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Introduction

Purpose of this guide
This guide is designed to provide clear information to help you understand and implement Personalised Care Planning (PCP).

It focuses on the key information that you will need to support you in deciding how to take PCP forward and is designed to be easily used like a reference manual.

The expectation is that you will use this guide to help you to choose how you would like to deliver a PCP approach. It isn’t a prescription; it just provides you with the supporting tools to help you to engage in PCP and make it work for your service and patients.

Who is it aimed at?
This guide aims to offer something that will be of use to everyone. PCP should be a combined approach and is appropriate for anyone who is involved in providing care for people affected by long term health conditions, whether this be GPs, practice nurses, community matrons, community specialist services and pharmacists.

Why be concerned about PCP?
Now is the time to embrace new ways of working to produce better outcomes. Outcomes that will deliver the Quality, Innovation, Productivity and Prevention (QIPP) programme and high quality self management support.

“If we continue to do what we have always done, we will always get the results we have always got”.

PCP is at the forefront in helping people to help themselves, it’s one of the Department of Health’s recommendations to ensure that all people affected by long term conditions have been offered a PCP and it is now within NHS Derbyshire County’s Basket of Services that GP practices across Derbyshire are expected to provide.

It has been recognised that people with long term conditions should be experts in their own care. If we can develop new ways of working to build on this it will mark the starting point for a new approach to long term care and one that needs to be systematic across all areas of Derbyshire.

Using this guide
To gain a full, clear understanding of PCP it is recommended that you go through each section of this guide. However you may pick and choose the sections depending on where you are at in the process and what support you feel you need to help you to start implementing PCP.
For the purposes of this guide the key elements for consideration are placed within coloured boxes that correspond to the different sections. This will help you to quickly pick out important information to support implementation.

A reflection exercise is outlined below which will help you to think about what you currently do in your working practice that contributes to PCP. It isn’t designed to highlight what you are not doing but to help you to make steps to know what you need to consider to implement PCP.

**A time to think...**

Think about how you currently run your consultations and your overall contribution to self care; can you answer yes to the following questions?

- I always offer my patients the opportunity to prepare for their consultation offering them support in doing so
- I always ask my patients what they would like to get out of their consultation
- I always support my patients to identify actions and goals
- I always provide information in a format that the patient will easily understand e.g. information prescriptions
- I know where to signpost patients to for other sources of support e.g. local support groups, education programmes
- I always offer my patients with a written plan of action

These questions will help you to reflect on what you currently do in practice and consider how this may be altered to adopt a PCP approach.
PCP explained

PCP is an approach to the management of care for people who have long term conditions. It aims to empower people affected by long term health conditions to take responsibility of their own care and management, with the support of the healthcare professionals involved in their care.

It also aims to:
- Identify the individual person’s needs and priorities.
- Raise awareness of the resources available to support self care.
- Embed the principles of personalisation, patient information, choice and self care into service delivery.
- Increase the number of people with Long Term Conditions using a PCP approach to manage their care.

This is achieved through involving people from the start in the planning of their care, offering them choices in how to manage their condition and allowing them to be the owners of their conditions to improve their overall quality of life.

Culture change is key to the successful implementation of PCP. The focus needs to shift from health care professionals leading the care, to care where people are empowered to be the experts in identifying their needs and systems to be delivered according to these needs. There needs to be a change in the mind-set of healthcare professionals so that they are using a different set of skills that support and encourage people rather than prescribe and there needs to be a change in what people expect so that the greater expectation comes from themselves, as the experts in their care.

There is still a long way to go in achieving this aim as there are gaps in what people affected by long term conditions want and what they are actually provided with. People may be provided with an annual review but how many actually get to discuss what really affects their lives the most enabling them to set goals to achieve a better quality of life?

**As a minimum personalised care planning should provide people with the opportunity to discuss their own goals and what is important to them at that time**

**PCP Benefits**

PCP can offer the following benefits:
- Joint decision making between people affected by long term conditions and health care professionals
- A better level of understanding about the condition by the person it affects
- More productive consultations
- An increase in positive lifestyle and behaviour change
- More effective self management
- Reduction in NHS utilisation
Example of good practice

A GP and clinical lead from NHS Yorkshire and Humber has piloted a care planning approach in his practice which has yielded positive results for patients with long term conditions. This approach is now being implemented in other general practices across the Yorkshire and Humber region.

