Department of Health

Supporting People with Long Term Conditions

Commissioning Personalised Care Planning

A guide for commissioners

Putting **People First**
Transforming Adult Social Care

NHS

DH INFORMATION READER BOX

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Executive Summary

The aims of this guidance

This document aims to provide commissioners of health and social care services with the information and support they need in order to fulfil their obligation to embed personalised care planning in their localities. It describes what personalised and integrated care planning is, what the benefits are and what this means for them as commissioners. It supports World Class Commissioning and the aims of *Putting People First: A shared vision and commitment to the transformation of Adult Social Care)*[1] with a focus on truly personalised services, promoting health and well-being, ensuring proactive, planned, co-ordinated and integrated services.

What is personalised care planning?

Personalised and integrated care planning is essentially about addressing an individual's full range of needs, taking into account their health, personal, family, social, economic, educational, mental health, ethnic and cultural background and circumstances. It recognises that there are other issues in addition to medical needs that can impact on a person's total health and well-being. It is therefore a holistic process, seeing the person 'in the round' with a strong focus on helping people together with their carers to achieve the outcomes they want for themselves, for example to live independently, achieve at school or return to work. For people with a terminal condition this could mean helping them to be cared for and to die in the setting of their

1 Department of Health. *Putting People First: A shared vision and commitment to the transformation of Adult Social Care*. London 2007.

choice. Providing people with quality, timely and relevant information is crucial, as is self care and self management advice. Risk management and crisis and contingency planning are integral to the process, in particular for people with complex needs or for those approaching the end of life.

The importance of providing people with information and support for self care means that personalised care planning is seamlessly linked to other Department of Health policies and commitments, in particular *Your Health, Your Way*[2] (formerly called the Patients' Prospectus), the Evaluation of *Information Prescriptions*[3] and the *Generic choice model for Long Term Conditions*.[4] Further details about these are provided at Annex A.

Health and social care professionals need to support people and their carers in having their say and in order for them to be equal partners in the care planning discussion. A more empowering and less paternalistic approach is required. The health and social care workforce therefore needs support to develop the skills, approaches and behaviours to deliver personalised care. **Further, practical guidance is planned for the NHS workforce in early 2009**. Guidance for the social care workforce will be set in the context of the forthcoming adult social care workforce strategy.[5]

Why is there a focus on personalised care planning? What are the benefits?

Personalised care planning can lead to a range of benefits for individuals, commissioners, providers of services and the health and social care workforce. These centre on:

- embedding the personalisation of care and services 'adding life to years';
- promoting health through information and self care, people staying healthier for longer and therefore 'adding years to life';
- promoting independence and achievement of other goals such as returning to work or living independently;
- reducing health inequalities by standardising care across the country;
- promoting integration and partnership working;
- stimulating genuine choices, and those choices feeding into commissioning decisions;
- promoting a more planned, proactive approach to health and social care services;
- efficiency savings, eg reductions in hospital admissions, outpatient appointments and GP consultations; and
- improved user and staff satisfaction, including fewer complaints.

What does this mean for health and social care commissioners? How can they implement it locally?

Personalised care planning is recognised throughout health, social care and the voluntary sector as a means of standardising excellent management of long term conditions across the country, supported by the care planning commitment in *High Quality Care for All*.[6] Its importance is further reinforced by inclusion in the NHS Operating Framework:[7]

2 Department of Health. *Your Health, Your Way: Your Guide to Long term Conditions and Self Care*. London. 2008.
3 Department of Health. *Evaulation of Information Prescriptions*. London. 2008.
4 Department of Health. *Generic choice model for long term conditions*. London. 2007.
5 Department of Health. Adult Social Care Workforce Strategy – Interim Statement 2008
6 Department of Health. *High Quality Care For All: NHS Next Stage Review Final Report*. London. 2008.
7 Department of Health. *The Operating Framework for the NHS in England 2009/10*. London. 2008

The Operating Framework for the NHS in England 2009/10

Page 15, Para 36: "Over the next two years, to ensure that those living with a long term conditions receive a high quality service and help to manage their condition, everyone with a long term condition should be offered a personalised care plan."

There will be monitoring of uptake and quality of care planning through methods such as use of patient experience surveys.

Primary care trust commissioners, in partnership and through joint commissioning with local authorities and the voluntary sector, will need to understand how personalised and integrated care planning fits with World Class Commissioning.

Commissioners will need to:

- understand how personalised care planning supports World Class Commissioning;
- make use of initiatives such as Joint Strategic Partnerships, Joint Commissioning Boards and Local Area Agreements to support planning and commissioning;
- work with providers so they are able to put in place the necessary framework to be able to adopt a care planning approach and generate care plans for people with long term conditions and those approaching end of life;
- consider how information from care plans can be aggregated to feed into commissioning decisions and commission appropriate services based on the needs of the long term conditions (LTC) population; and
- understand how care planning will be monitored and measured.

Introduction

The issue

Despite a growing recognition of the importance of taking a personalised and integrated approach to care planning and the existence of good practice in some local contexts, the experience of people accessing services varies significantly. The approach is still not widespread enough and barriers persist. In particular, the cultural change needed to embed good practice in local organisations has often not benefited from full support and leadership at senior management level.

The specific commitments

The *Our health, our care, our say*[8] White Paper commitment:

"By 2008 we would expect everyone with both long term health and social care needs to have an integrated care plan if they want one. By 2010 we would expect everyone with a long term condition to be offered a care plan."

The High Quality Care for All: NHS Next Stage Review Final Report:

"Over the next two years, every one of the 15 million people with one or more long term conditions should be offered a personalised care plan, developed, agreed and regularly reviewed with a named lead professional from among the team of staff who help manage their care."

8 Department of Health. *Our health, our care, our say: A new direction for community services*. London. 2006.

The *End of Life Care Strategy*[9]:

"All people approaching the end of life, and their carers, should be entitled to…have a care plan which records their preferences and the choices they would like to make. The care plan should be reviewed as their condition changes."

The purpose of this document

This document aims to provide practical guidance for commissioners (including practice based commissioners) in embedding personalised care planning for people with long term conditions. It is for everyone involved in commissioning local services so they can work together to improve the health, well-being and independence of everyone living in their local area. Personalised care planning supports World Class Commissioning and complements the *Commissioning for Health and Well being* guidance,[10] both of which describe how commissioners have the opportunity to make a real difference by focusing on the outcomes that people want for themselves and for their communities. It also supports the key aims of *Putting People First*.

Scope

This guidance is focused on care planning for all people with a long term condition, including adults and children. However, the principles should be applied to any individual receiving health and social care services.

Consultation

The guidance has resulted from feedback from the *Our health, our care, our say* consultation on community services and feedback during the *NHS Next Stage Review* consultation, and in addition has been developed and shaped by an assessment and care planning policy collaborative made up of around 80 key stakeholders from health, social care, third sector and patient representative groups.

Using the guidance

The guidance aims to describe **what** personalised and integrated care planning is, including the key principles; **why** it should be undertaken; what the **benefits** are; **how** this supports World Class Commissioning and other priorities; and how commissioners can embed the process. For ease of reference, many of the policy documents and publications cited in this guidance can be accessed by clicking the hyperlinks in the text of the electronic version. A glossary of some of the words and phrases used in this guidance is given at Annex B.

