No decision about me without me

13th December 2012
Liberating the NHS

Patient involvement:

- • Shared decision-making: involving the patient and their carers in decisions about their care and treatment.
- • Self-care: the patient being supported in taking more responsibility for the things that they can do to maintain and improve their health.
- • Care planning: the patient jointly agreeing with the clinician a plan for their care, including as appropriate advanced planning for terminal care.
- II. Patient Choice: the ability for patients to choose the provider of their care, when and where it takes place, and who provides it.

NICE – Shared Decision Making Guideline (June 2021)

Shared decision making (SDM) ensures that individuals are supported to make decisions that are right for them. It is a collaborative process through which a clinician supports a patient to reach a decision about their treatment.

- Shared decision making is a joint process in which a healthcare professional works together with a person to reach a decision about care.
- It involves choosing tests and treatments based both on evidence and on the person's individual preferences, beliefs and values
- It makes sure the person understands the risks, benefits and possible consequences of different options through discussion and information sharing.

Benefits

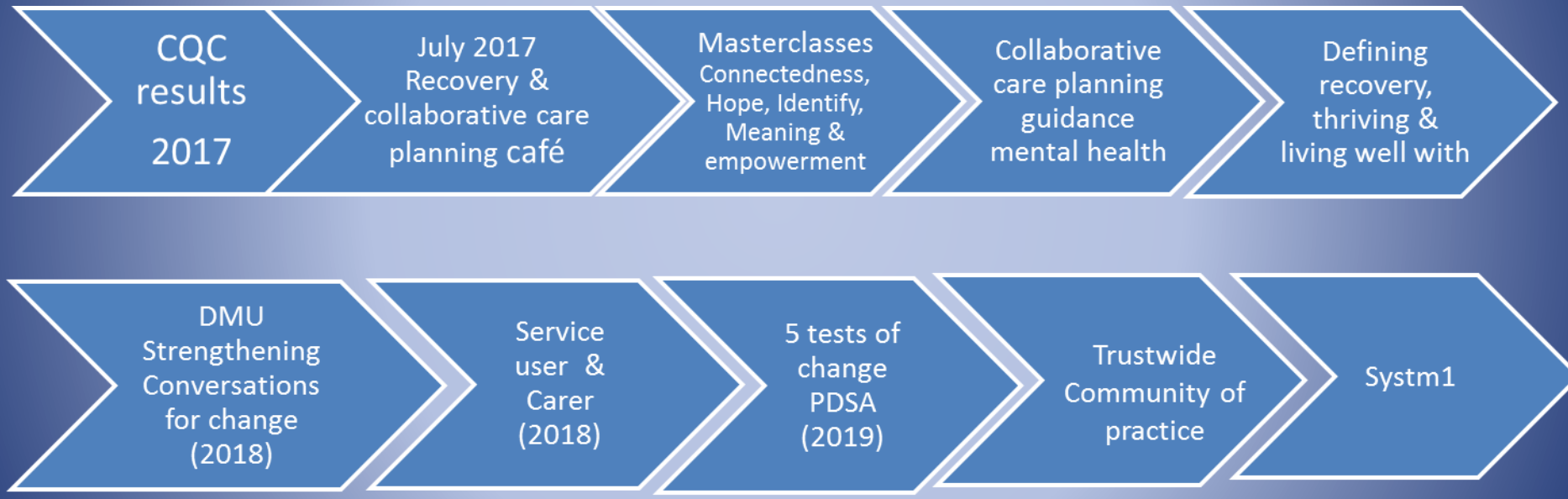
•It allows people to discuss and share information. This makes sure people have a good understanding of the benefits, harms and possible outcomes of different options.

•It empowers people to make decisions about the treatment and care that is right for them at that time. This includes choosing to continue with their current treatment or choosing no treatment at all.

•It allows people the opportunity to choose to what degree they want to engage in decision making. Some people prefer not to take an active role in making decisions with their healthcare professionals.