The practice identified all patients with long term conditions and categorised them into groups of having one, two, three or four more conditions. Patients who had two or more conditions (25%) were invited to attend a care planning appointment. Patients were asked to identify the issues that were important to them and how they impacted on their ability to self manage along with setting goals to address these issues.

A personalised action plan was then developed between the health care professional and the patient and parameters relating to the quality outcomes framework were recorded.

This process was followed for each patient’s long term condition and collated into one appointment rather than several different appointments over a period of time.

The results have shown a trend in all patients (but one) of a reduction in patient practice contacts along with some reduction in outpatient appointments, A&E attendances and admissions. Over the period of one year the pilot reduced the total number of healthcare contacts from 529 to 246 and a reduction in costs from £47,346 to £17,860 for the 19 patients involved.

For more information on this work visit www.hsj.co.uk/resourcecentre
Making it happen

In order to fully implement PCP there needs to be a whole systems approach that encompasses health care professionals that are committed to changes in working practice, informed patients and organisational process in place to make it happen.

The three PCP principles
There are three key principles that form the main process within PCP; preparation, consultation and implementation. Underpinning these three elements are the processes that should be followed along with the support tool that is available to support implementation.

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The three key principle areas have been divided to describe what is required to implement PCP. These are detailed further over the following pages.
1. **Preparation...**

At the start of the PCP process there should be preparation to help people to understand the changes to their consultations and the reasons why they are being involved.

**Healthcare professional commitment to changes in working practice**

Implementation begins with healthcare professionals that are committed to changing the way they organise and conduct consultations along with developing new skills to enable them to follow the PCP process.

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**Skills development programme**

Healthcare professionals had the opportunity to expand their skills and understanding of PCP through a specific skills development programme. This programme allowed professionals to gain a practical knowledge of care planning and explore their own approach to self care, developing skills to implement a partnership approach.

Programmes ran throughout 2008, 2009, 2010 and 2011 and well over 150 healthcare professionals attended these programmes.

Future programmes should now be arranged through your own clinical commissioning group:

**South Derbyshire**
- Southern Derbyshire Clinical Commissioning Group – Cardinal Square, Derby
- Erewash Clinical Commissioning Group – Toll Bar House, Ilkeston

**North Derbyshire**
- Hardwick Health Clinical Commissioning Group – INSET
- Chesterfield and North Derbyshire – Scarsdale, Chesterfield
Patient buy in and understanding

Patients should fully understand how PCP will work and why it may help them before going into their consultation. They need to understand that their consultations may be different and that their experiences, thoughts and feelings will be taken into consideration. They may need to have written information about what PCP is and what they need to do to take an active role.

Consultation planning

A key part of the PCP process is encouraging people to prepare for their consultations. Part of the preparation process should be a time for reflection and an opportunity for the patient to think about what they would like to get out of their consultation, any issues they are faced with and any questions they would like to ask. By offering patients the opportunity to prepare for their consultation it helps to move towards a consultation that is based on their needs and the actions that they would like to take with the support of the healthcare professional.

Patient leaflet: Making the most of your appointment

The *Making the Most of your Appointment* patient information leaflet aims to help patients to understand how PCP will work and what will be expected of them to take a more active role. It separates the essential information into three sections: before the appointment, during the appointment and after the appointment detailing instructions and advice to help patients with preparing for their consultation along with informing them what will happen during the consultation and suggestions for what to do after it.

For details on how to order this leaflet go to the [menu of implementation tools](#) section.

Patient leaflet: Planning for your Appointment

The *Planning for your Appointment* patient information leaflet aims to help patients reflect, prepare and plan for their consultations. It separates the planning process into three small stages; before, during and after the appointment. The first section, ‘before your appointment’, asks people to reflect on what has been happening in their lives since their last appointment along with identifying any questions they would like to ask. The second section, ‘during your appointment’, allows for the patients to write down important information that was discussed and their plans. The final section, ‘after your appointment’, offers people space to write down when their next review is due and any other appointments they may need to attend in the meantime.

For details on how to order this leaflet go to the [menu of implementation tools](#) section.
**Information sharing**
As part of the PCP process patients could be offered the opportunity to have access to their results prior to the consultation. This will allow patients time to digest the information and consider what they might mean and what action they might need to take in the future.

Results should be provided in a format that is appropriate and understandable to the person and should always be followed by the appropriate level of support to help people to make sense of what the results might mean in the day to day management of their condition.

**Example of working practice**

One practice in Derbyshire has decided to offer patients the choice of having their results prior to their appointment.