Implementation

A programme of work to support implementation has been developed which includes more detailed, practical guidance for the workforce (to be published in early 2009), development of an e-learning tool to support the workforce, and plans to procure an external support programme for primary care trusts (PCTs) to help them implement care planning.

9 Department of Health. *End of Life Care Strategy – promoting high quality care for all adults at the end of life*. London. 2008.
10 The NHS confederation. *Commissioning framework for health & well-being*. London. 2007.

Information for service users and carers

This guidance is mainly aimed at commissioners, who will want to share it with providers of health and social care services. The Department of Health is also planning a communications strategy aimed at service users and carers so that they can understand the principles and what they should expect from care planning.

Impact assessments

As part of its statutory obligations, the Department of Health is required to assess the impact of any policy proposals on different groups in the community in terms of equality of access and impact on the rights and needs of these groups. In addition, DH must undertake an assessment of the impact any new policy may have on private and public organisations, in particular if there are new regulations or financial implications. In producing this guidance we have undertaken an equality impact assessment (EqIA) to help ensure that it takes into account equality issues for service users such as gender, race, disability, age, sexual orientation, religion or belief. We have also undertaken a general impact assessment (IA), which considers the impact of the policy in terms of costs and benefits (the guidance does not introduce any new statutory obligations or regulations, therefore these are not considered in the IA). The EqIA and IA can be found on the DH website at **www.dh.gov.uk/longtermconditions.**

Section 1: What is personalised care planning?

1.1 The national commitment that everyone with a long term condition should be offered a care plan aims to embed the **process** of care planning rather than creating a bureaucratic system of form filling. This is not about simply scheduling a list of treatments. Care planning should bring together all information about the individual into a single, overarching care plan. This could be a written document; electronically recorded, eg as an electronic care plan; or recorded in the person's notes, and be accessible by the patient and by all who have a legitimate reason to access them, including out of hours and emergency/urgent care services.

Agreement of what care planning is

1.2 This guidance has been shaped in collaboration with NHS, social care, third sector and patient groups and represents their experience, knowledge and views. It also consolidates learning from established good practice from areas such as the Care Programme Approach in Mental Health, Person Centred Planning for people with Learning Disabilities and practical experience from the Year of Care programme. The following key elements of what care planning is have been agreed in collaboration with stakeholders:

Box 1: Key elements of the care planning process

The care planning process:

- **puts the individual, their needs and choices that will support them to achieve optimal health and well-being** at the centre of the process;
- **focuses on goal setting and outcomes** that people want to achieve, including carers;
- **is planned, anticipatory and proactive** with **contingency** (or emergency) **planning** to manage crisis episodes better (for those with complex needs);
- **promotes choice and control** by putting the person at the centre of the process and facilitating better management of risk;
- **ensures that people**, especially those with more complex needs or those approaching the end of life, receive co-ordinated care packages, reducing fragmentation between services;
- **provides information** that is relevant, timely and accredited to support people with decision making and choices (eg supported by an **Information Prescription**);
- **provides support for self care** so that people can self care/self manage their condition(s) and prevent deterioration (eg supported by ***Your Health, Your Way***);
- **facilitates joined-up working** between different professions and agencies, especially between health and social care; and
- **results in an overarching, single care plan** that is owned by the person but can be accessed by those providing direct care/services or other relevant people as agreed by the individual, eg their carer(s). **This may be a written or electronic document or may be something that is recorded in the person's notes. The important aspect of this is that the care planning discussion has taken place with an emphasis on goal setting, equal partnership, negotiation and shared decision making.**

1.3 Stakeholders have also agreed the following statement of values and principles that underpin care planning for all:

Box 2: Statement of values and principles of care planning

Statement of values and principles of personalised care planning

- Personalised care planning is a **continuous process**; however it will result in an overarching care plan that is regularly reviewed.
- It is a dynamic process of discussion, negotiation, decision making and review that takes place between the individual and the professional – who have an equal partnership.
- The process should be led by the individual with them at the centre, and be based upon their strengths, goals, aspirations and lifestyle wishes.
- Assessment and care planning views the person 'as a whole', supporting them in all their needs and individual diverse roles, including family, parenting, relationships, housing, employment, leisure and education.
- The person should be encouraged to have an active role in their care, be provided with information or signposting to enable informed choices, and supported to make their own decisions within a guidance of managed risk.[12]
- Care planning is an essential element of supporting a person to self care effectively.

1.4 The diagram below represents views from service users on what personalised care planning means for them:

Aims of personal centred planning	Outcomes for individuals
Planning is person-centred, based on listening to the person, what matters to them and the support they need. It views the person "in the round" understanding that people need to be seen in the full context of how they live their livesand their aspirations including their family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality.	• I am listened to and respected as an equal partner in planning. • My plan is based on what is important to me and what I want to do; how I want to be supported and what I want for the future • The plan is developed with people who are important to me if I choose. • I choose the actions that come from my plan • I don't have to keep repeating my story. • I choose who has access to information about me. • I understand who needs to have access to my personal information, and the reasons why.
People, including carers have the information they need to make choices and be in control of their support and treatment. Planning includes contingency plans for when things change.	• I have the information that I need to make decisions about my life. • Information is timely (when I want it) and is given in ways that I can understand. It is also relevant to my specific needs and is trustworthy - ie comes from trusted accredited sources)
People, including carers are partners in reviewing progress.	• We review progress together, this is based on what is working - what needs to change, and this informs what happens next.
Plans make a positive difference to peoples, including carers lives.	• As a result of planning: • I feel more confident about managing my condition/ life • I am using services that are right for me • I have more choice • Services and support are organised around me- not me around them.

11 Department of Health. *Independence, choice and risk: a guide to best practice in supported decision making*. London. 2007.

The challenge of offering over 15 million people a care plan

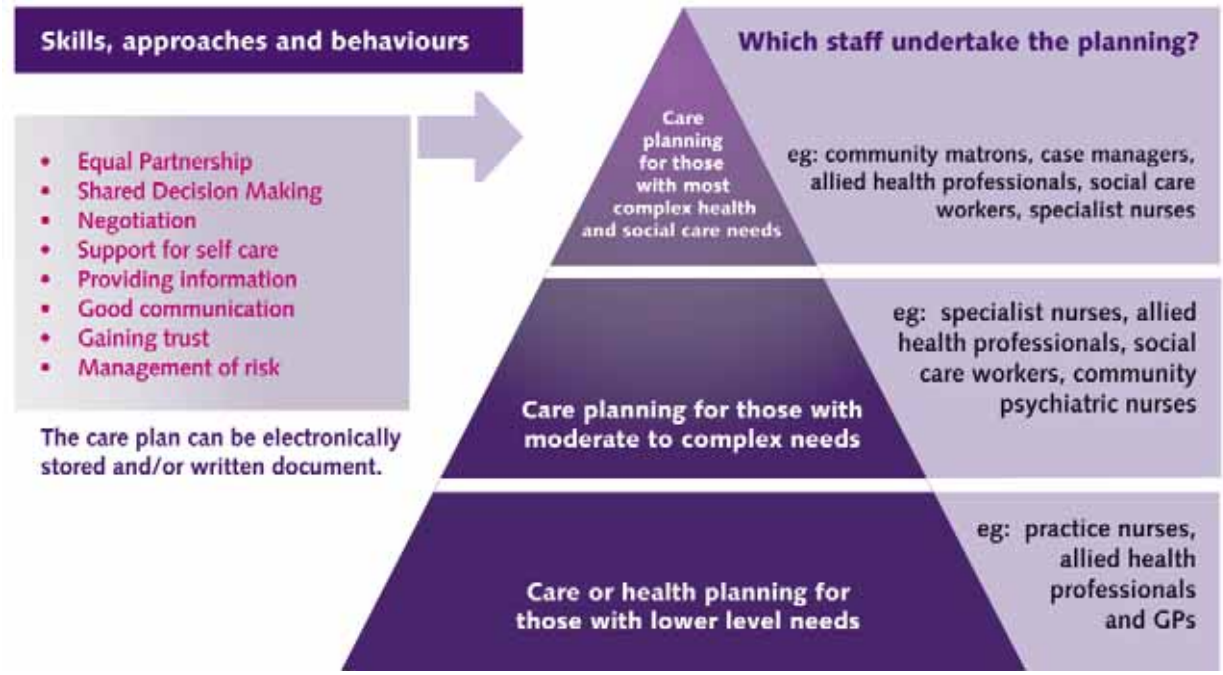
1.5 **Commissioners should understand that the concept of personalised and integrated care planning is not new – this is not starting from scratch with a new offer**. The aim is to embed it in the system and standardise better long term conditions (LTC) and end of life care throughout the country, building on established good practice.

