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Care planning for long term conditions in primary care: indicators of embeddedness

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Abstract

Rationale, aims and objectives: Healthcare systems are continuously challenged to develop new ways of working to meet the demands of an increasing prevalence of multi-morbid long term illness. *Care planning* has been proposed as one solution. This analysis used the Normalisation Process Theory as a framework to identify precursors of embeddedness of care planning in 10 primary care practices.
Methods: GPs, Nurses and Practice Managers from the selected practices took part in a series of collaborative learning workshops and a training programme. The data informing this article derive from 15 semi-structured interviews and from observational data collected during 4 collaborative meetings.
Results: A key step in the meetings was collaboratively to differentiate the care planning function from previous practice. Later interviews showed a clear movement towards the generation and implementation of pragmatic solutions. These included the adaptation of pre-existing tools, IT systems, call and re-call procedures and documentation and communication procedures in order to implement care planning for diverse patient needs. Implementing the care planning function entailed a renegotiation of roles between clinicians as well as with patients, the explicit inclusion of practice managers and a consideration of relationships with secondary care and other local services. Participants provided anecdotal evidence of the benefits of care planning and reported having received positive feedback from patients.
Conclusions: The learning collaborative enabled participants to shape care planning to fit their individual practice contexts, in terms of resources, structures and systems as well as in terms of the patient population. It emphasised the need for differentiation from prior practice, individual and communal specification and internalisation and fostered a sense of ownership.

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Introduction

Healthcare systems are continuously challenged to develop new ways of working in order to meet the demands of an ageing population with increasing prevalence of multi-morbid long term illness [1-3]. Care planning has been proposed as one solution [4-6] which has been implemented in the UK, Australia, Canada and the United States [7]. This movement has been further consolidated in the UK with the launch of NHS England's associated guidance, which promotes the use of personalised care plans [6]. However, evidence suggests that clinical guidelines, professional education, financial incentives and research remain focused on single disease issues [8,9]. This leaves primary care practitioners in particular with the challenging task of translating disease specific targets and guidelines to fit the unique and complex contexts of patients' lives, while often operating within ill-fitting

Table 1 Summary of NPT constructs[*]

Coherence (sense–making work)
-Differentiation (Sense-making work to understand how the intervention is different from current practice);
-Communal specification (Sense-making work that participants undertake to build a shared understanding of the aims, objectives and expected benefits of a practice)
-Individual specification (Sense-making work undertaken by individuals to understand their specific tasks and responsibilities in implementation)
-Internalization (Sense-making work involved in understanding the value, benefits and importance of a set of practices)
Cognitive participation (relational work)
-Initiation (The work of key individuals drive the intervention forward)
-Enrolment (Organisation and reorganisation of participants, which can involve the rethinking of individual and group relationships between people and things, in order to collectively contribute to the work of implementing a new practice)
-Legitimation (Ensuring other participants believe it is right for them to be involved)
-Activation (Collective definition of the actions and procedures needed to sustain a practice)
Collective Action (operational work)
-Interactional workability (Interactional work of people with each other, artefacts and other elements of a set of practices to operationalize practices)
-Relational integration (Knowledge work that people do to build accountability and maintain confidence in a set of practices)
-Skill set workability (Allocation work that underpins division of labour)
-Contextual integration (The work of allocating resources and execution of different policies, protocols and procedures)
Reflexive monitoring (appraisal work)
-Systematisation (Participants collect information in order to appraise how useful it is for them and others)
-Communal appraisal (Participants work together to evaluate the worth of a set of practices)
-Individual appraisal (Participants work experientially as individuals to appraise its effects on them and the contexts in which they are set)
-Reconfiguration (Appraisal work can lead to attempts to redefine procedures or modify practices)

[*]adapted from www.normalizationprocess.org

systems (including, for example, short consultation times, substantial caseloads and disease-specific recall systems) [10,11].

Care planning is a systematic way of operationalizing person-centered care for long-term conditions and involving people in their care in order to provide support and guidance for self-management [12-14]. It requires the 4 following inter-dependent elements: 1) engaged and informed patients; 2) healthcare professionals committed to partnership working; 3) facilitative organisational structures & 4) supportive commissioning processes [15]. Although adoption in practice has been variable [16,17], formal evidence of effectiveness of care planning is beginning to emerge [13,15,18,19].