World Café Guidelines
HAVE FUN!
PLAY... DRAW
DOODLE
Facilitate yourself & others
CONTRIBUTE YOUR THINKING
Listen together for patterns, insights, & deeper connections
LISTEN TO UNDERSTAND
FOCUS on what matters
LINK and Connect IDEAS
Speak with your MIND... and HEART
SLOW DOWN so you have TIME to think & reflect

Recovery and Collaborative Care Planning Café 2017

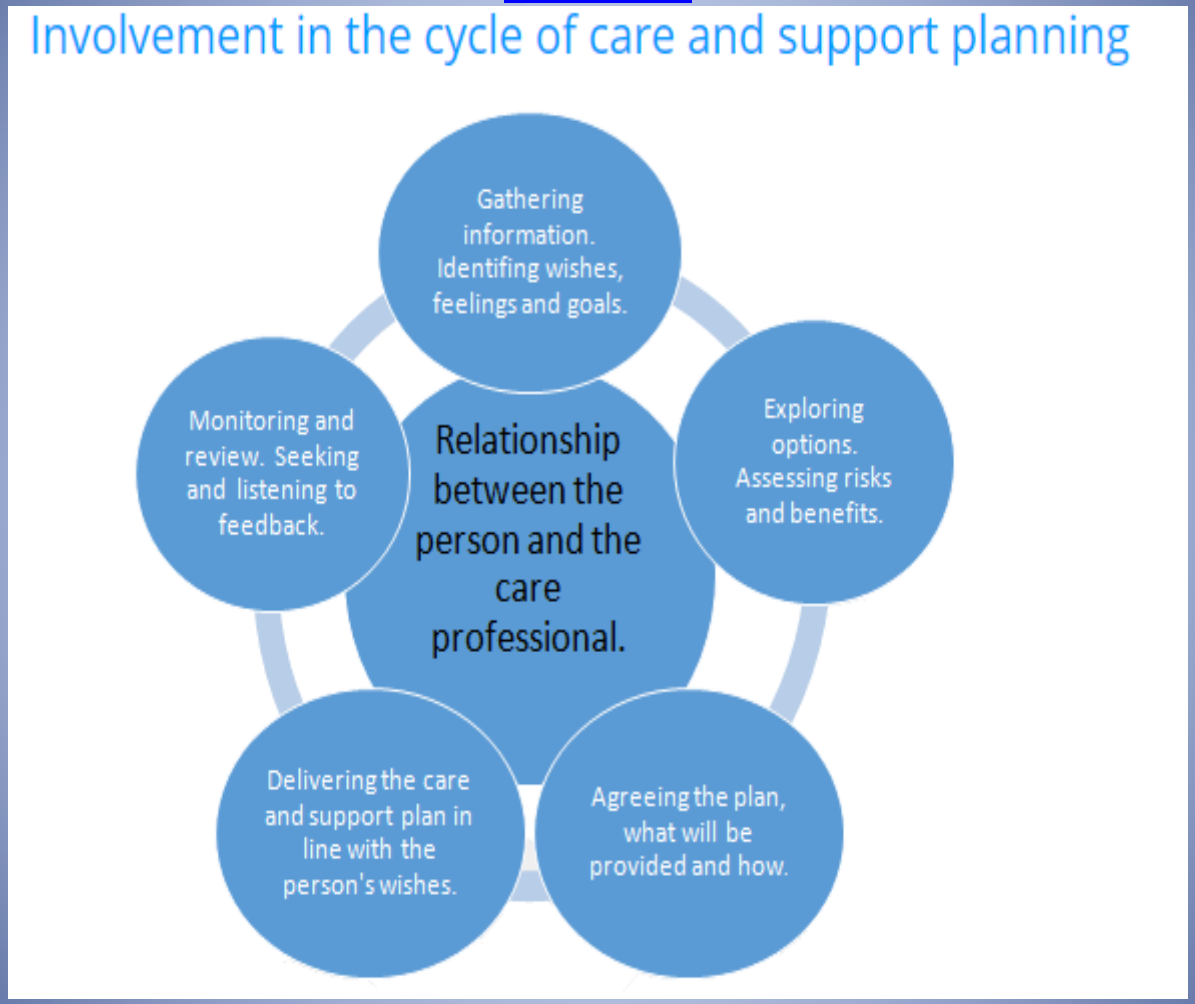


