Collaborative Care & Support Planning

Step Two: Preparation

Introducing collaborative care and support planning into your practice will involve some organisational and cultural changes, not only amongst your practice team and patients but across your wider federation and CCG. Changes can still start at an individual general practitioner level but sharing with and involving more clinicians and commissioners will make any wholesale changes more widespread and cost-effective. Preparations should therefore be considered for the professional, processes within the practice and the individual.

For the professional

- With any new changes in general practice, the questions of time and financial resources always come to the fore. In areas of the country where care planning is already being successfully implemented the local CCG’s have played a pivotal role. The examples of Leeds CCG and Somerset CCG in The Health Foundation’s Building the house of care describes the differing approaches to commissioning this type of service from developing it as an enhanced service to supporting and encouraging a wider cultural change.
The RCGP’s Improving the lives of people with long-term conditions explores the options around commissioning care planning in General practice and associated costs.

The Year of Care’s Thanks for the petunias discusses commissioning services involving non-traditional service providers allowing care planning to be shared beyond the confines of just the practice team.

House of Care training provides a one-and-a-half day course on carrying out care planning and more person-centred consultations. On completion of this training a toolkit and further resources such as templates for recall systems are available.

For the practice and its processes

Within the practice itself, introducing a care planning process will require the development of a practice pathway for care planning, identifying a team who will carry it out and then training for the team to support the new processes. The team will need to be multidisciplinary, including not only clinical, reception and admin staff from the GP practice but also incorporating support from local and community services. Identifying an experienced person from the administration team to lead will help with development and implementation.

Some of the new models of care across the UK are looking at the use of non-clinical roles such as health coaches (e.g. the Symphony Programme and Village Agent Project in Somerset) who can either be commissioned by the CCG to work across practices, employed by individual practices or from the voluntary sector. They can act as a support for the person explaining and guiding them through the care planning process.

Think Local Act Personal have developed a personalised care and support planning tool which lists the preparations needed within the process, team and individual.

A designated team is needed to develop, administer and deliver a care planning service. It shouldn't remain the sole domain of the general practitioner; involvement of practice nurses with long-term condition expertise, healthcare assistants, allied health and social services professionals and the voluntary sector can become involved. There may need to be a shift in the way a care planning consultation is delivered, moving from the traditional 10 minutes consult to one of 20-30 mins. Appendix C of the RCGP’s Improving the lives of people with long-term conditions provides examples of how a care planning consultation could run as well as templates and questionnaires.

The aim is to make sure the time spent in a care planning consultation is focused on planning for the future, identifying personal goals and creating a self-management action plan. Training for the team and then the subsequent use of social prescribing can help make the care planning process more personalised to need and de-medicalised where appropriate.

The GP should not be doing it all but where possible they should work with care / community navigators to support the person to prepare and, if possible, accompany the person at the next stage.

For the patient

Patients and their carers also need to be informed and educated about care planning. National Voices have developed a resource for patients, which can be used online, is printable but also has short films which could be displayed in waiting rooms.
Information can be sent out to patients before the appointment to inform them but also encourage their involvement – using bubble diagrams to stimulate conversation, but also providing information back to the care planner – including PAMS, LTC6, PH9Q etc self-assessment tools.

Health navigators can help patients to identify their goals and signpost them to resources and help within local and community services. Patients should experience a shift from the more traditional GP involvement in their care (which has become more reactive) to that of a proactive integrated team, which includes their GP.

Any initial plans for introducing CCSP within the practice will need to be trialled on a small enough group of patients to be manageable but large enough to be able to see the impact of change. The processes may well need adapting and it is important to make sure any problems are captured and fed back into quality improvement.