The current article emanates from a pilot study initiated by the North East Strategic Health Authority in the UK to explore the practical implications of implementing care planning in primary care for all of the long term conditions. The initial phase of the programme engaged 10 primary care practices across the Region to form a learning collaborative, in order to develop the lessons learned from the Year of Care approach for care planning in diabetes [20] and to facilitate operational implementation within health services. Concurrently with the first phase, a formative evaluation was undertaken, assessing the applicability of the programme, reporting on knowledge translation processes and the systematic

harnessing of key experiential learning. Practitioners engaged with the principles underpinning care planning from the outset, but also highlighted the complexity of implementation, questioning the feasibility of translating a model developed for a single condition to all of the long term conditions. This led to further investigative work, which sought to highlight indicators of sustainability of the changes implemented and forms the focus of the current paper.

Normalisation Process Theory (NPT) [21,22] is a theory driven approach, which provides a robust analytical framework to understand the operationalisation of complex interventions and their embedding in practice. We used NPT to describe the steps undertaken by practitioners in making sense of the care planning model and adapting it to their particular practice contexts. As such, this paper responds to calls for research to further understanding of the ways that care planning is integrated and embedded in primary care for people with complex needs [17].

Methods

During the course of the pilot study, GPs, Nurses and Practice Managers from the 10 participating primary care practices took part in a series of collaborative learning

workshops, a training programme and a series of interviews. The data informing this article derive from 15 semi-structured interviews conducted in 3 rounds, between December 2010 and December 2011, as well as observational data collected during 4 collaborative meetings. Data collection was undertaken following ethical approval from Northumbria University and clearance from the local Research and Development Department. NPT was used to structure data analysis, so that indicators of embeddedness could be sought for, in the light of changes in participants' responses and researchers' observations over time. NPT, which has been used in similar studies [23], poses that implementation occurs as a result of the 4 'generative mechanisms' as described in Table 1.

Descriptive codes were generated from the data and organised in the 4 NPT mechanisms. Thus, this analysis does not form an in-depth test of the normalisation of care planning, but seeks to identify precursors of embeddedness from the data. All data presented here have been anonymised.

Results

Coherence: sense-making work

A key step in the meetings was collaboratively to differentiate care planning from current practice. Participants rapidly identified with the need to "see the person as a whole" and provide responsive and individualised care, including helping patients to prepare for the consultation, irrespective of their various conditions. However, in the early stages, a great deal of discussion focused on the structures and organisation of care necessary to achieve this:

"At the moment we're still trying to pursue this generic model and it remains to be seen whether we need to be picking it apart and trying to come up with slightly different models for slightly different conditions" (A2).

Some participants suggested that a different approach to care planning was needed for those conditions, such as COPD, for which patients have little control over biological results, in contrast to those more amenable to lifestyle changes (A2). In particular, participants were concerned that the provision of test results prior to the consultation might increase anxiety (A2, E2), represent interruption in the lives of patients whose conditions were controlled (D2), discourage attendance (J2), or be too complicated for patients to understand (J2, E2).Where patients have more than one long term condition, the challenges of developing appropriate preparatory strategies to address multiple conditions in one consultation were even greater (E2, G2). The need to balance the tailoring of care planning according to individuals, while relying on systems that require a degree of standardisation (H1, F2), therefore created a dilemma over the target group for initiating care planning implementation:

"We could care plan for 20 people absolutely marvelously, but we still have another 200 people who still need to be looked after and it's that balance that we've been struggling with." (F2).

"There are so many long term conditions and to try a singular approach is difficult but to have separate care plans for each would be too big a job" (H1).

Later interviews showed a clear shift away from this early problem definition phase, towards the generation and implementation of pragmatic solutions. Participants demonstrated an openness to 'try out' care planning and reflect on the process. They described benefits such as increased satisfaction, the prioritization of the issues or conditions most important to patients (G2, F2) and reducing duplication when conditions need similar management:

"you shouldn't be spending half an hour on diabetes where the problem could well be in the heart failure or COPD... they might have all these different conditions some of the management is very similar" (G2).

In later interviews, practitioners expressed greater optimism that care planning would lead to time savings through a reduction in exacerbations and numbers of appointments. One practitioner expressed hope that care planning would shift the attention away from a focus on clinical markers to a prioritization of patients' agenda (A1).

"Before we learnt how to do it, it was very much doctor agenda…where care planning involves sharing information, sharing data and then engaging the patient and then we come together with the priorities" (G2).

The learning collaborative provided a valuable forum whereby practitioners could engage in communal sense-making work through discussing approaches to and experiences of implementing care planning.