EQUIP Enhancing the quality of user involved care planning in mental health services – 10 C's to care planning

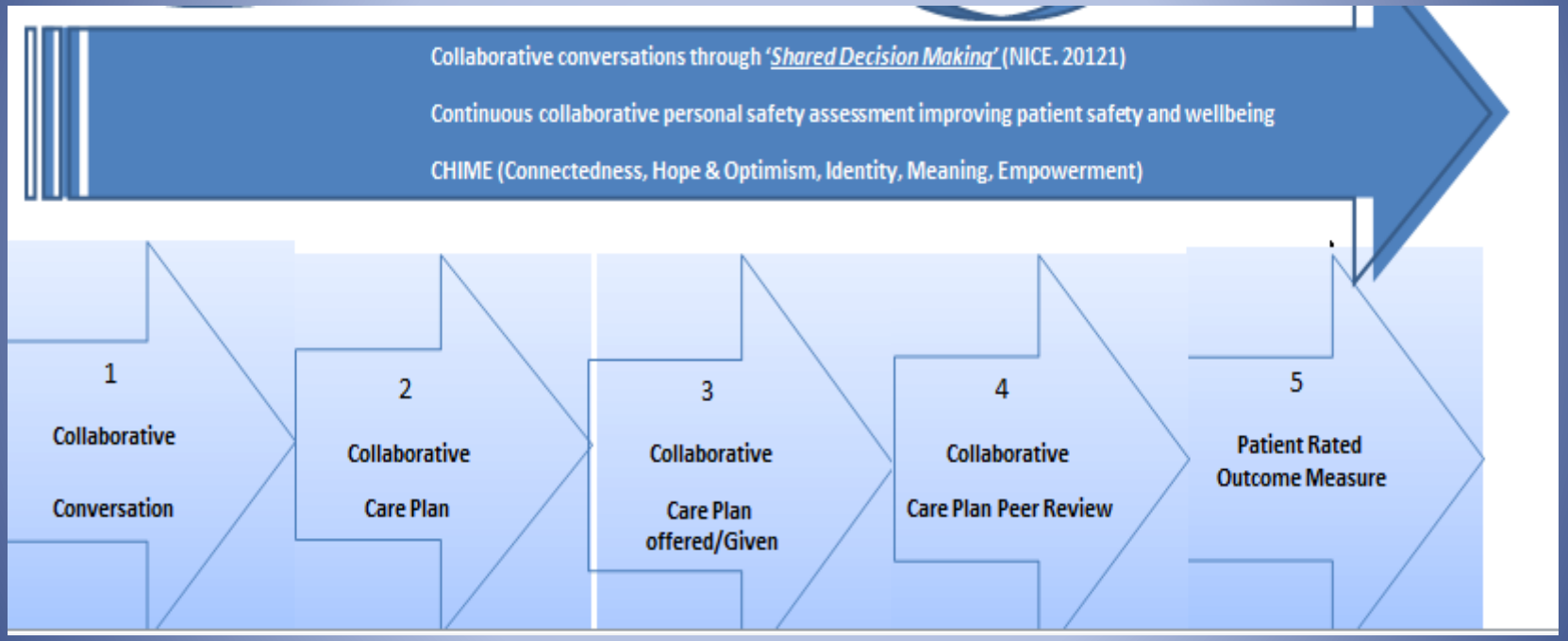
Link to video – cut and paste into your browser

https://www.bing.com/videos/search?view=detail&mid=D25D06B713D488D59A32D25D06B713D488D59A32&q=10 cs to care planning youtube&shtp=GetUrl&shid=f2e8f43e-3867-4580-9db7-45506a47c74f&form=VDSHOT&shth=OVP.X0BqkzXvU7ZurqQUgHgFo