1.6 It is also important to recognise that this is not about developing a major industry where care planning will be the same for everyone. There is a need for proportionality in care planning. So, for example, for those that have a range of complex needs, care planning is likely to be led and co-ordinated by one professional; it will follow a joint assessment of need, will take more time and be more detailed. There may be a strong emphasis on co-ordination of services and contingency planning. For those with less complex needs, from a service perspective the planning process must include information about how their condition will impact on their lives, and support for self care so that each individual can make the best decisions about how to best manage their condition.

1.7 Effective care planning (with joint assessment for those that need it) is already being delivered by many health and social care professionals, eg by community matrons, childrens' community nurses, specialist nurses, allied health professionals and social care workers. However, we need to ensure that high quality standards for care planning are adopted throughout the LTC population, and that planning is delivered in proportion to need.

1.8 Guidance for the workforce is planned for early 2009 and will go into more detail about proportionality of care planning, with practical examples of care planning for people with a range of conditions and different levels of complexity. The diagram below aims to give commissioners a general overview of care planning across all people with long term conditions and who might undertake the process:

Care planning for the LTC population



Section 2:
Why is there a focus on personalised care planning?

The importance of offering people with long term conditions a personalised care plan is signalled by its inclusion in *High Quality Care for All* and the NHS Operating Framework.

2.1 Personalised care planning underpins excellent management of long term conditions and end of life care, and completely supports the key themes described in *Commissioning for Health and Well-being*, our vision for World Class Commissioning, *Putting People First* and *High Quality Care for All*, including:

- more individualised services;
- more focus on prevention of disease and complications;
- greater choice – including supporting people to make healthier and more informed choices;
- reducing health inequalities; and
- providing care closer to home.

2.2 There is evidence of the benefits of certain elements of the care planning process, eg evidence of self care and self management reducing GP and outpatient appointments.[12] International best practice suggests that control by a patient is best achieved through agreement of a personal care plan.[13]

2.3 Box 3 below outlines some of the benefits we would expect from care planning:

Box 3: Potential benefits

Potential benefits for people with long term conditions

Potential benefit	Achieved through care planning by…
• Supported goals to remain healthy, independent and sustain or achieve social inclusion • Greater ability to work, or for those in work less time off sick	Focusing on outcomes and goal setting such as walking unaided, living at home, returning to work
• A broader range of choice, tailored to what people really want, with services centred around individuals rather than them fitting around services • Improved mental health	Having a discussion with the person about their full needs. This recognises that many things can impact on health and well-being, such as addressing psychological or emotional needs, social care needs or housing problems
• Empowered individuals with more confidence and the ability to self manage their condition • People learning about their condition, how it will impact on their lives and how best to manage it • Individuals having the information they need to make choices and be in control of their support and treatment • Better management of medicines and understanding of risks	Providing people with timely and relevant information in a way that they understand, and support self care and self management
• More joined-up, co-ordinated services • Less duplication of information – individuals not having to repeat their story over and over • More support for carers in their caring roles, enabling them to meet their outcomes	Having someone to lead on the care planning process and co-ordinate services can have a hugely positive impact for the person and their carer, particularly for people with a range of complex health and social care needs

12 Department of Health. *Research evidence on the effectiveness of self care support* report. London. 2007.
13 The Commonwealth Fund. International Health Policy Survey of Primary Care Physicians in Seven Countries. 2006.

Potential benefits for people with long term conditions

- Reductions in:
  - crisis episodes and unnecessary admission to hospital
  - unnecessary outpatient visits
  - unnecessary GP visits
  - admissions to residential and nursing homes

Having contingency planning, eg who to contact, what to do in a crisis episode

Increased self care and self management – there is evidence of reductions in GP and outpatients appointments

Supporting people to be independent, better management of risk, and perhaps use of assistive technology to support people to live at home if that is one of their goals

- Better long term outcomes

Improved self care and self management, including better use of medications

Potential benefits for health and social care commissioners, providers and the workforce

- Improved care and outcomes for people with long term conditions and those at end of life, ie the right care provided at the right time and in the right setting
- Supporting achievement of World Class Commissioning, including a number of WCC competencies
- Decisions made based on evidence and need
- Better management of risk

Focusing on personalisation and outcomes. Meeting holistic needs and true discussion and engagement should promote more choice. Information from care plans can support needs assessment

- Value for money, clinical cost effectiveness
- Proactive rather than reactive care and services
- Efficiency savings resulting from reductions in hospital admissions, outpatient appointments, GP consultations, residential and nursing home care admissions, and avoidance of unnecessary complications such as contracture and pressure sores
- Longer term efficiency savings from people self managing their condition, preventing rapid deterioration and unnecessary reliance on health and social care services
- Reduction in complaints

Having contingency planning, eg who to contact, what to do in a crisis episode

Increased self care and self management – there is evidence of reductions in GP and outpatient appointments

Supporting people to be independent, better management of risk, and perhaps use of assistive technology to support people to live at home if that is one of their goals

Potential benefits for health and social care commissioners, providers and the workforce

- Facilitation of joined-up working between multi-agency, and health and social care teams

Having someone to lead on the care planning process and co-ordinate services can have a hugely positive impact for the person and their carer, particularly for people with a range of complex health and social care needs

Section 3:
How can commissioners implement care planning locally?

3.1 It is important that commissioners understand that the process of personalised care planning can lead to improved management of long term conditions and that it can also support them in achieving World Class Commissioning. It may, however, appear to be intangible in terms of how they actually commission. It should not be thought of as a single service or entity that can be commissioned, but as a process of delivering care and support requiring training, time and high quality information resources. This section aims to describe to commissioners what they have to do to include care planning in their commissioning plans, what tools and resources are available to help them, and how the process will be monitored and measured.