Cognitive participation: relational work

Implementing care planning entailed a renegotiation of roles between clinicians as well as with patients, the explicit inclusion of practice managers and a consideration of relationships with secondary care and other local services. Practitioners taking part in the pilot were key drivers for the implementation of care planning and evaluated the training positively. In many practices, care for people with long term conditions had previously been led by nurses and they were described as instrumental in the implementation process:

"Nurses I think if it's within their armoury they will deliver it even if they've been doing something different, as long as its deemed to be good practice and usually there's an evidence base behind that, the GPs probably use an excuse and say where's the evidence to do that" (A2).

The support of the practice manager was crucial for ensuring that care planning was incorporated into the strategic direction of the practice (E1, E2, B1, G2):

"People doing it on their own will never succeed because if your direction of travel is not in line of the practice policies you will be running into trouble" (G2).

Participants suggested that engaging other practitioners in the care planning agenda was a key challenge (F1, B1). The provision of training (A1), demonstrating tangible results (G2) and demonstrating 'quick wins' (A2) were suggested as strategies to encouraging the broader adoption of care planning. Finding communal planning time, particularly in multi-site practices, to undertake this work was a key challenge (C1, E1). Care planning was seen as needing to transcend different care settings in order to ensure continuity of care (G2, J2). In particular, improved relationships and referral mechanisms with local services needed to be fostered (B1).

In the early stages, participants expressed concern over patient responses to a change in care. For example, they may not utilise materials designed to increase their involvement (G2, J2, B1), could view care planning as an extra intervention, or might demand more, rather than less, appointments as a result (D2). Older people, or those who had become patterned into a particular model of care, were perceived as less likely to be responsive (B1, E2, G2):

"[the]older generation... they're so used to the system as it is, they come along and we tell them and that's it and they follow instructions almost, whereas the younger people are much more open I think now to this sort of care where they're taking responsibility" (B1).

However, there was considerably more reference to patients 'buy in' in the final round of interviews. Participants noted strategies they adopted to try and increase patient receptivity, including restricting the length of consultation (E2), 'selling it in the right way' to patients (A1) and providing repeated explanations about the change in care (A1, E1).

Collective action: operational work

As the pilot progressed, participants demonstrated a clear movement towards identifying operational solutions to the issues explored initially. This included the adaptation of pre-existing tools, IT systems, call and recall procedures and documentation and communication procedures in order to implement care planning for diverse needs. Identifying patient groups with whom care planning could be initiated was a key early implementation decision. Common groupings of conditions were COPD with asthma, or diabetes with heart disease, for example. One practice focussed on 'frequent attenders' to attempt to minimise unnecessary appointments (F2). Other solutions included using the NHS health checks template as a more generic results sheet (E2) and using letters prompting patients to shape the consultation (A, J, G, E). From the early stages of the pilot, practitioners described a change in

their practice with respect to listening skills and having more 'equal' relationships with patients. Participants referred to adopting a more proactive approach to managing long term conditions, "addressing concerns rather than 'fighting fires'", though this was not without challenges (B1, E2).

It was evident from several participants' contributions that a great deal of deliberation had taken place over which staff member(s) should conduct the care planning consultation. Such difficulties hinged on a tension between the aim of addressing needs holistically while acknowledging that practitioners often have specialist knowledge:

"As clinicians we have slightly different specialties…as a patient what you want is a relative expert dealing with you. What you don't want is someone that who knows a lot less than you do" (E3).

Generally, the need for all practice members to be involved was important in order to increase the potential to match patients with staff most qualified to address their needs (G2, J2). Concerns around the difficulty in matching patient needs and staff specialism had lessened in later interviews, with participants viewing the care planning appointment as a way to identify and prioritise, using signposting where necessary (E2, J2,B1, A1):

"Care planning should also be about bringing them back to whoever's appropriate, it isn't necessarily about solving everything in one appointment" (E2).

Concerns were raised about the availability of resources to support the intervention across all sets of interviews. Although it was anticipated that care planning would reduce costs in the long term, participants expressed concern about the initial investment of time and cost incurred through preparing and administrating the care planning consultation (A1) as well as the increased length of appointments:

"I think the problem is that if you're talking about, let's call it probably about 4000 extra consultations then there just is not the resource in the system to appoint people to do that" (D2).

The on-going environment of change "everything is so much up in the air" (F1), uncertainty about commissioning and the "ramping up of the productivity agenda" (E1) were referred to as creating some anxiety about making whole system changes. Concern was expressed over the uncertainty of funding streams and whether "someone somewhere is going to pull the plug because they've got to make short term savings" (A1).

