Effective use of care planning
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Approved by

This document must be approved by the following people:

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<tr>
<td>Angelique Edwards</td>
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1. Introduction

The long-term trend within the NHS is one of greater volumes of both urgent and emergency care and elective activity. A&E attendances are up 2.3%, with emergency admissions up 3.0%, diagnostic tests up 6.4% and consultant-led treatment up 3.9%\(^1\). Avoiding emergency hospital admissions is a major concern for the National Health Service (NHS), not only because of the high and rising unit costs of emergency admission compared with other forms of care, but also because of the disruption it causes to elective health care – most notably inpatient waiting lists – and to the individuals admitted\(^2\).

Health expenditure in England has risen year on year but there is a NHS net deficit; for the 2014/15 financial year this was £471 million\(^3\).

Research has looked at how these trends could be addressed whilst maintaining high quality patient care. Research has revealed that:

A co-ordinated management care plan for prospective out-patient patients can\(^4\):

- reduce the number of out-patient appointments needed (first plus follow-up) by 40%.

The following interventions can reduce unplanned hospital admissions.\(^5\)

- Continuity of care with a GP
- Hospital at home as an alternative to admission
- Assertive case management in mental health
- Self-management
- Integration of primary and secondary care

Patients have the following needs\(^6\):

- health care information, referrals and records to be shared/joined up so that healthcare is managed as a whole
- when seeing a consultant or GP they to have the whole picture of a patient’s health so the patient does not have to repeat themselves and can feel confident about their care

Multidisciplinary care planning is one way of meeting the patient needs to ensure good quality, effective, responsive care of patients, with the potential to prevent unnecessary secondary care interventions, whilst empowering patients to self-manage their healthcare problems.

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2 Audit Commission 2009
3 http://www.nhsconfed.org/resources/key-statistics-on-the-nhs
5 https://www.rcpe.ac.uk/sites/default/files/purdy.pdf
6 NHS e-Referrals 2016 HSCIC
2. What is a good care plan?

A good care plan can be used by care professionals and the patient to optimise a patient’s care through shared goals and shared proactive treatment of the patient’s care needs.

Good care planning aims to:

- Meet the professional, local and national standards
- Involve the patient in every aspect of the plan
- Empower the patient to be proactive in their care
- Outline goals, actions and responsibilities of services, family members and the patient
- Explain the risks and their management to make the care as safe as possible
- Outline the holistic management plan of a patient to optimise the patient’s care.
- Be accessible to everyone involved in the care planning
- Ensure that informal carers’ health and wellbeing is considered (*)

A good care plan:

- Uses language and phrases that everyone is familiar with, and avoids jargon and abbreviations
- Is in a format that the patient is comfortable with but accessible to all stakeholders
- Is agreed with the patient, health/social care professionals, family members and anyone else involved with a patient’s care (i.e. all stakeholders)
- Records the patient’s needs, agreed actions, known risks, and the responsibilities of the patient and professionals involved
- Outlines the benefits of any course of action
- Set a realistic timeframe for creating and agreeing on the care plan
- Is a tool for managing risks, recording a contingency plan, and for managing the patient’s care in a holistic manner
- Has the patient’s consent to share the plan with all professionals involved in that patient’s care
- Is dynamic, being reviewed and updated as the patient’s needs change
3. How to develop a good care plan?

A care plan needs to be developed in partnership with everyone involved in a patient’s care and should be open to input from all stakeholders.

The care plan should initially be composed with the patient by the patient’s care co-ordinator (for PACT their GP) using the PACT care plan template in EMIS.

The care plan should contain the patients’ personal details:

- Age
- Gender
- Sex
- Contact details
- Cultural / religious needs
- Communication needs
- Social circumstances
- Care package with the names and contact numbers of all carers
- Next of kin – relationship with patient, name and contact details
- Healthcare Power of Attorney details with contact details
- The name and contact details of all professionals involved in that patient’s care
- Chronic health problems/ disabilities and medication
- Any special considerations or risks

The content of a Care Plan should be able to answer the following questions to address the patients met and unmet needs:

- **Why** is this care plan being prepared? - Aims
- **What** are we planning to achieve? - Outcomes
- **How** is it going to be achieved? – Actions
- **Who** is going to be involved? – Responsibilities
- **Where** will it be done? – Locations / Services involved
- **When** will it be done? – Timescales

A care plan should also:

- Be dynamic and should be updated as the patient’s needs change
- Able to be updated and shared by any professional stakeholder
- Include and prioritise needs identified by the patient.
- Empower the patient to self-manage their care to reduce risk
- Contain the risks assessments, crisis and contingency plans
- Contain useful and Emergency contact details for the patient to use
- Record the next review date, and who will conduct the review

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7 NHS England introduced Accessible Information Standard in July 2015, and all healthcare providers must demonstrate that they meet it by 31st July 2016.
https://www.england.nhs.uk/2015/07/access-info-standard/
4. Top tips for composing a care plan with the patient

When sitting with the patient and composing the patient's care plan it is essential to engage the patient in the process. When talking with the patient:

- Use short sentences and where possible present tense
- Explore with the patient their barriers to optimising their health (consider compliance with medication, attitudes to their health problems, psychological factors). Ask open ended questions:
  - What bothers you most about your health?
  - What is the one thing you would change if you could?
  - Talk me through your day, from the time you get up, how you feel, how you remember to take your medication etc?
- Help the patient look at practical and psychological ways that the patient could optimise their health (e.g. having a rescue packs for COPD in the repeat meds to use as soon as an acute exacerbation starts, rationalising dosing of medication to just twice a day to aid compliance or using a dosette box,
- Signpost the patient to organisations/services that can help a patient optimise their health. For example, consider supplying a patient with a wheelchair if they have someone willing to take them out to improve their mood, or suggest the patient contacts Age Concern to help the patient check they are getting the right benefits or to arrange for someone to shop for them or visit regularly. Lists of organisations who can help can be found on DXS.
- Ask about informal carers and endeavour to ensure that the health and wellbeing of the carer is considered (*).

The care plan should set out the patients' needs and unmet needs:

- Be specific about the needs: e.g. instead of “Need – Help with food” it should be “Need – help with food shopping and preparing meals"
- Be specific if that need is being addressed e.g. “The care worker visits Johnny every Tue and Fri to do the food shopping with him; they also plan the meals for the following days"
- Detail the persons involved with contact numbers, e.g. “Tom Smith – Care Worker 07891011112; Ann Parker – Daughter 012345678”

The care plan should set goals. Think of following the SMART rule when setting the goals:

- **Specific**
- **Measurable**
- **Attainable**
- **Realistic**
- **Time bound**

The care plan needs to set out an action plan for professionals/the patient to follow:
• Specify the expected outcomes of the actions, e.g. “Johnny will have the chance to interact with other people/ manage his money/practice his memory skills/ prepare a meal he likes”.

• Record the patient’s expectations of their care especially for end-of-life patients (where they want their care to be, what interventions they don’t want etc.). Generally, this will be held on CMC but patients might like it repeated on their care plan to ensure their voice is heard.

• Consider referrals to the self-management service (*), rehabilitation (Falls service, COPD rehab etc.) and specialist nurses (diabetic, renal, heart failure, COPD)

• Add timescales for the action to be completed

The care plan must be comprehensible to anyone who reads it, including the emergency services. Therefore, the document needs to contain enough information for anyone involved with the person’s care to implement the plan.

5. On-going care

The patient should hold a copy of their latest care plan and be encouraged to show it to all professionals involved in their care, and take it with them to any appointment or emergency attendance related to their health or social circumstances.

Ensure the care plan is shared and updated

• Share with the relevant services (CAHS, out-of- hours services, relevant hospital consultants)- for PACT patients’ details of how to share this document will be on the PACT template in EMIS.

• Ensure that the patient’s named GP is aware of any referral to community of hospital services

• Ensure the patient’s named GP is aware of any changes in the patient’s health or social service needs

Remember the care plan is dynamic

• Review the patient after a hospital admission (*)

• Review mental state and physical health twice a year (*)

• Arrange a follow up meeting to review the care plan (*)

• Keep the care plan up to date

(*) indicates specific PACT payments.

Practices in Wandsworth CCG are contracted to provide care planning for the most needy patients in their practices through an enhanced service known as PACT, which also acts as a wrap around for the Admission avoidance enhanced service. Wandsworth practices are also contracted to provide enhanced care planning for the top 500 patients in the borough through the ECP PACT enhanced service.

If you have further questions, please contact PACT Team via email: waccq.pact@nhs.net.
6. Example of an Exemplar Care Plan

Here is an example of what a word document exemplar care plan would look like, mail merged from the EMIS care plan template.

**My Wandsworth Shared Care Plan**

This is your care plan. It contains details about you, your health, how to manage your health and who helps you.

*Please take this care plan with you whenever you go to hospital or to a clinic appointment. Please show it to any health professional who visits you.*

Date care plan commenced: 13-Apr-2016  
Updated:  
Next review due: 13-Oct-2016

My GP details:  
KOONER, Mona (Dr)  
WANDLE MEDICAL CENTRE 50 Wandle Road, Battersea, London, Greater London, SW11 XXX  
Tel number: 020 1234 5678  Fax number: 020 9876 5432  
Email: WACCG.wandlemedical@nhs.net

My Details:  
Name: Mr Emis A Test  
D.o.b: 01-May-1944  NHS number:  
Address: 1 Princes Street, London, SW11 3UJ  
Tel: 02073505220  Mobile: 07940125653

Next-of-kin: 13-Feb-2013 - Martha Hobbs  
Power of attorney: No power of attorney or lasting power of attorney appointed  
Door key safe availability not recorded

How I communicate:  
Sensory disabilities: No record of visual impairment  
13-Feb-2013 Hearing difficulty  
Communication needs: 15-Mar-2016 Main spoken language Polish  
Translator needed: no

Consent to share information:  
Mental capacity not recorded  
15-Mar-2016 Consent given to share patient data with specified 3rd party -ambulance service, out-of-hours service, community adult health services and social services  
No consent recorded to take part in a feedback questionnaire  
Consent for local clinical audit not recorded