Commissioners (including practice based commissioners) will need to:

(i) understand how personalised care planning supports World Class Commissioning;

(ii) make use of initiatives such as Joint Strategic Partnerships, Joint Commissioning Boards and Local Area Agreements to support planning and commissioning;

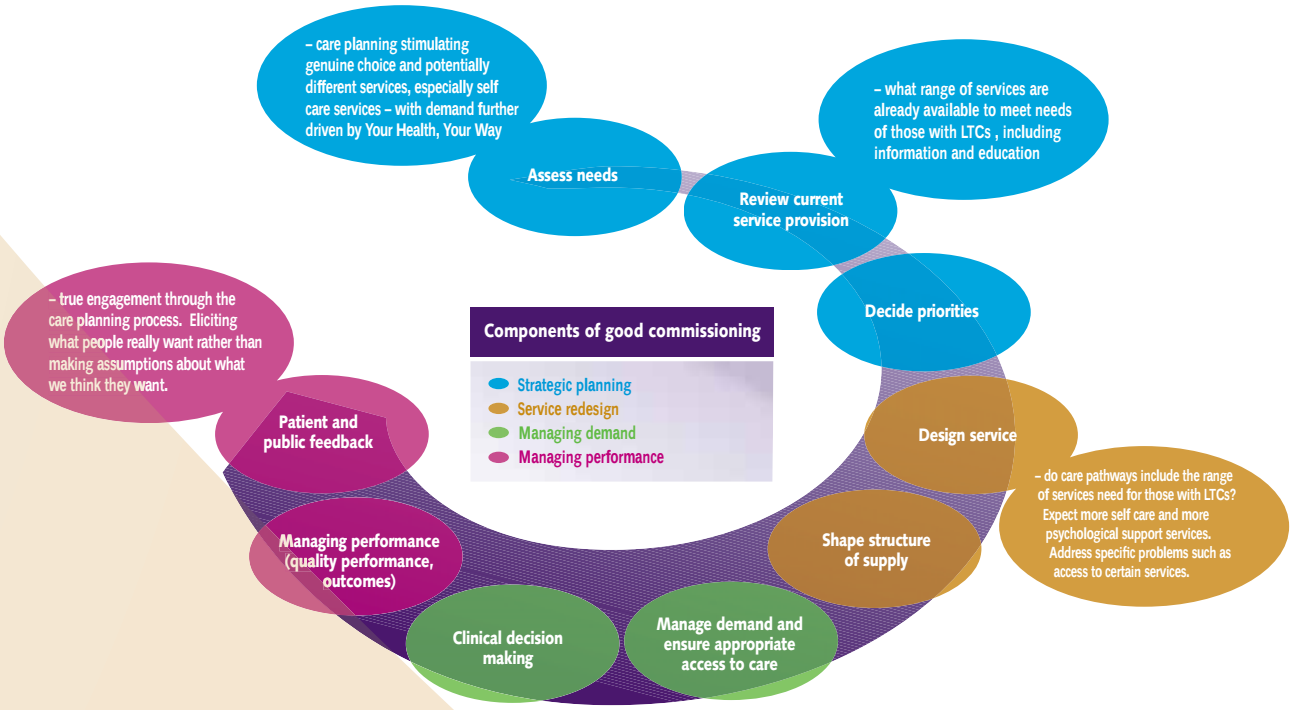
(iii) work with providers so they are able to put in place the necessary framework to be able to adopt a care planning approach and generate care plans for people with long term conditions and those approaching end of life;

(iv) consider how information from care plans can be aggregated to feed into commissioning decisions and commission appropriate services based on the needs of the LTC population; and

(v) understand how care planning will be monitored and measured.

(i) Understand how personalised care planning supports World Class Commissioning

3.2 The vision for World Class Commissioning places much emphasis on personalisation of services and putting people at the centre of commissioning. The challenge to commissioners is how to make local voice, choice and control a reality. Personalised care planning supports genuine choices through a discussion that addresses holistic needs. Commissioners should consider how they can aggregate the information from within an individual (micro) care plan to inform commissioning at macro level. Commissioners will be familiar with the commissioning cycle below. Care planning supports various points in the cycle as shown:



World Class Commissioning competencies

3.3 Personalised care planning can also support commissioners in achieving the competencies required to deliver WCC. Box 4 below describes the links to a number of competencies:

Box 4: Achieving World Class Commissioning Competencies through implementation of care planning

World Class Commissioners are recognised as the local leaders of the NHS – Ensuring that people with long term conditions are offered personalised, proactive care planning and a wider range of choice to support them to manage their condition will help build their reputation within the community.

World Class Commissioners work collaboratively with community partners to commission services that optimise health gains and reduce health inequalities – Developing fully integrated care planning promotes partnership working between health and social care providers, local government and the third sector at both strategic and individual levels.

World Class Commissioners proactively seek and build continuous and meaningful engagement with the public and patients to shape services and improve health – The essence of care planning is about truly engaging with people, encouraging their input and views about their care and finding out what can really make a difference to support them to achieve optimal health and well-being. This means that 'micro level' engagement is taking place across the whole population of those with long term conditions who take up the offer of care planning. This could be deemed one of the most effective ways to engage with people whose voice would otherwise not have been heard.

World Class Commissioners lead continuous and meaningful engagement with clinicians to inform strategy and drive quality, service design, and resource utilisation – Working with local clinicians such as GPs, nurses and specialist consultants to implement care planning, and feeding information from care planning into commissioning decisions, will ensure that services commissioned as part of the process are based on local knowledge and needs.

World Class Commissioners manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements – Care planning tailored to individual need is a way of establishing local needs and requirements through aggregated data collection from individual care plans. It also has the ability to provide granular information that can identify health inequalities and unmet needs.

World Class Commissioners prioritise investment according to local needs, service requirements and the values of the NHS – Personalised care planning can be a vehicle to understanding where local requirements are most needed and determining where investment priorities lie. It can also reveal services that are less popular which can support decommissioning.

World Class Commissioners promote and specify continuous improvement in quality and outcomes through clinical and provider innovation and configuration – Allowing the patient voice to feed into decision making through localised implementation of personalised care planning will result in better quality service driven by the needs of the local population.

World Class Commissioners effectively stimulate the market to meet demand and secure clinical, health and well-being outcomes – Personalised care planning, together with *Your Health, Your Way*, should stimulate provision of a wider range of services by a plurality of providers to meet holistic needs. This should drive choice, continuous improvement and innovation by stimulating new services together with information to support decommissioning.

3.4 Personalised care planning can really help to secure better health and well-being, better care and better value. Delivery of care planning will be measured, in particular through patient experience surveys. More details on this are provided in paragraph 3.20 on page 25.

(ii) Make use of initiatives such as Joint Strategic Partnerships, Joint Commissioning Boards and Local Area Agreements to support planning and commissioning

3.5 Delivery of care planning requires joint working and information sharing by the health and social care workforce, eg through multi-disciplinary teams. However, to sustain multi-disciplinary working there must be **integration at strategic level**. This means making use of initiatives such as Joint Strategic Partnerships, Joint Commissioning Boards and Local Area Agreements to support planning and commissioning.

3.6 Joint managed health and social care networks and/or teams will support and sustain integration through joint planning and shared goals based on outcomes. There are also a number of approaches and mechanisms that can help with this:

- **Joint commissioning** for a range of services to meet service users' and carers' needs
- **Integrated care pathway approaches** to service delivery
- Improved **information sharing** between agencies
- **Promoting the benefits** of information sharing to service users/public and encouraging early determination of who should have access to information about them
- Protocols and arrangements for working between **different assessment and planning systems**
- Improving **local shared provider agreements**
- Effective Joint Strategic Partnerships, Joint Commissioning Boards and Local Area Agreements to facilitate **planning across agencies**.