Care planning, involvement and person-centred care | SCIE



Collaborative Care Planning



We Improve Q
Trustwide Quality Improvement

Traditional care planning	Person-centred, MCA-compliant care planning
The professional assesses the person's needs.	Care and support plans are developed with the person. The conversation is led by the person who knows best about their needs and preferences.
Care planning follows a medical model of disability.	Care planning follows a social model of disability.
There is a focus on what the person is unable to do.	There is a focus on goals and aspirations, what the person would like to achieve with their care and support.
There is a static view of the person's ability or capacity.	Care planning explores potential for change, opportunities to develop capacity and ability.
The professional writes the care plan with little or no input from the person or their representative.	The person is supported to express how they would like their care and support to be delivered. The professional provides information about what the service can offer. They agree what will be in the care and support plan. A copy of the plan is made available to the person and/or their representative.
The emphasis is on protecting the person from risk.	The emphasis is on safe care that respects a person's right to take risks that they understand.
The process takes place when it is convenient for the professional.	The care planning conversation takes place at a time when the person is most or more likely to have capacity.
Power is with the professionals.	Power is equally shared.

EQUIP Patient Rated Outcome Measure

EQUIP Care Planning Audit Tool

This tool is designed to measure service user involvement in care planning in mental health services. There are no right or wrong answers.

Q. Have you ever received a care plan? Yes ☐ No ☐

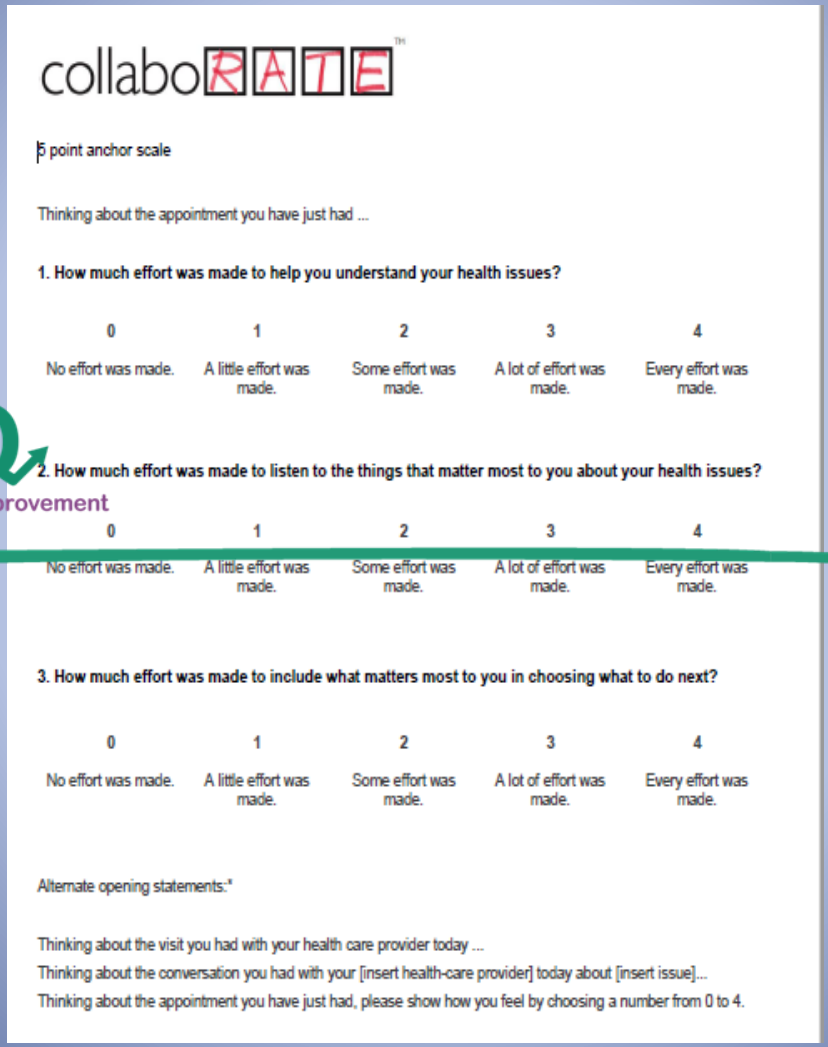
- Yes → Please continue to answer the following questions
- No → Unfortunately, you do not meet the eligibility criteria for this audit.

