Developing and implementing care and support planning - realising a person-centred approach to routine long-term condition care

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When I listen to patients, friends and family who use the NHS, many of whom live with a long-term condition, I constantly reflect that it isn't as person centred as it aspires to be. I worry that this disconnect between people's experience and the love affair the general public often has with the NHS will ultimately be its downfall – this seems to be about the systems of care than necessarily the people who work within it. Staff within the NHS are hard pressed and working to the very edge of their capacity, sometimes following procedures and guidance that get in the way of any focus on what might matter most to the people they see.

But I wonder, how do we know if we are offering a truly personalised approach? Do we sometimes think we know what is best for people? What is it about what we are doing today that's different to what we did 12 or even 24 months ago and how do the people we see feel about this? There is a real risk that the headspace needed to consider this is little to non-existent and that thoughts about any form of service improvement or transformation of care will get subsumed in a backlog of long-term condition care following the stalling of routine care during the pandemic.

But maybe this is the opportunity – time to start afresh with a different approach which also includes some of the lessons we learned about self-monitoring, self-management and remote consultations during the pandemic.

It's now over 20 years since NHS Diabetes first published ***Partners in Care*** - their guide to implementing a model originally called 'care planning' for people with diabetes. In her foreword to this publication Sue Roberts, when asked to name her vision for improvement in diabetes care, wrote *"it would be properly supporting and empowering people with diabetes so that they are truly confident about managing their own condition on a day to day basis, calling on help from professionals when they choose and for the reasons that are important to them".*

Out of this aspiration grew many initiatives, including the Year of Care programme, which aimed to work out a method of changing the way routine care for people with long term conditions such as diabetes was delivered. The core objective was to put in place a different way of working that created the conditions for a collaborative approach between patients and clinicians. This was an 'antidote' to the template driven approach of the quality and outcomes framework that tends to promote care which treats people as an assembly of different and separate conditions and may lose sight of the person's agenda.

The Year of Care approach was developed with grassroots practitioners, patient representatives, charities and communication experts to define a reorganised care pathway which created the space for a collaborative conversation, whilst also tending to the medical and psychosocial aspects of care. This was built on a philosophy that recognised the role the person has in managing their own care and the significance of people getting what they need out of their relatively brief encounters with the health care system.

At the heart of this approach is people being in control and involved in decision making, based on their priorities and goals. It includes 3 core components: ***Preparation***, a ***productive conversation*** based on what matters to the person and identification of ***support or self-management*** activities following the conversation, including social prescribing alongside traditional care provision. As part of the development of the programme we created supporting materials such as patient preparation tools and described in detail the consultation structure and communication skills needed to work in this way. These were all brought together as a new 'clinical' method, **care and support planning,** building on much of what was already in place and with existing resource.

It is testimony to the hard work of so many people that this approach is now applied to a range of long-term conditions, including people with multiple long-term conditions who have a single care and support planning process which includes all of the conditions and issues they live with. The feedback from patients and clinicians is that *"it is simply a better way to work".*

Year of Care is recognised as a gold standard approach to the delivery of care for people with long term conditions, and care and support planning is highlighted within the Scottish GMS contract and the Universal Model of Personalised Care in England. The training, facilitation and resources developed support a model which brings together many personalised approaches at a primary care system level, including shared decision making, and linking into new primary care roles such as social prescribing.

However, whilst the Year of Care model of care and support planning has evolved, improved and extended its scope it is not universally applied and, whilst NHS policies ask that we do so, there still seems to be relatively patchy adoption of the model which brings many benefits to patients, practitioners and the organisations they work with. I guess this is why I continue to think that we don't prioritise patient experience and person-centred care to the degree that we prioritise other areas of quality improvement.

So, if your vision is to refresh your long-term condition care with a person-centred focus, and the time is right to get started, then Year of Care might be something to embark on and we'd certainly love to work with you.

You can contact us at enquiries@yearofcare.co.uk and follow us on Twitter at @YearofCare for the latest news.

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Lindsay is National Director of Year of Care Partnerships who support and provide training for organisations and practices to implement care and support planning for people with single and multiple long-term conditions.