Identifying and engaging with patients with the support of the wider health and social care team is the foundation for this process.

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