Please choose one option for each of the six statements presented below:

		Completely Disagree	→	Neither Agree nor Disagree	→	Completely Agree
1.	I am satisfied with the care plan.	0	1	2	3	4
2.	My preferences for care are included in the care plan.	0	1	2	3	4
3.	The care plan helps me to manage risk.	0	1	2	3	4
4.	The information provided in the care plan is complete.	0	1	2	3	4
5.	Important decisions are explained to me.	0	1	2	3	4
6.	The care plan caters for all the important aspects of my life.	0	1	2	3	4

Scores for all 6 items should be summed to produce a total score ranging from 0 to 24.

Rating your experience - CollaborRATE



collaboRATE™

5 point anchor scale

Thinking about the appointment you have just had ...

1. How much effort was made to help you understand your health issues?

0	1	2	3	4
No effort was made.	A little effort was made.	Some effort was made.	A lot of effort was made.	Every effort was made.

2. How much effort was made to listen to the things that matter most to you about your health issues?

0	1	2	3	4
No effort was made.	A little effort was made.	Some effort was made.	A lot of effort was made.	Every effort was made.

3. How much effort was made to include what matters most to you in choosing what to do next?

0	1	2	3	4
No effort was made.	A little effort was made.	Some effort was made.	A lot of effort was made.	Every effort was made.

Alternate opening statements:*

Thinking about the visit you had with your health care provider today ...
Thinking about the conversation you had with your [insert health-care provider] today about [insert issue]...
Thinking about the appointment you have just had, please show how you feel by choosing a number from 0 to 4.

http://www.glynelwyn.com/uploads/2/4/0/4/24040341/collaborate_for_patients_5_anchor_point_scale.pdf

CHIME

Let's talk about recovery…

Connectedness

Relating with other people in positive ways.

Hope and Optimism

Belief that a better life is possible.

Identity

Regaining a positive sense of yourself as a whole person.

Meaning

Encouraging dreams and aspirations.

Empowerment

Focusing on your strengths and control over life.

Success

- Recovery and Collaborative Care Planning Café since 2017 and CHIME (Connectedness, Hope & Inspiration, Identity, Meaning and Empowerment)
- Changing conversations through CHIME
- CHIME Introduction to Recovery Course – Recovery College
- New electronic patient record with CHIME and collaborative care planning screens
- Collaborative Care Planning learning set for practitioners
- Training module at DMU – Strengthening Conversations for change
- Collaborative care planning bite size training
- Patient rated outcome measure – peer to peer
- Volunteer/Patient Leader with lived experience in Quality Improvement Team

To continue improving…..

- Staff being given time to have collaborative conversations on care planning and to collaboratively write the care plan
- Copies of care plans being given to patients routinely
- Understanding what a care plan is and what it means
- Make ‘Shared decision making’ routinely happen
- Measure experience routinely for feedback - Patient rated outcome measures
- Increase numbers of clinicians/practitioners at the Café to share stories with
- Bring back speakers into the sessions

We Improve Q
Trustwide Quality Improvement