(iii) Work with providers so they are able to put in place the necessary framework to be able to adopt a care planning approach and generate care plans for people with long term conditions and those approaching end of life

3.7 Commissioners need to work with providers to ensure that:

- they are offering care planning as part of the service, care pathway and/or local models of care for people with long term conditions; and
- services to support self care and structured patient education are incorporated into local pathways as routine, and that they specifically link to care planning.

They also need to consider:

- how to ensure resources are in the right place to support care planning;
- how funding will be moved in line with any movements in care provision; and
- what this means for local workforce development plans.

3.8 It is envisaged that care planning will take place mainly in primary and community care and will involve staff such as GPs, practice nurses, community matrons, allied health professionals and social care workers. It may also take place in secondary care by specialist staff such as specialist nurses or, sometimes, specialist consultants. All staff, including those in the third sector, need to be aware of personalised care planning and what their role is in delivering it. **Guidance planned for the workforce in early 2009 will support this**.

3.9 Commissioners should also consider how they can use contracts with service providers as a mechanism to deliver care planning. The Department of Health is currently developing a Primary Care Service Framework, which PCTs will be able to use to commission care planning

as a Locally Enhanced Service from General Practice. We expect this to be available early in 2009. Care planning is included as a service specification in the Community Services Standard Contract. For the acute sector, care planning could be included under Schedule 3 Part 4B of the Standard NHS Contract for Acute Services as a locally agreed performance indicator.

Commissioning care planning – Case study

Year of Care programme

The Year of Care programme has worked with three pilot sites to discover what needs to be commissioned to ensure that care planning can take place. The findings are that three different elements all need to be present and working together, though commissioners at each of the three sites (Calderdale and Kirklees, North of Tyne and Tower Hamlets) approached each in slightly different ways. In each case they needed to provide **clinical team training** to ensure staff were committed to partnership working and had the skills to do it. They also had to work to **engage people with LTC in the process**. This ranged from commissioning patient education courses as part of the overall care pathway for diabetes in their area, to written material and public information. Finally they recognised that **clinical teams need to reorganise how they worked,** including sending any relevant test results to people one to two weeks before a scheduled appointment so the person had time to think about these before they came. Support for this alone, sometimes in the form of a new Local Enhanced Service, was highly effective in embedding care planning because it was satisfying and popular with patients and clinicians alike and provided an easy first step. Patients responded:

"I could focus on the important things for me and get help"

"time to read [results] and think about what to raise…you know what is coming"

"more non-judgmental than in the past…wasn't dominated by anxiety…more motivated"

"liked the fact you are being involved"

And staff said:

"I enjoy doing the clinic a lot more now. I enjoy working with them, not at them"

"people feel more relaxed as they already know what we are going to say"

"it's absolutely 100 per cent better for me"

Further information on the Year of Care programme, including contact details, can be found at Annex A.

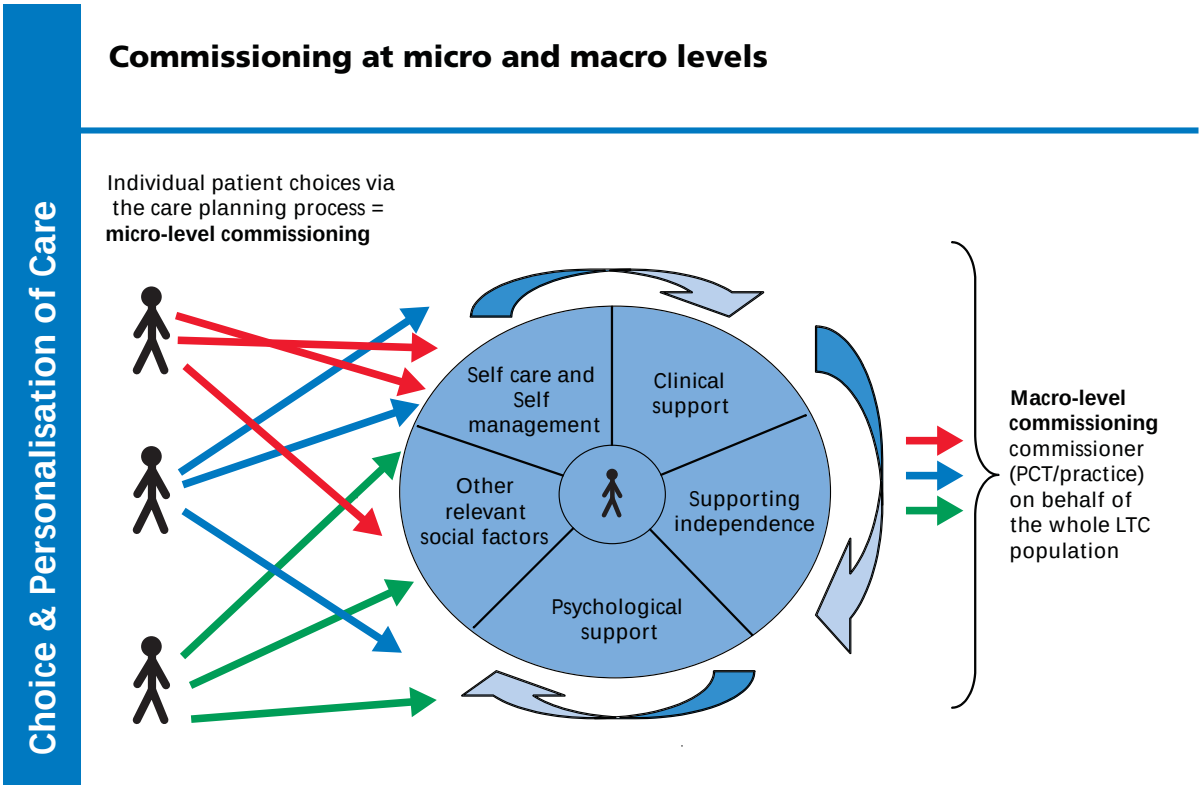
(iv) Consider how information from care plans can be aggregated to feed into commissioning decisions and commission appropriate services based on the needs of the LTC population

3.10 Personalised care planning should embed a more holistic approach to delivery of care, which should drive demand for a wider range of services, eg discussing psychological needs and how the person best wants those needs met could drive demand for services such as exercise on prescription or cognitive behavioural therapy. These could be used alongside or as an alternative to the person being prescribed anti-depressant medication. The focus on self care, together with implementation of *Your Health, Your Way*, should drive demand for a wider range of services to support people with long term conditions to self care, such as access to support groups, smoking cessation and weight management programmes. Demand for advanced assistive technologies such as telehealth and telecare may also increase, given their huge potential to support people to live independently and self manage their conditions. Such innovations need to be considered as part of the care planning process.

3.11 The person's preferences regarding both the type of care they would wish to receive and the setting or location in which they wish to be cared for should also be elicited. Advance care planning (ACP) is a very helpful way of achieving this and this is set out clearly in *Advance Care Planning: a Guide for Health and Social Care Staff*.[14] As this document points out, it is important to understand the role of an advance care plan and the Mental Capacity Act 2005 (MCA). The outcome of the ACP may be the completion of a statement of the person's wishes and preferences about their future care, or an advance decision to refuse specific treatment. The MCA gives people specific ways to plan ahead in terms of their care or treatment for a time when they may lack capacity. People do not need to plan in this way if they do not want to. Alternatively, an individual may decide to appoint a person to make treatment decisions on their behalf by authorising the person to do so under a Lasting Power of Attorney.