The appointment letter that is sent out to the patients provides them with information on how to contact the practice to obtain their results if they would like them in advance of their appointment.

This method helps to empower patients by giving them the ownership of contacting the practice and getting their results for themselves. It also allows for patients who would prefer to wait until their appointment to get their results the opportunity to do so.

This is a relatively new concept in working practice and may take some time before people get used to this part of the process but over time, as they learn what their results mean, it will help to encourage patients to identify areas for discussion as part of their consultation.
2. **Consultation...**

At the heart of PCP lies the conversation that takes place between the healthcare professional and the person affected by a long term condition. People should be supported to reflect on their condition, the impact it has on their lives and what they can do for themselves to be confident in managing it better.

There should also be an understanding amongst healthcare professionals that people affected by long term conditions have a wide range of needs beyond their medical condition, such as emotional and psychological needs. These should also be identified as part of the consultation helping to take a more ‘holistic’ approach with the aim of improving the person’s overall health and well being.

Patients should be encouraged to exchange information within the consultation so they are based on their concerns, their goals and the actions they wish to undertake. This will help healthcare professionals to gain a greater understanding of their needs and to help make people aware of the consequences associated with any choices so that people can then make informed decisions.

**Sharing stories**

A good starting point within the consultation is for the patient to be encouraged to share their story, talking about any important events since their last appointment and to communicate any needs that they may have, which they may have identified within their planning for your appointment leaflet.

Some patients may come to their consultation with numerous issues. These will need to be prioritised with the patient so that they can focus on what is most important to them at that time.

---

**Patient leaflet: Good Days, Bad Days**

The *Good Days, Bad Days* patient information leaflet can support patients in communicating their needs and what is important to them. It may also help them to share with others what it feels like living with the condition. It helps to give the health care professional an insight into a patient’s life and what it is like for them living and dealing with their long term condition on a daily basis.

There are three sections which allow patients to consider what they are able to do on a good day living with their condition/s, what they have difficulty with on a bad day and what they may need others to do to help them to have more good days.

For details on how to order this leaflet go to the menu of implementation tools section.
Lifestyle and behaviour change

Once a patient has shared their story they should be encouraged to identify things that they would like to change or achieve through setting personal goals.

Goal setting and action planning is a powerful, motivational process for people to think about their lives and choose changes that they would like to make. It helps people to identify what they would like to achieve and where they need to concentrate their efforts to realise the goal and helps to create a long term vision and short term motivation.

Goal setting also helps people to organise their time so that they can make the most out of their lives along with raising people’s self confidence as they recognise their ability to achieve goals that they have set.

Action planning is the process that people follow in order to achieve their goal. It breaks down the steps to achieving a goal and sets out a process for people to follow. The goal is the outcome; the actions are the steps that people to take achieve the goal.

Good Days, Bad Day’s patient consultation exercise

To test Good Days, Bad Days a number of patients were provided with the leaflet to complete. An example of one of the responses is below:

**On a good day I can:**
- Read books
- Chat more with my carers
- Feel more in charge of what I do
- Attend day care centre twice a week
- Get myself up and out of bed with less pain

**On a bad day I have difficulty with:**
- Clearing my mood; I do not feel like talking
- Apply my system for coping
- Take a shower comfortably and shampoo my hair
- Get a good nights sleep
- Get out of bed without intense pain

**To have more good days I need:**
- Help with dealing with the depressing days
- Doctors to understand that my elderly constitution does now always cope with extra medication – an explanation about my symptoms will help more than pills
- Doctors and nurses to take time to explain the progress of my conditions as far as I can cope with it

A time to think…
What does this tell you about the patient’s life?
How could you help a patient who presented this information as part of a consultation?
Some people may not have considered making lifestyle changes. In these situations a starting point may be for someone to set a goal on deciding whether they want to make a change. The action plan may include looking at the advantages and disadvantages to making or not making the change.

It may take time to clarify the goal with the patient to ensure that what they set is realistic along with looking at ways in which the patient can overcome obstacles and failure if they don’t achieve what they set out to do.

Patient leaflet: Setting yourself Goals

The Setting yourself Goals patient information leaflet can support patients in setting goals and identifying the actions they need to take to achieve the goal. The leaflet breaks down the process of setting and achieving goals into sections to help patients to:
- identify how important the goal is
- plan what they would like to do and how they will do it
- assess how confident they are in achieving it

For details on how to order this leaflet go to the menu of implementation tools

Self Management Support

Patients should be supported to learn how to manage their own conditions effectively. They should be aware of when their symptoms may be changing, know what action to take and when. Encouraging patients to self manage will support people to make informed choices about what support they need and when to access it.

