Logic model for implementation of Year of Care (YOC) approach to personalised care and support planning (PCSP)

Rationale

Evidence suggests current systems of planned care for people with LTCs can feel disempowering, professionally and system driven and often doesn't attend to the needs of the individual or recognise their agency in the management of their health. Care is often fragmented particularly where people live with multiple LTCs and many healthcare professionals feel dissatisfied with the care that they can offer within the current health care system. The Year of Care (YOC) approach to PCSP seeks to rearrange how routine planned care for people with LTCs is delivered so that they can feel more involved and informed and can have conversations with HCP which support them to live with and manage their conditions. PCSP is a key component of personalised care within the NHS long-term plan. The logic model sets out the rationale and actions needed for the introduction of PCSP and how this can improve a range of outcomes and contribute towards long-term health care ambitions.

Inputs

Staff engagement

- Articulate rationale/clarity about purpose (YOC case for change)
- YOC introductory team session
- Champions and exemplars

Workforce

- Clinical lead
- Steering group
- PCSP specific clinical/admin staff
- Time to plan and implement the change in processes
- Identified social prescribing pathway

Training and facilitation

- Staff training in PCSP communications skills (YOC)
- Process mapping (YOC)
- Patient and professional resources (e.g. YOC preparation materials)
- Clinical training and supervision as required (e.g. HCA foot screening)
- Ongoing reflection and review

IT and processes

- Standard operating procedures
- IT templates which separate task-based care from conversations and support completion of key care process
- Codes embedded into templates to facilitate monitoring of the process

User involvement e.g.

- Patient participation groups
- Patient surveys
- Service user events

Incentives and funding to support the system change and coordinate activities

Activities

Planning for implementation

- Identify the population who will be offered PCSP
- Promote the approach to the intended population
- Work out logistics around appointments, rooms and staffing (including sufficient time to do both the reviews)
- Identify and implement adaptations for different groups such as interpreters or support workers for people with communication needs
- Identify the MDT and admin support
- Run call and recall

Implementation of PCSP

Preparation

- HCA systematically gather information and complete assessments to inform the PCSP conversation
- People receive high quality, accessible preparation materials (agenda setting prompts and/or routine results) ahead of the PCSP conversation
- Staff have the opportunity to review information gathered and seek support if needed/triage appropriately (including promoting continuity)

Conversation

- Time is made available for a PCSP conversation, because task-based activity is moved into information gathering
- The HCP and patient work collaboratively and share their respective expertise
- The conversation is structured and intentional and is solution focused and proactive
- The resultant care plan is owned by the patient and documented in the clinical record

Support beyond the PCSP conversation

- Referrals are appropriate and are aligned to the individual's priorities and what will make a difference
- The process supports self-management, coordinates complex care and sign posts to more than medicine.

Support across the systems

- Overarching support team coordinates activities such as training and staff development
- Develop IT templates to support the process
- Monitor implementation

Outputs - short term

Patients

- People are offered and attend their PCSP appointments
- People feel prepared and informed and have time to reflect ahead of conversation
- People feel involved and their expertise is recognised during the conversation
- People feel they are having conversations that are useful and effective
- People work in partnership with HCP to create their own personalised plan

Practice and professionals

- There is a clear process that defines how PCSP will work in the planned care setting
- The process coordinates a high quality comprehensive biomedical review and combines that with the person's priorities
- Staff are clear about their roles and responsibilities in the process
- Staff confidence improves in the use of person-centred communication skills
- Staff see the value of a biopsychosocial approach including more than medicine
- Staff feel they are they are routinely having effective and meaningful conversations with patients

System

- People are offered comprehensive, proactive, coordinated care which includes systematic review of medicines
- People are appropriately referred to statutory and 'more than medicines' activities
- Unmet needs are identified and responded to

Outcomes – medium term

Patients

- People feel listened to and valued
- People have a better experience of care
- People have an improved relationship with and trust in healthcare staff
- People understand their role in managing their health and know how to access appropriate support when needed
- People have improved knowledge, skill and confidence in how they live with and manage their condition on a day to day basis
- There is improved continuity and coordination of care
- For people with complex care there is a reduction in treatment burden

Practice and professionals

- Improved use of skill mix within the team
- Improved completion of key care processes
- Staff feel more confident and able to support people to self-manage their conditions
- Staff feel they are doing a good job and are making a difference to people
- Staff morale and retention improves
- Improved attendance rate and reduced use of unplanned care
- Less complaints/more compliments

System

- Care is better integrated and coordinated
- Improved utilization of resources e.g.
  - People take medicines as prescribed
  - Planned versus unplanned visits
- Services are commissioned based on need e.g
  - patient education
  - more than medicine
- Increased uptake of more than medicine activities
- Improved attendance across all groups including those who find using health services more challenging

Impact/Outcomes – long-term

Patients

- People experience person-centred care which is coordinated and joined up
- Improved health literacy
- People manage conditions more independently and need less support from healthcare services
- Improved health and wellbeing

Practice and professionals

- Practice teams value the role that individuals play in managing their health and work in a way that supports self-management

System

- Improved population health outcomes
- Reduced health inequalities
- Appropriate use of healthcare resource and more effective systems of care