Are we stripping the care out of care plans?

INTRODUCTION

In 2013, NHS England specified that:

'... every person with a long-term condition or disability has a personalised care plan supporting them to develop the knowledge, skills and confidence to manage their own health'.[1]

Around 40% of the UK population experience a long-term condition while 65% of people aged 65–84 years have two or more.[2] This is an all-time high, with figures set to rise. This places significant personal, social, and economic burden on individuals, their families, and the community.

The use of care plans to manage multiple long-term conditions — by assessing individual behaviour, setting joint goals, supporting self-management, and ensuring proactive follow-up — is based on Wagner's Chronic Care Model.[3] The model takes into account the need to provide support and structure to patients, and the fact that all long-term conditions have common challenges.

Care planning has received extraordinary interest in the NHS. Policymakers endorse care planning as a way of containing high costs, encouraging a more person-centred approach, improving quality of life, and reducing mortality rates and emergency admissions to hospitals. But are care plans effective in this regard and what challenges do GP practices face in implementation?

EVIDENCE FOR CARE PLANNING

Systematic literature reviews on the impact of care planning show that it leads to only limited reductions in admissions and small improvements in patients' physical health.[4] However, it does improve patients' confidence and skills in self-management. There is evidence that among engaged patients it can improve health outcomes,[4] although most patients are not meaningfully engaged. Out of the 95% of patients with diabetes that are seen annually, only 50% have a discussion on the management of their diabetes, and <50% discuss their health goals.[5]

NHS England introduced the 'Avoiding Unplanned Admissions Direct Enhanced Service' in 2014–2015.[6] This is a financial incentive scheme for care planning, as part of GP contractual changes, with a view to avoiding unplanned hospital admissions.

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General practices are required to create a register of their top 2% of patients at highest risk of an emergency hospital admission, and for each to develop a personalised care plan. If practices succeed in identifying and case managing these patients they will receive significant financial incentives.

WHO SHOULD BENEFIT?

The evidence base for care plans is patchy, and yet financial incentives are being used to drive its use. Is it right to encourage their use? Could this money be better spent elsewhere? By setting goals and raising expectations with patients, are we causing psychological harm if we cannot meet these goals and expectations?

Setting aside these concerns, a key challenge for practices is to identify those patients who are most likely to benefit from care planning. There are several case-finding tools available to do this. However, these risk tools vary significantly. Most risk tools identify those suitable for care planning by using key variables such as age, sex, and prior admission. Some risk tools also identify patients who have multiple coded comorbidities or 'problems', but this does not mean that these patients are more at risk of an unplanned admission. Accordingly, the software used to identify patients can produce results that are overly inclusive. This has two consequences. First, there are the associated wasted time and the expense from unnecessary care plans. Second, genuinely higher-risk patients may be neglected.

One case-finding tool, the electronic frailty index, is used by many practices to identify adult patients who are in need of a care plan. It was originally developed to identify frailty among patients aged 65–95 years, but not in younger age groups.[7] Therefore, its use among younger patients aged <65 years presents issues of validity.

Additionally, the financial schemes set an arbitrary benchmark of 2% for case finding. This uniformity is inappropriate, as each practice will vary significantly in their numbers of vulnerable or frail patients. For example, a practice with a high proportion of nursing home patients would skew the results and many 'high need' patients would not be care planned, as they would fall outside the top 2%.

BARRIERS TO EFFECTIVENESS

'Care planning' can be defined as the process whereby clinicians and patients discuss, agree, and review plans to achieve goals. A 'care plan' is a written document recording the process. The aims of care planning can vary widely depending on one's professional background: social worker, doctor, nurse, manager, policymaker, or as a patient. Consequently, this can lead to incongruence between the objectives of patients, health professionals, managers, and politicians.

The main focus of commissioning organisations and managers is the collection of care planning data for contractual assurance. Meanwhile, clinicians contend with long patient lists, short consultation times, and may be asked to do care plans for patients that they barely know or see on any regular basis. Therefore, taking the time to do a good care plan with a focus on the outcome and quality of care can be challenging.

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The financial incentive scheme makes the GP the care coordinator, as the GP is the first point of contact for most patients. However, it is debatable whether they are the most appropriate person to undertake the care planning process. It may be that other healthcare professionals, such as community matrons or nominated care plan coordinators, would be better placed to help patients achieve their goals and ensure that continuity of care is achieved.

MOVING FORWARD

A recent series of *BJGP* articles described a House of Care framework model.[8] This model calls for a coordinated service where patients and clinicians jointly work together to manage the patient's condition. It considers the evidence that patient involvement improves health outcomes, and consequently assumes an active role for patients. It puts emphasis on the whole-system approach needed to improve care, with good commissioning and organisational processes, symbolising these as the roof and foundations of the 'House'. These aspects will support care if they use best current evidence, and work to continually improve processes, rather than simply procuring a service.

Genuine patient engagement is vital to success, but currently some patients are not even aware that they have a care plan.[9] Patients want a broader, more holistic view, with support to help them live better with their condition. Doctors are still frequently adopting narrower approaches, focusing on managing the condition rather than the person as a whole.[10] This may be a coping mechanism, where lack of time prevents patient empowerment to take place, and the patient–doctor relationship is affected.

There is evidence to show that a broader approach helps patients live better with their long-term conditions, and ultimately improves quality of life.[10] However, this will only take place in practice if organisational and commissioning processes support the interaction between patients and professionals.

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Provenance
Freely submitted; externally peer reviewed.

Competing interests
The authors have declared no competing interests.

DOI: https://doi.org/10.3399/bjgp17X690377

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