Self management means different things to different people so it should be tailored to an individual’s needs, circumstances and wishes through access to appropriate information, tools, techniques and practical support from others.

Patient leaflet: Guide to your Diabetes Results

The Guide to your Diabetes Results patient information leaflet can support patients in understanding their results and what it means to them. It divides the results into different coloured zones which help to highlight what action a patient should take.

Patient leaflet: Respiratory Action Plan

The Respiratory Action Plan patient leaflet divides symptoms into coloured management zones and is developed for individual patients symptoms. Each zone details the actions patients should take should their symptoms change.

For details on how to order this leaflet go to the menu of implementation tools section.
Capturing information
Information should be formally recorded for both the healthcare professionals and patients so that progress can be monitored and reviewed.

I.T. templates and systems to capture the care planning information can offer a way in which the outcomes of the consultation can be recorded. They can also help to inform local commissioning and identify any gaps in service provision and any unmet need.

I.T. templates
There is an I.T. template available to support the PCP process. This template is compatible with different I.T. systems and offers a formal way of recording the PCP consultation.

The templates are divided into three stages, the first and last stages being generic to any long term condition and specific to the PCP process and the middle stage linking directly to existing disease specific QoF templates (dependant on which clinical system you use), enabling healthcare professionals to utilise only one template for long term conditions.

The PCP I.T. template can be downloaded directly from SharePoint:

You will be asked to insert a login which is as follows:

**Windows 2000**
Username: practice_ss
Password: pcis_ss
Domain: district

**Windows XP**
Username: district/practice_ss
Password: pcis_ss

Once you have logged in you will need to:
- Select your clinical system e.g. TPP SystmOne
- Select Clinical System Templates
- Select Personalised Care Plan
- Select LTC Care Planning Linked Template or the Word Template Personal Care Plan TPP
- Follow the guidelines for importing templates (this can be found within the Template Instructions folder which is located on the previous level) as required.

For technical support contact Primary Care Informatics by e-mailing dcpct.primarycare@nhs.net
3. Implementation...

The time for the outcomes of the consultation to be put into practice is after the consultation. Patients should be able to implement their action plans and take steps towards achieving any goals that they have set in-between appointments.

Patients need information to help them to understand the options available to them and to be able to make informed choices based on this information. Without information there is no choice and without information decisions cannot be made.

**I.T. template Summary**

The I.T. template allows healthcare professionals to print out a summary of the patient's consultation and given to them for their own records.

This summary includes the patient's test results, the goals that have been identified and any actions that the patient is to take.

Signposting is an integral part of the PCP process. There should be support available to help people to achieve their personal goals by healthcare professionals and through easy access to information, services and education as appropriate for their level of needs. Healthcare professionals need to have a good understanding of the information and services available and how they can be accessed to support any needs that people may have.

People can’t participate fully in their care and making decisions related to their care without access to sufficient information.

**Information Prescriptions**

There are 15 Information Prescription health directories available for different long term conditions. These directories contain signposts to where patients can access information and services at every stage of their journey. They don’t provide patients with the information but they do give enough detail so that patients know how and where to request information along with a choice of formats (leaflets, help lines etc) depending on their learning style and needs.

In addition, Information Prescriptions can act as a directory of services for healthcare professionals so that they are aware of all the local services available for people with long term conditions across Derbyshire.

Information Prescription postcards are available to provide people with the details on how to request an Information Prescription. These can be placed in waiting areas and reception desks or given directly to people who may have an information need. There are also posters available that can be displayed in public areas to help raise the awareness of Information Prescriptions.

For details on how to order this information go to the [Menu of implementation tools](#) section.
**The format of a PCP Consultation**

**Preparation**
- Appointment letter
  - Patient provided with an annual review appointment letter inclusive of:
    - Date and time of annual review appointment
    - Contact number for opportunity to obtain results if wanted
    - Making the most of your appointment patient leaflet
    - Planning for your appointment patient leaflet (patient preparation and reflection tool)

**Consultation**
- Setting the scene
  - Consultation process explained to patient and understood.
- The patient’s story
  - Patient encouraged to discuss thoughts and feelings regarding their condition through use of the planning for your appointment patient leaflet, open questions and listening skills.
- The healthcare professional’s story
  - Summary of patient’s story to check understanding. Sharing the patient’s results and discussing where the patient is at
- Exploring and discussing
  - Dealing with immediate medical concerns.
  - Identifying what is important for the patient e.g. “what aspect of your condition would you like to work on?”
- Goal setting
  - Use the patient setting yourself goals leaflet to go through the steps for setting any goals and action planning how the patient will achieve it.

