Year of Care Partnerships®

Personalised care and support planning across a lifetime

Personalised care and support planning (PCSP) recognises that people who live with long-term conditions (LTCs) make the majority of decisions that affect their lives, spending relatively little time with a health and/or social care practitioner. PCSP 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 change as their health profile and needs change. The aim is for PCSP 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 PCSP process could enable better care and how the focus of the conversations might change across a lifetime.

Prevention

A PCSP approach could be introduced and used for all types of health checks, including diabetes and cardiovascular prevention, frailty and 'over 75' health checks. Introducing the concept of PCSP at this stage could delay the onset of health problems, has the benefit of orienting 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 or multiple condition(s)

All routine care of LTCs, either in specialist care or primary care could be delivered using a PCSP 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 PCSP which would introduce a solution focused approach, bringing together the person and professional 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 LTCs. 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 PCSP process and conversation for all conditions.

Becoming 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 PCSP for people with LTCs or as part of over 75 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.

PCSP 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, PCSP is an important route for the person to determine how their 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, they may be cared for and may have other LTCs alongside. The severity and complexity of their dementia may change the context in which PCSP is delivered. PCSP could be completed either within the current PCSP 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 PCSP becomes increasingly important here. Ideally PCSP should establish the individual's preferences at an early stage and include mechanisms to ensure these preferences are available and clear to all involved in their care, particularly once the person lacks capacity.

For the professional, preparation for PCSP 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

Conversations about end of life care wouldn't come out of the blue if the individual was asked to plan ahead and consider the future as part of routine PCSP. 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 healthcare professional would record decisions about resuscitation preferences and where the person would like to end their life within the clinical record, sharing across health and social care providers with the permission of the individual.

PCSP 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.

PCSP 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