3.12 The diagram below, taken from the *Generic choice model for long term conditions*, illustrates how the choices that people may make at micro level through care planning can be aggregated at macro level which commissioners can then use as a basis for commissioning for the whole LTC population. The *Generic Choice Model*, which aligns with personalised care planning, *Your Health, Your Way* and the *Evaluation of Information Prescriptions*, was developed following a commitment to offer more choice for people with long term conditions. It outlines five key areas where choice should be made available, which promote the personalised and holistic approach needed so that people can live their life with a long term condition rather than the condition dominating their life.

Commissioning at micro and macro levels



3.13 The introduction of **personal health budgets** could see the scope for choice widened even further, eg access to alternative therapies such as acupuncture or services to support well being such as massage. It is important that commissioners understand any shift in demand for services as a result of personalisation. The information captured in personalised care plans should be used in conjunction with other means of information collection to inform joint needs assessment and commissioning decisions. Commissioners should consider how they can access this information and monitor changes in demand for services. Information from care planning may lead to the decommissioning of services that emerge as being less popular.

14 Department of Health. *Advance Care Planning: A Guide for Health and Social Care Staff*. London. 2007.

Low-demand services and unmet need

3.14 Commissioners should consider that care planning may identify needs (at micro level) where there is currently no existing service. This could be a service that is in high demand or one that is requested by only a very small number of people. As a starting point, commissioners should work with providers to establish how they will record and monitor services requested that are not currently available. They will then need to agree a model for how they will aim to address these needs. This may sometimes mean providing needs for a very small cohort of people or even at individual level. It may be possible, for example, to develop a model with providers whereby the provider holds a brokerage budget for one-off needs.

3.15 Commissioners (and practice based commissioners – see below) may wish to consider working together to pool resources in order to meet identified needs where there is currently low demand and no service available, perhaps based on the model for specialist commissioning of services. These services would still need to be considered clinically appropriate and cost effective with the potential to have a positive impact on health and well-being. In developing such a model, local health communities would need to consider where and how people would access such services; for example, this should not automatically mean centralising a service if that would make it inaccessible to certain people.

Practice based commissioning (PBC)

3.16 PBC is at the heart of World Class Commissioning and key to delivering more personalised services and choice, which can lead to improved health outcomes and reduce inequalities. *Practice based commissioning – budget setting refinements and clarification of health funding flexibilities, incentive schemes and governance*[15] lays out an expectation that PCTs should support practice based commissioners (PBCs) to use their indicative commissioning budget more flexibly in order to make the simple changes that would improve the situation for people. This could include commissioning services more responsive to people's needs as identified through personalised care planning.

3.17 The guidance on budget setting and funding flexibilities outlines how PCTs should agree with practice based commissioners a menu of local flexibilities to support their achievement of local and national priorities working with local authority partners and reflecting priorities in Local Area Agreements. Where practice based commissioners wish to spend funding on services that are not on the locally agreed menu, they should submit a business case to their PCT. PCTs may wish to encourage practice based commissioners to set aside part of their budget that can be used flexibly in-year to meet the variation of local demand that will be stimulated not only through personalised care planning but through the implementation of *Your Health, Your Way*.

Aggregating information from care plans

3.18 Aggregating information from care plans for commissioners to use should be supported in the future by the Summary Care Record (more information on the SCR is provided at Annex A) which supports the sharing of information across organisations and people having access to their record through HealthSpace. PCTs should be working towards developing information systems to support the systematic sharing of information; in particular they should be working with their GP practices, which can provide them with a rich source of information gathered through the care planning. Ideally this should include recording of unmet needs.

3.19 Some PCTs are already developing systems that integrate patients' care records; for example, in the Yorkshire and the Humber Strategic Health Authority (SHA) region an IT system has been

15 Department of Health. *Practice based commissioning – budget setting refinements and clarification of health funding flexibilities, incentive schemes and governance*. London. 2007.

developed to link up front-line practitioners with other clinicians and healthcare professionals from different organisations to deliver personalised diabetes care services (see Box 5).

Box 5: Yorkshire and the Humber integrated IT system

Yorkshire and the Humber

Although data sharing for diabetes has been in place for eight years in Bradford and Airedale, the diabetes teams across the SHA have worked together to design a system that records individual needs, including emotional, social, educational, economic and cultural circumstances and biomedical information.

It also enables multi-disciplinary team members, wherever they work, to access and contribute to the full electronic patient record (if they have appropriate access rights) and see what their colleagues have recorded. This integration of information enables a whole new approach to the delivery of diabetes care.

By linking together those who deliver and receive diabetes care, questions and tests no longer have to be duplicated at each consultation, and proactive planning and effective co-ordination of care services can be made. Linking the IT to innovative remote consultation technology enables the expertise to be delivered by the right person at the right time in the right place. This reduces the need for hospital outpatient appointments and provides early intervention to help prevent emergency admissions.

The IT solution also reflects the Year of Care approach to care planning and consultation style, and captures key information about joint goal setting and action planning agreed between a person with diabetes and their clinician.

Capturing information (anonymously) from individual care plans supports a rich evaluation of service choice to be incorporated into local population requirements. This information means commissioners can consider how to use funds most efficiently to best support self care, identify popular services, and recognise gaps in services.

Links to social care will be enabled with the introduction of the Common Assessment Framework. HealthSpace may provide the link to the record for service users.

The IT system will be in use across five PCT local health communities throughout Yorkshire and the Humber during 2008/09, before being made generally available within the national programme for IT. If evidence shows the system to be positive, the principles of the integrated care planning approach based on the IT tool will be relevant to support all complex long term care processes.

(v) Understand how care planning will be monitored and measured

3.20 The inclusion of care planning in *High Quality Care for All* and the NHS Operating Framework emphasises the commitment to its implementation. A range of metrics are being developed that will assess not only the uptake of care planning across the country but also the impact it is making in terms of improvements in patient care and outcomes together with any cost implications, either through efficiency savings or any extra costs. A full Impact Assessment has been undertaken which can be found at the Department of Health website; however, further research is needed to understand the anticipated versus the actual impact of care planning. The Department of Health is therefore considering an academic research evaluation into the uptake and impact of care planning across the country.

3.21 The table below summarises the key areas for monitoring and measuring (i) the uptake of care planning, (ii) the qualitative aspects of it, and (iii) the impact in terms of people reporting improved outcomes in terms of health and well-being:

Key area/method	What it says/the indicator	When it will be measured/ frequency	Direct link to PCT performance measure?
NHS Operating Framework	Over the next two years, in order to ensure that those living with a long term condition receive a high quality service and help to manage their condition, everyone with a long term condition should be offered a personalised care plan	During 2009/10	No
Public Service Agreement (PSA) target; Departmental Strategic Objective and a Local Area Agreement (LAA) indicator	All people with long term conditions are supported to be independent and in control of their condition	2008/09–2010/11	Yes
GP Patient Survey	Questions in the GP Patient Survey on who has been offered care planning and whether it has improved their health and well-being	2008/09 Annual Survey 2009/10 Quarterly Survey	No
Health Survey for England	Questions to the wider population on who has been offered care planning and whether it has improved their health and well-being	2009/10 Annual Survey	No

3.22 There are also plans to develop a range of metrics to cover the implementation of the wider LTC strategy that should give indications as to the impact of care planning. These will cover a wide range of information that is already collected such as emergency bed day usage, outpatient appointments, and other patient experience surveys linked to greater personalisation and choice. Further work is also taking place on how to commission for long term conditions through the principles of World Class Commissioning which will link to the WCC Assurance Framework.