Reflexive monitoring: appraisal work

Participants were aware of the need to show tangible results, robust evidence of effectiveness and demonstrable value for money. They provided anecdotal evidence of the benefits of care planning and provided suggestions having

received positive feedback from patients through surveys and patient forums. However, the gathering of 'hard' evidence was noted to be a complex process which few practices had the capacity to undertake. Furthermore, it was acknowledged that changes in patient outcomes would only be demonstrable in the long term. Consequently, while examples of monitoring various aspects of care planning implementation were cited, there were few references to systematic evaluation of impact. However, participants in practices where care planning was longer established had seen improvements in key outcomes, such as diabetes control, BMI and cholesterol levels. Some indication of an impact on the total number of appointments made was also mentioned.

Participants discussed the relationship of care planning to existing policy agendas such as the Quality and Outcomes Framework (QOF) (B1, J2, G2):

"Obviously you still have your own agenda to meet in terms of QOF." (J2).

However, one participant in later interviews expressed hope that the implementation of care planning would encourage a shift away from the results driven approach demanded by QOF towards a focus on the patient's agenda (A1).

Participation in the learning collaborative provided the opportunity for participants to share experiences:

"we're all committed to be testing this and then feeding back, then the positive aspects of it will, I know, certainly the health managers in our locality are very keen to hear our experiences with a view, they see it very simply as spreading good practice" (A2).

Participants reflected on the impact of care planning for their individual practice, highlighting the benefits of being able to engage in 'meaningful conversation' with patients and suggesting an increase in job satisfaction:

"It is more time consuming but again it's more satisfying as well I think, you get more out of it, definitely" (B1).

Participants referred to the value of obtaining patient feedback as a way of evaluating progress in care planning, for instance through patient surveys and forums, audits and 360 degree appraisal and suggested that this had contributed to the implementation process. In addition, many practitioners described implementing changes based on what worked in other practices, including changes in the wording used to communicate with patients and changing recall systems to correspond with patients' birth month.

Discussion

This study has explored the complexity of translating care planning ideals into workable practice. The learning collaborative was most effective in developing a sense of coherence around the driving principles of care planning.

In parallel to these kinds of practice implementation efforts, researchers have begun to develop the conceptual clarity of care planning [7,12]. A sense of coherence being a pre-requisite to successful implementation, these combined efforts are contributing to the translation of care planning policy into practice in the broadest sense.

At the level of individual practices, professional boundaries were being challenged in order to meet the administrative, logistical as well as medical requirements of care planning. Competing priorities, such as the division of care planning labour and financial incentives, remain a significant barrier to embeddedness. However, there was evidence of sustainable operationalisation, with logistical issues being resolved and care planning being seen as less disruptive to, but yet clearly distinct from, prior practice. The appraisal of practitioners' engagement with the care planning process, both with individual patients and within the practice (and wider) system was cautiously positive.

Care planning, like most practice innovations, requires organisational 'buy in' and systematic support, as well as the dedication of individual practitioners who are embedded in the technical, spatial and social context they attempt to change. This poses a particular set of challenges both for practitioners and evaluators, which are beginning to be documented [24]. It was beyond the scope of this study to contribute to implementation debates, but instead using NPT has helped to highlight areas of strength. Implementing and embedding a new intervention reflects the varying degrees of cooperation, collaborations and conflicts in practitioners' attempts to impose structure on contending and sometimes conflicting patterns of social action [24]. The learning collaborative used here enabled participants to shape care planning to fit their individual practice contexts, in terms of staffing resources, structures and systems as well as patient population. It explicitly avoided the temptation of prescribing implementation pathways, emphasising instead the need for differentiation from prior practice, individual and communal specification and internalisation. This approach is quite novel and fostered a sense of ownership, which was a key implementation enabler.

Acknowledgements and Conflicts of Interest

References

[1] Department of Health. (2012). The Mandate - A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015. London: HMSO.

[2] Department of Health. (2012). Long Term Conditions Compendium of Information - Third Edition. London: HMSO.

[3] Eaton, S., Collins, A., Coulter, A., Elwyn, G., Grazin, N. & Roberts, S. (2012). Putting patients first. *British Medical Journal* 344, e2006.

[4] Department of Health. (2006). Our Health, Our Care, Our Say. London: Department of Health.

