# Care and support planning across a lifetime

Care and support planning (CSP) recognises that people who live with long term conditions (LTCs) make the majority of the decisions that affect their lives, spending relatively little time with a health or/and social care practitioner. CSP seeks to transform the brief contact that does occur into a meaningful and useful discussion, enabled by “preparation” and with a focus on looking forward and planning. Over the course of an individual’s lifetime the nature of these conversations may well change as their health profile and their needs change.

The aim is for CSP to become the usual approach to normal care, being understood as a continuous process, not a one off event, supporting continuity and planning to meet the changing needs of people. This paper describes how an established CSP process could enable better care and how the focus of the conversations might change across a lifetime.

**Prevention**

A CSP approach could be first introduced and used for all types of health checks, including diabetes and cardiovascular prevention, frailty and well woman/man/over 75 health checks. Introducing the concept of CSP at this stage, could delay the onset of health problems, has the benefit of orientating people to the process and to some of the basic terminology used in health including the idea of individualised risk and risk factor management. Preparation could help people gain more understanding of their risk and give them the opportunity to implement behaviour change. The focus would be on self-management and could identify broader health determinants and signpost to community based support.

**Managing a single/multiple condition(s)**

All routine care of LTCs, either in specialist care or primary care could be delivered using a CSP approach. This would be a means of supporting everyone living with LTCs including both the QoF and non QoF conditions, people with learning difficulties and mental health conditions. At the point the individual is diagnosed with a condition they would enter annual CSP, which would introduce a solution focused approach, bringing together the person’s and professional’s agendas, and focusing on the individual’s priorities which emerge from the conversation. It would include elements of shared decision making, supporting self-management and contingency planning e.g. ‘rescue meds’ for COPD. The focus would be on living well with long term conditions. If the individual then developed more LTCs, where the care is delivered by generalists (primary care and care of the elderly), these would be included in a single CSP process and conversation for all conditions and issues.

**Becoming more frail (“slowing down”)**

Whilst frailty has only recently been recognised as a LTC, it has a significant impact on an individual’s ability to live independently and manage day to day activities. Screening for frailty could be completed either as part of routine CSP for people with LTCs or as part of older person health checks. Preparation might focus less on results and more on agenda setting prompts or self-assessment tools to identify specific issues which are the main concerns for the individual, such as social isolation or feeling unsteady. The focus of the conversation might be about supporting people to maintain their independence and it could include rationalisation of medicines, supporting the individual with basic tasks or preventing further deterioration, including the use of social prescribing e.g. “staying steady groups”, clubs and social activities. CSP could be completed by health or social care workers depending on the needs of the individual. Where social care is involved or very complex health issues exist, CSP is an important route for the person to determine how their personal / personal health budget is spent. Preparation would include supporting the individual to know the size / scope of the budget available as well as the options for managing it.

**Developing dementia**

People may have dementia as their only condition, may be cared for and may have other LTCs alongside. The severity and complexity of their dementia may change the context in which CSP is delivered. CSP could be completed either within the current CSP processes within primary care or when dementia is the dominant issue or care provision is complex this may be completed within integrated health and social care teams. Including carers in CSP becomes increasingly important. Ideally CSP should establish the individual’s preferences early on and include mechanisms to ensure these preferences are available and clear to all involved in their care, particular once the person lacks capacity. For the professional, preparation for CSP should ensure all information from all agencies involved, is available to inform the planning. There should be less focus on separate assessments and more on supporting the individual to express their preferences using agenda setting or self-assessment/reflection tools.

**Nearing end of life care**

Conversations about end of life care wouldn’t come out of the blue if the individual is asked to plan ahead and consider the future as part of routine CSP. Year of Care agenda setting prompts include an option to talk about the “Future”, which could encourage people to identify when they are ready to talk about their decisions and preferences around death and dying. The conversation might include topics ranging from prognosis to looking after dependants, wills and funeral plans, but also what to do if capacity is lost and the use of advance directives. The health care professional would record decisions within the clinical record about resuscitation preferences and where the person would like to end their life, sharing across health and social care providers with the permission of the individual.

Care and support planning (CSP) is a **systematic process** to ensure that people living with one or more LTCs have **better, solution orientated conversations** with health / social care practitioners **focused on what matters to them**.

These identify what is important to the person, discuss and explore issues and develop priorities, goals and actions to support them to live well with their condition/s. CSP brings together physical, mental and social health / care issues in a single care and support plan however many conditions or issues the person may live with. This includes

- **linking** traditional clinical care with support for self-management
- **signposting** the person to activities within a supportive community
- **coordinating** across health and social care