**Implementation**
- Signposting
  - Signpost patient to Information Prescriptions and resources to help them to achieve their goal
- Next steps
  - Patient to progress with goal and action plan.
  - New appointment organised for follow up and review or action plan/goals.
## Menu of implementation tools

The range of PCP implementation tools available can be used in conjunction with each other or individually chosen depending on the service development needs. They all help to contribute towards the PCP process and offer a way in which PCP can be implemented.

Accessing the tools couldn’t be easier. The information below provides you with the details on how to access the implementation tools.

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<td>Diabetes results card</td>
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<td>Information prescriptions postcards</td>
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Fill out the form on the next page and e-mail the order to: [record.request@derwentsharedservices.nhs.uk](mailto:record.request@derwentsharedservices.nhs.uk)

Respiratory Action Plan: E-mail orders: [record.request@derwentsharedservices.nhs.uk](mailto:record.request@derwentsharedservices.nhs.uk)

Fax order forms available from:
North: 01246 253067
South: 01332 861189 option 1
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<tr>
<td>Information Prescription Postcards</td>
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Please complete this form and return by e-mail to: record.request@derwentsharedservices.nhs.uk
Getting started

The following PCP checklist will help to support you to move forward with PCP in your area of work:

Check list
We have an established system in place for Long Term Condition patient reviews .............................................................. 
All staff have bought into the PCP concept .......................................................................................................................... 
We have decided the staff that will be involved and their roles are clarified ................................................................. 
We have decided which implementation tools to use ......................................................................................................... 
We have decided on a system to follow for appointments ................................................................................................ 

Example:
Admin staff will send out appointment letter along with ‘making the most of your appointment’ and ‘planning for your appointment’ patient leaflets
Patients will be offered the choice to contact the service to get their results in advance of their appointment

We have decided on the structure of each consultation ........................................................................................................ 

Example:
Consultation explained to the patient ➔ Information sharing: patient story followed by health care professional story ➔ Exploring and discussing concerns ➔ Goal setting and action planning ➔ Signposting ➔ Review date set and summary given to patient

We have decided how long each consultation will take........................................................................................................ 
We have decided how information will be made available to patients .................................................................................... 
We have a template to capture all relevant information ......................................................................................................... 
We have decided that patients will be invited to have their results prior to their consultation and have a process in place to enable this to happen ........................................................................................................ 

As a minimum you could try:
- Sending out the **getting the most of your appointment** and the **planning for your appointment** patient information leaflet with appointment letters
- Download and use the I.T template to follow the acre planning process and capture all information
Further information

Further information and support for healthcare professionals / patients.

Well-being Star
The Well-being star is a free tool that can support healthcare professionals with care planning consultations.
The tool helps to encourage patients to look at a range of factors that impact on their quality of life. These factors are not just applicable to health but get the patient to look at other issues such as lifestyle management and looking after themselves.
There is a free version available to download, visit www.outcomesstar.org.uk to register.

Living with Long Term Conditions Self Management Programme
The Living with Long Term Conditions Self Management Programme is a free NHS programme for all people affected by any long term condition. This programme supports the care planning process through helping people to take more control of their health and life by teaching them new skills to manage their condition better. The programme looks at the following topics:
- Dealing with pain and extreme tiredness
- Coping with feelings of depression
- Relaxation techniques and exercise
- Healthy eating
- Communicating with family, friends and health professionals
- Planning for the future
The programme is run over six weeks sessions lasting 2 ½ hours each session.
For more information contact 01246 868400 ext 457

E-learning Information Prescriptions & self care
There are two e-learning packages available to help develop the skills and knowledge related to information prescriptions.
Visit www.nhsemployers.org for more information.

Self Care e-learning Toolkit
This toolkit has been designed to support health care professionals who are supporting people with long term health conditions
Visit www.e-ffh.org.uk for more information

Share Decision Making Decision Aids
Shared Decision Making offers a new kind of relationship between health care professionals and patients which also supports the care planning process. Patient Decision Aids are one way in helping shared decisions to take place between a health care professionals and patient.
Visit www.nhsdirect.nhs.uk/decisionaids for more information