Annex A: Linked policies and initiatives with supporting information

Listed in alphabetical order:

Care Programme Approach (CPA)

CPA was introduced in 1990 to provide a framework for effective mental health services for people with severe mental health problems. It places an emphasis on personalised care planning, ensuring that individuals and their carers are involved in decisions about their care. Effective co-ordination of services with a key worker taking the lead and a multi-disciplinary approach are also key elements of CPA. More information can be found at **www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_083650**

Carers Strategy

The Carers' Strategy sets out the Government's short-term agenda and long term vision for the future care and support of carers. A more integrated and personalised support service for carers will be offered through easily accessible information, targeted training for key professionals to support carers, and pilots to examine how the NHS can better support carers. The strategy can be downloaded at **www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_085345**

Commissioning framework for health and well-being

This framework sets out the eight steps that health and social care should take in partnership to commission more effectively. It places an emphasis on personalisation of services, putting people at the centre of commissioning. The framework is aimed at commissioners and providers of services in health, social care and local aouthroities and is part of the White Paper '*Our health, our care, our say*' implementation. The guidance can be downloaded at: **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604**

Common Assessment Framework (CAF) for Adults

The White Paper *Our Health, Our Care, Our Say* included a commitment to develop a common assessment framework (CAF) for adults which would:

- improve outcomes for adults by ensuring a personalised and holistic assessment of need, focused on delivering individual outcomes;
- support improved joint working between health and social services; and
- increase efficiency through better information sharing.

The CAF will improve the sharing of information around assessment and care/support planning. It is a generic approach to assessing the health, social care and wider support needs of individual adults and supporting this with appropriate IT solutions and potential focus around Connecting for Health (CFH). It is a necessary part of *Putting People First*'s vision of every locality having a single community-based support system focused on the health and well-being of the local population. The development of CAF is expected to support personalisation and help underpin the wider agenda of the NHS Next Stage Review, in particular, through supporting delivery of an integrated person-centred approach to assessing people's need for support from health and social care services and the support needs of their carers. More information can be found at **www.cpa.org.uk/sap/caf_more_about.html**

Common Core Principles to Support Self Care

Skills for Health and Skills for Care have worked with key stakeholders, including people who use services and carers, to develop a set of *Common core principles to support self care*. The principles capture best practice in order to support service reform and promote choice, control, independence and participation of people who use services. This guide can be downloaded at **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084505**

Confidentiality: NHS Code of Practice

The Code's purpose is to provide guidance on patient information confidentiality issues within the NHS and NHS-related organisations. The Code of Practice can be downloaded at **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253**

Dignity in Care

The Dignity in Care Campaign aims to eliminate tolerance of indignity in health and social care services through raising awareness and inspiring people to take action. To date the campaign has focused on older people; since August 2007 the campaign has been extended to include people with mental health needs. More information can be found at **www.dh.gov.uk/en/SocialCare/Socialcarereform/Dignityincare/index.htm**

End of Life Care

In July 2008 the Department of Health published a national End of Life Care Strategy for adults, this country's first. Implementation of the Strategy will deliver increased choice to all adult patients, regardless of their condition, about where they live and die. It will cover adult patients with all conditions; care given in all settings (home, hospital, care home and hospice); care given in the last year(s) of life; and patients, carers and families. It will help to take forward the commitments in the election manifesto and in the White Paper *Our health, our care, our say*.

End of life care is also one of the eight pathways the strategic health authorities (SHAs) examined to produce the reports that helped shape the NHS Next Stage Review. As the Strategy developed we shared its emerging findings with SHAs to inform the Review, and in turn we took account of this important local work in the development of the final version of the national Strategy itself.

Good end of life care should attend to the needs of the whole person and those who are important to them. People approaching the end of life should reasonably expect that their care will be pre-planned wherever possible; well co-ordinated; equitable; and ethical with regard to preferences and personal beliefs. Involving the person and their carer in planning and agreeing a care plan, which identifies the needs and preferences for care at the end of life, ensures that they remain in control. This is fundamental to retaining a person's dignity at a time when they are likely to be feeling at their most vulnerable. End of life care is also an area where there is input from a range of care providers, from health, social care and the voluntary sector, and it is equally important to ensure that these services are well co-ordinated.

The End of Life Care Strategy can be downloaded at **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277**

The NHS End of life Care Programme can be found at **www.endoflifecare@foradults.nhs.uk**

Generic Choice Model for Long term Conditions

The generic model helps commissioners to understand the process and range of services that need to be commissioned, to improve and personalise services and support people with long term conditions. The model, developed in conjunction with a number of patient organisations, provides good practice examples, and aims to reduce inequalities. The model can be downloaded at **www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_081105**

Health, Work and Well-being

Health, work and well-being – Caring for our future is an ambitious strategy put together by two government departments, the Department of Health and the Department for Work and Pensions, and the Health and Safety Executive to improve the health and well-being of working-age people. It places real responsibility not just in the hands of government, but also with employers, individuals, the healthcare profession and stakeholders. The strategy can be downloaded at **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4121756**

Improving Stroke Services: a guide for commissioners

Improving Stroke Services promotes the benefits of taking an integrated approach across the whole of the stroke patient journey to ensure that opportunities for improving care and making more efficient use of resources are realised. It works through the commissioning cycle to set out how each stage may be applied to stroke. At the centre of the cycle is the role of patients and the public, to whom commissioners must be accountable for their commissioning decisions. The guidance can be found at: **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063260**

Improved Access to Psychological Therapies

This Commissioning Toolkit seeks to deliver on the Government's 2005 General Election manifesto commitment to provide improved access to psychological therapies for people who require the help of mental health services and to offer a more personalised service based around their individual needs. The toolkit can be downloaded at **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084065**

In Control

In Control works to improve the system of social care. It is for everybody who wants to control their support by ensuring that people know what they are entitled to, and that they can control their money through Individual Budgets as much as they want as part of their Self-Directed Support. For more information visit **www.in-control.org.uk/**

Independence, choice and risk: a guide to best practice in supported decision making

This best practice guide is for the use of everyone involved in supporting adults (aged 18 and over) using health and social care within any setting, whether community or residential, in the public, independent or voluntary sectors. This includes all NHS staff working in multi-disciplinary or joint teams. The guide can be downloaded at **www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_074773**

Individual Budgets

Individual Budgets will empower those people needing social care support to take control and make decisions about the care they receive by bringing together a number of different funding streams and offering a transparent way of allocating resources to individuals. Knowing the level of resources at their disposal can help individuals to plan and control how their support needs will be met. For more information about Individual Budgets visit **individualbudgets.csip.org.uk/index.jsp**

Information prescriptions

Information prescriptions will guide people to relevant and reliable sources of information to allow them to feel more in control and better able to manage their condition and maintain their independence, and will be nationally recognised as a source of key information on services and care that will be seamlessly and formally integrated into the care process. For further information visit **www.informationprescription.info/**

National Evaluation of Partnerships for Older People Projects (POPPS): Interim Report