My health professionals’ details:  
My Key worker: No record of key worker
Other community team involved:

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joan Smith</td>
<td>Respiratory Nurse</td>
<td>020 789 1011 (8am to 4pm Monday to Friday (111 all other times)</td>
</tr>
</tbody>
</table>

My care package:

<table>
<thead>
<tr>
<th>Type of care provided</th>
<th>Details of care provided</th>
<th>Name and contact number</th>
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<tbody>
<tr>
<td>15-Mar-2016 Has a paid carer</td>
<td>Comes in each morning, washes me and makes my breakfast and leaves me food out for the day.</td>
<td>Bluebell Agency 020 7777 8888</td>
</tr>
<tr>
<td>No record of care from family members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No record of care from the voluntary sector</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No record of care from friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing:</td>
<td>13-Feb-2013 Independant housing, lives alone</td>
<td></td>
</tr>
<tr>
<td>Voluntary services:</td>
<td>Does not attend a day centre</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Befriending service visits: No</td>
<td></td>
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Note: if you have a carer, he/she may be eligible for help

My health problems and baseline measurements:

Problems

Active

- 22-Nov-2012  Chronic obstructive pulmonary disease
- 30-Jul-2012  Essential hypertension
- 23-Jul-2007  Type 2 diabetes mellitus
- 31-Jul-1994  Asthma

EOLC register: No

Note: EOLC care plans are held on the CMC website

Mobility: 15-Mar-2016 Mobility poor

- 15-Mar-2016 Uses two walking sticks - if he goes out but that is rare
- No record of wheelchair use
- No record of provision of a falls alarm

Toileting: No record of Bladder continence

- 13-Feb-2013 Bowels: fully continent -
Smoking status: 15-Jun-2015 Ex smoker

Alcohol: 0 units per week

Height: 15-Jun-2015 : 154 cm BMI: 28-Nov-2012 : 37.5 kg/m²

Weight: 15-Jun-2015 : GFR: 28-Nov-2012 : 37.5 kg/m²

Haemoglobin: WCC: Platelets:

BMI: 28-Nov-2012 : 37.5 kg/m²

GFR: 

Weight: 15-Jun-2015 : 

HbA1c:

BP: 15-Jun-2015 : 120/68 mmHg Pulse rate: 15-Jun-2015 : 67 beats/min

Pulse oximetry: not recorded PEV1: not recorded

FEV1: not recorded

PEFR: not recorded

My last anxiety and depression score (PHQ9) 15-Jun-2015 : 8/27

Depression Severity: 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe.

My last memory test score (6ICIT) 15-Jun-2015 : 6/28

Scores of 0-7 are considered normal and 8 or more significant.

My allergies:

28-Nov-2012 Adverse reaction to Chlormezanone rash

12-Jul-2012 Adverse reaction to senna

My medication on 13-Apr-2016 :

Repeat

Salbutamol 100micrograms/dose inhaler CFC free 2 PUFFS 4 HOURLY AS REQUIRED

Atorvastatin 40mg tablets One To Be Taken Each Day

Metformin 500mg tablets 2 TABLETS TWICE A DAY FOR DIABETES

Eklira 322micrograms/dose Genuair (AstraZeneca UK Ltd) One Dose To Be Inhaled Twice A Day

Doxycycline 100mg capsules 1 CAPS TWICE A DAY FOR 7 DAYS

Prednisolone 5mg tablets WHEN YOU HAVE A CHEST INFECTION

6 TABLETS DAILY FOR 5 DAYS WHEN YOU HAVE A CHEST INFECTION

My health and social needs and action plan:

My worries/concerns/problems/barriers to improving my health:

I cannot go out as my legs are too weak, I worry I will fall

I never see anyone apart from my carer

I cannot breathe properly

My wishes/goals/what I can do to help myself: Review date:

Attend a class to help strengthen my legs and stop me falling 1.6.16

Get a falls alarm to wear in case I fall so help will come 14.5.26

Contact my Polish church to see if someone can take me to church/ social 14.5.26
activities

Phone Age Concern to visit to see what else is available in my area 14.5.16
See someone to see if I can improve my breathing

Action plan and referrals:  
Review date:

GP to refer to the falls service to improve walking 1.6.16
GP to liaise with patient over referral for wheelchair if someone can take you out 14.5.16
GP to refer to respiratory nurse to optimize breathing 1.6.16
Respiratory nurse to liaise with GP re: COPD rehab programme

Referral to community geriatrician: not needed.
Referral to pharmacist for medication review: not needed
Referral to social worker: not needed
Referral to community respiratory nurse: 13-Apr-2016

My emergency care plan:
If you feel your breathing is getting worse start your emergency pack and phone 020 789 1011 (8am to 4pm Monday to Friday (111 all other times) and ask to speak to your respiratory nurse.

If you feel your health is getting worse please phone your GP 020 1234 5678 or 111 as soon as you can so that the health services in Wandsworth can help you.

Emergency medication:
Emergency respiratory rescue medication supplied