

Pulse

Are care plans worth it?

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Dr Carrie Chill says a shared plan is essential for urgent care while Dr Pipin Singh argues they have become a tick-box exercise



YES

Care plans have become disturbingly fashionable and a patient may end up with a number of different ones, compiled by different people for different conditions.

A single, shared, high-quality urgent care plan can really help clinical decision making, particularly at night or over the weekend. The right care plan is a valuable tool that can save time and improve personalisation of care. In other words, the answer to the above question is a resounding

'yes'.

What is really useful to support urgent care out of hours is a single, concise, accessible version that tells clinicians what is wrong with the patient, and sets out contingencies, ceilings of treatment and resuscitation decisions.

I think the Coordinate My Care (CMC) electronic shared urgent care record, developed in London, fits the bill. Plans can be created, viewed and updated by professionals involved with the patient's care, and viewed by emergency services and patients themselves. A total of 77% of patients with a CMC care plan and preferred place of death die in that place. Only 18% die in the acute sector, whereas 47% of patients nationally die in hospital.[1,2]

A patient of mine ended up in hospital more than 20 times within six months with symptoms related to his end-stage heart and renal failure. I was also being called for urgent visits at least twice a week. Creating a CMC plan enabled the ambulance and out-of-hours GP service to see his diagnoses, identify deterioration and to follow his wish to avoid admission where possible. As his GP, I am only available for 30% of the week and I wanted his care to be consistent for the other 70%.

And you don't need CMC for care plans to be useful. Provided a plan is shared and trusted, it supports safe phone advice and allows visiting clinicians to administer or adjust medication. Patients feel reassured that those involved in their care have the information to treat them safely and they don't have to keep repeating their story. A Cochrane review concluded that care planning is a 'promising approach' for patients with long-term conditions.[3]

I can't deny good care planning and creating care plans takes time but I feel it helps clinicians make better decisions more quickly in complex situations and saves much more time than it takes.

Dr Carrie Chill is a freelance GP and clinical director at NHS Merton CCG covering unplanned and end-of-life care. She has been involved in a CMC primary care pilot

NO



The theory behind care planning is relevant and, yes, we do need to change how we approach patients with multiple comorbidities. But the reality is that in modern general practice, care plans have become a tick-box exercise with no real substance and are unmanageable given the time constraints we have.

The aim of a care plan is to empower patients and put them at the centre of their own care, enabling them to make their own decisions about interventions in conjunction with their GP and the wider primary care team. But plans require time, thought and in-depth discussion with patients and often their families and carers. Most GPs have just 10-minute appointments to deal with intense volumes of work, and most of us just scrape by.

Although a recent Cochrane review[3] suggested care plans may be beneficial, it also suggested they work best when integrated into routine care and the intervention is more comprehensive. So for this to work well, an adequately funded service and newer models of care are required.

In my experience, properly done care plan discussions can take up to 45 minutes or may require two or three appointments if patients need to go away and think about the issues raised. If there is more than one problem, which is often the case, even longer discussions may be required. The current system is not fit to allow these discussions to be had routinely, regularly and with the vast amount of people who require them.

And if care plans are rushed they can lead to unnecessary anxiety, and often pose more questions than are answered.

As with many things in medicine, most patients' situations are evolving, so if care plans are initiated, thought must be given to how often they should be reviewed, and by whom? If patients develop another condition, who will address this and revise the care plan accordingly?

All this adds up to time and resource. If the funding does not exist, we cannot be expected to give this work the thought and attention to detail it requires.

The counter argument may be that care plans allow patients to discuss what's important to them and be aware of important issues arising with their condition, but more often than not, good clinical care means these scenarios will be addressed anyway in a more holistic, shared approach rather than a robotic exercise, which lacks warmth or compassion.

Dr Pipin Singh is a GP in Wallsend, Tyne and Wear

References

1 CMC data on file, October 2016.

2 NEOLCIN data, 2014-15

3 Coulter A et al. Effects of personalised care planning for people with long-term conditions. [Cochrane Database Syst Rev](https://www.ncbi.nlm.nih.gov/pubmed/25733495) (URL=<https://www.ncbi.nlm.nih.gov/pubmed/25733495>) 2015;3:CD010523