[5] Department of Health. (2010). Equity and Excellence: Liberating the NHS. London: Department of Health.

[6] NHS England. (2013). Transforming participation in health and care. London: NHS England.

[7] Burt, J., Rick, J., Blakeman, T., Protheroe, J., Roland, M. & Bower, P. (2013). Care plans and care planning in long-term conditions: a conceptual model. *Primary Health Care Research & Development* 15 (4) 342-354.

[8] Hughes, L.D., McMurdo, M.E. & Guthrie, B.G. (2013). Guidelines for people not for diseases: the challenges of applying UK clinical guidelines to people with multimorbidity. *Age and Ageing* 42 (1) 62-69.

[9] Guthrie, B., Payne, K., Alderson, P., McMurdo, M. & Mercer, S. (2012). Adapting clinical guidelines to take account of multimorbidity. *British Medical Journal* 345 e6341.

[10] O'Brien, R., Wyke, S., Guthrie, B. & Watt, G.S.M. (2011). An 'endless struggle': a qualitative study of general practitioners' and practice nurses' experiences of managing multimorbidity in socio-economically deprived areas of Scotland. *Chronic Illness* 7, 45-59.

[11] Blakeman, T., Bower, P., Reeves, D.& Chew-Graham, C. (2010). Bringing self-management into clinical view: a qualitative study of long-term condition management in primary care consultations. *Chronic Illnes.* 6 (2) 136-150.

[12] Lhussier, M., Eaton, S., Forster, N., Thomas, M., Roberts, S. & Carr, S.M. (2013). Care planning for long term conditions – a concept mapping. *Health Expectations.* http://onlinelibrary.wiley.com/doi/10.1111/hex.12063/pdf.

[13] Year of Care. Report of findings from the pilot programme. http://www.diabetes.nhs.uk/year_of_care/the_year_of_care_pilot_programme/. Accessed 10/05/2013.

[14] de Silva D. (2011). Helping people help themselves - a review of the evidence considering whether it is worthwhile to support self-management. London: The Health Foundation.

[15] Coulter, A. & Roberts, A.D. (2013). Delivering better services for people with long-term conditions. Building the House of Care. London: The King's Fund.

[16] Burt, J., Roland, M., Paddison, C., Reeves, D., Campbell, J., Abel, G. & Bower, P. (2012). Prevalence and benefits of care plans and care planning for people with long-term conditions in England. *Journal of Health Services Research and Policy* 17 (Supplement1) 64-71.

[17] Newbould, J., Burt, J., Bower, P., Blakeman, T., Kennedy, A., Rogers, A. & Roland, M. (2012). Experiences of care planning in England: interviews with patients with long term conditions. *BMC Family Practice* 13, 71-79.

[18] Kennedy, A., Nelson, E., Reeves, D., Richardson, G., Robinson, A., Roberts, C., Robinson, A., Rogers, A.E., Sculpher, M. & Thompson, D.G. (2004). A randomised controlled trial to assess effectiveness and cost of a patient oriented self-management approach to chronic inflammatory bower disease. *Gut* 53 (11) 1639-1645.

[19] Zwar, N., Hasan, I., Hermiz, O., Vagholkar, S., Comino, E. & Harris, M. (2008). Multidisciplinary care plans and diabetes: benefits for patients with poor glycaemic control. *Australian Family Physician* 37 (11) 960-962.

[20] Diabetes UK. (2011). Year of Care: Report of findings from the pilot programme. London: Diabetes UK.

[21] May, C., Murray, E., Finch, T., Ballini, L., Mac Farlane, A., Murray, E., Mair, F., Treweek, S. & Rapley, T. (2010). Normalization Process Theory On-line Users' Manual and Toolkit. http://www.normalizationprocess.org. Accessed 23rd January, 2014.

[22] May, C., Finch, T., Ballini, L., MacFaralane, A., Mair, F., Murray, E., Treweek, S. & Rapley, T. (2011). Evaluating complex interventions and health technologies using normalization process theory: development of a simplified approach and web-enabled toolkit. *BMC Health Services Research* 11, 245.

[24] Lloyd, A., Joseph-Williams, N., Edwards, A., Rix, A. & Elwyn, G. (2013). Patchy 'coherence': using Normalisation Process Theory to evaluate a multi-fasceted shared decision making implementation program (MAGIC). *Implementation Science* 8, 102.

[25] May, C. (2013). Towards a general theory of implementation. *Implementation Science* 8, 18. http://www.implementationscience.com/content/8/1/18/abstract.