Figure 1: The care planning process as envisaged by English Department of Health policy.

- **PERSON WITH LONG TERM CONDITION/S**
  - Stage (newly diagnosed up to end of life)
  - Level of need (case management / disease management / self care support)

- **CARER / FAMILY**

- **CONTACT WITH HEALTH CARE PROFESSIONAL**
  - GP
  - Practice nurse
  - District nurse
  - Community matron
  - Specialist nurse
  - Consultant
  - Social care worker
  - Other health care professional

- **CARE PLANNING DISCUSSION**
  - Provision of information/guidance
  - Agreement of goals
  - Support for self-care
  - Agreement on treatment, medications and other services
  - Agreement of actions
  - Agreement of review date

- **REVIEW**

- **CARE PLAN/S**
  - Record of outcomes of discussion
  - Electronic or written
  - Part of patient’s notes or stand alone
  - “Overarching care plan” for patients with complex needs who may have multiple care plans