A total of 29 local authority-led partnerships, including health and third sector partners (voluntary, community and independent organisations), have been funded by the DH to deliver and evaluate local, innovative schemes for older people. The Interim Report published in October 2008 reveals a number of positive messages, including POPP pilot sites having a demonstrable effect on reducing emergency bed days compared to non-POPP sites, and patients reporting improved quality of life. The interim report concludes that POPPs can lead to better investment and disinvestment decisions, faster development of joint commissioning involving voluntary and community groups, and more locality working to identify needs and inform commissioning. The Oct 2008 interim report can be found at: **http://networks.csip.org.uk/_library/Evaluation_of_POPP_interim_report.pdf**

Joint Strategic Needs Assessment

The Local Government and Public Involvement in Health Act 2007 requires primary care trusts and local authorities to produce a Joint Strategic Needs Assessment of the health and well-being of their local community. The guidance provides tools for local partners undertaking a Joint Strategic Needs Assessment and describes the stages of the process, including stakeholder involvement, engaging with communities and recommendations on timing and linking with other strategic plans. The guidance can be found at **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097**

National service frameworks

National service frameworks (NSFs) are long term strategies for improving specific areas of care. They set national standards, identify key interventions and put in place agreed time scales for implementation. A list of all the strategies and information about them can be found at **www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/index.htm**

Person-centred planning for learning disabilities

This is a method of supporting and working with people who have a learning disability. It helps to work out what the individual wants from life, how best to achieve it, the kind of support a person will need and how it would be best given. More information can be found at **www.publications.doh.gov.uk/learningdisabilities/planning.htm**

White Paper – Pharmacy in England

This White Paper sets out the Government's vision of the future role pharmacists can play in delivering world-class pharmaceutical services. This includes pharmacists acting as centres within the community promoting and supporting healthy living and healthy lifestyle, providing advice and support on self care, and offering new services to those with minor ailments and long term conditions such as routine monitoring, vascular risk assessment and support for making best use of their medicines. The full edition of the White Paper be downloaded at **www.official-documents.gov.uk/document/cm73/7341/7341.asp**

Putting People First

Across government, the shared ambition is to put people first through a radical reform of public services, enabling people to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual needs for independence, well-being and dignity.

This ministerial concordat establishes the collaboration between central and local government, the sector's professional leadership, providers and the regulator. It sets out the shared aims and values which will guide the transformation of adult social care, and recognises that the sector will work across agendas with users and carers to transform people's experience of local support and services. More information can be found at **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndguidance/DH_081118**

Also see: *Commissioning for Personalisation: A Framework for Local Authority Commissioners* at **http://networks.csip.org.uk/Personalisation/PersonalisationResources/Type/Resource/?cid=3241**

Personalisation Network – a place where people involved in changing the adult social care system can find guidance and examples from across the country. **http://networks.csip.org.uk/Personalisation/**

Single Assessment Process

The Single Assessment Process (SAP) was developed following recognition that many older people have a wide range of health and social care needs, and that agencies need to work together to ensure that assessment and subsequent care planning are effective and co-ordinated. Care should be holistic and involve service users. You can find our more about SAP at **www.dh.gov.uk/en/SocialCare/Chargingandassessment/SingleAssessmentProcess/index.htm**

Summary Care Record

The Summary Care Record is part of the NHS Care Records Service and is being implemented as part of the National Programme for IT in the NHS. Initially it will contain a small but important data set of current medication, allergies and adverse reactions which will be uploaded from GP systems. The Summary Care Record will be available throughout England to those who need to access it to deliver care and who have the necessary security permissions. Consequently, it has the potential to bring major benefits to both patients and clinicians, especially when treatment is being delivered in settings where the patient's usual records are not available. More information can be found at **www.nhscarerecords.nhs.uk/what-will-change/summary-care-record**

Whole System Demonstrators (WSD)

The WSD programme will explore the exciting possibilities opened up by truly integrated health and social care working supported by telehealth and telecare. The demonstrators will lead to a better understanding of the level of benefit associated with such innovative developments. The evaluation of the programme assesses the impact of telehealth and telecare services on clinical outcomes, service cost effectiveness, individuals' and carers' quality of life and well-being, and the impact on professionals' lives. The demonstrators in Cornwall, Kent and Newham will also help fast track future change by addressing the key implementation barriers and providing solutions for the wider NHS and social care. More information about this programme can be found at **www.dh.gov.uk/en/Healthcare/Longtermconditions/wholesystemdemonstrators/index.htm** and **www.wsdactionnetwork.org.uk**

World Class Commissioning

World Class Commissioning will transform the way health and care services are commissioned by delivering a more strategic and long term approach to commissioning, with a clear focus on delivering improved health outcomes. There are four key elements to the programme: a vision for World Class Commissioning; a set of World Class Commissioning competencies; an assurance system and support and development guidance. More information can be found at **www.dh.gov.uk/en/Managingyourorganisation/commissioning/worldclasscommissioning/index.htm**

Year of Care

Year of Care helps people to exercise choice and be partners in decisions about their own care, and supports them to self care effectively. It makes routine consultations between clinicians and people with long term conditions truly collaborative, through care planning, and ensures that the local services people need and want to support this are identified and made available, through commissioning.

The first year of this three-year project used the pilots as a 'test bed' for these ideas. They have produced a detailed commissioning model for care planning diabetes, which is generic for all LTC, and two practical guides to the programme and care planning specifically. A training programme for care planning is close to completion.

Further information can be found in the National Diabetes Support Team (2008) *Partners in Care: A Guide to Implementing a Care Planning Approach to Diabetes Care* at **www.diabetes.nhs.uk/news-1/Partners%20in%20Care.pdf** and *Getting to Grips with the Year of Care: A Practical Guide* (2008): **www.diabetes.nhs.uk/year-of-care-practical-guide-has-been-published**

Your Health, Your Way (formerly the Patients' Prospectus)

Launched on 2 November 2008 on the NHS Choices website, *Your Health, Your Way* will provide people with long term conditions with the information they need about the choices which should be available to them locally, to enable them to self care in partnership with health and social care professionals. For more information about the prospectus visit the NHS choices website at **www.nhs.uk/yourhealth/Pages/Homepage.aspx**

Annex B
Glossary

Care plan	A single, overarching plan that records the outcome of discussion between the individual and the professional. It could be electronically stored or written on paper. It should be accessible by the individual in whatever form is suitable to them.
Carer	A carer spends a significant proportion of their life providing unpaid support to family or potentially friends. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.
Commissioning	The means to secure the best care and the best value for local citizens. It is the process of translating aspirations and need, by specifying and procuring services for the local population, into services which:

- deliver the best possible health and well-being outcomes, including promoting equality;
- provide the best possible health and social care provision; and
- achieve this within the best use of available resources.

Complex	A term used to describe people who have an intricate mix of health and social care needs. Because of their vulnerability, simple problems can make their condition deteriorate rapidly, putting them at high risk of unplanned hospital admissions or long term institutionalisation.
Holistic	Used in medical terms as treatment which deals with the whole person, not just the injury or disease.
Long term condition	Those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies.
Multi-disciplinary	A team made up of professionals across health, social care and the third sector who work together to address the holistic needs of their patients/clients in order to improve delivery of care and reduce fragmentation.
Personalised	Care and services received by a person that are individualised and tailored to them.
Patient-centred	An organisation's provision to support personalised care delivery.
Self care/self management	Individuals being supported to take responsibility for their own health and well-being. This includes staying fit and healthy, both physically and mentally; taking action to prevent illness and accidents; the better use of medicines; treatment of minor ailments; and better care of long term conditions.

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