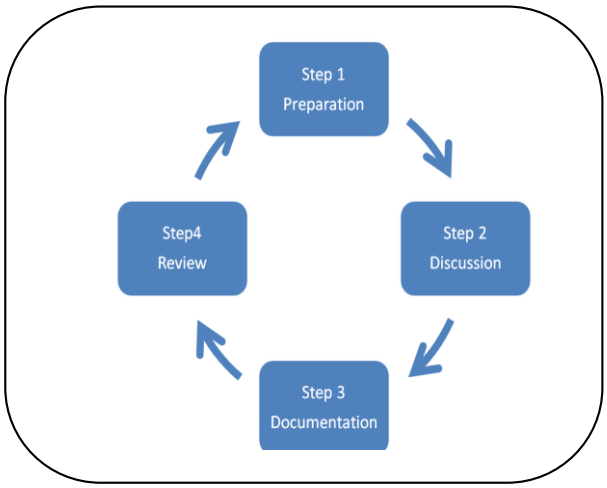
Introducing care and support planning: thinking it through.

Care and support planning is about enabling better conversations between people living with long term conditions (LTCs) and health care practitioners that are focussed on what matters to the individual so that support and services can be tailored for each person. It is a meeting between those with technical expertise and those with lived experience in which the person is supported to identify their priorities and goals for living their life and the actions that they and/ or the service can take to help them achieve these.

Because introducing care and support planning involves changes to attitudes (mindsets), skills and clinic infrastructure it is also a powerful lever for culture and systems change within teams and across the wider community. It also improves job satisfaction for health care professionals who describe it as a 'better way to work'.

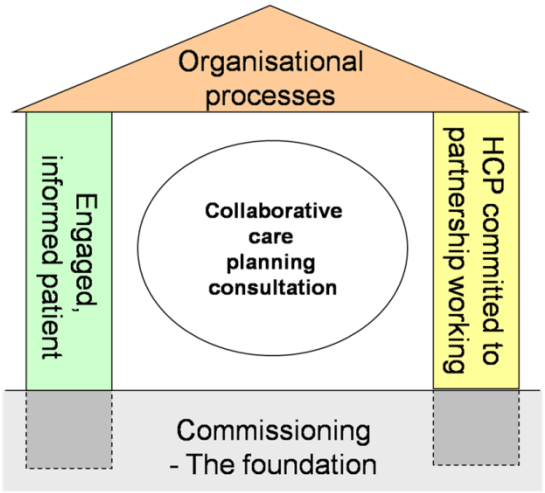
Care and support planning links traditional clinical health care with support for self-management, brings together physical, mental and social health issues and leads to a single care and support plan however many conditions or issues the person may live with. This may include sign posting to activities within a supportive community (social prescribing, 'more than medicine') or coordinating health and social care where relevant.

The Year of Care (YOC) programme identified how to embed and sustain care and support planning initially in a single condition, diabetes, and has now demonstrated that the underlying philosophy and core principles are applicable to everyone with single or multiple LTCs, multimorbidity or living with frailty. It has been summarised by National Voices as a four step process involving preparation, discussion (the better conversation), documentation and review.



YOC pilot sites highlighted that these steps cannot take place effectively within the confines of the current ways of working. For instance if the care and support planning conversation is to become a meeting between experts both the individual and the practitioner need to prepare for this, including making sure that they have access to the same information and time to reflect on this prior to the discussion. The details are often context specific and will vary according to which group of people with LTCs is the focus and where care and support planning will take place.

Year of Care pilot sites assigned the issues that needed to be addressed to four groups which became the walls, roof and foundations of the 'House of Care'. This emphasises that effective care and support planning consultations rely on four elements working together in the local healthcare system: an engaged, empowered person working with Health Care Professionals (HCPs) committed to a partnership approach (the walls), supported by appropriate/robust organisational systems (the roof) and underpinned by responsive whole system commissioning.



The House Model act is a check list of what needs to be in place, and also a metaphor for the interdependence of each part, if one is weak or missing the structure is not fit for purpose. It also provides a flexible framework to enable communities to get started and design the sort of house that suits their population. The YOC training and support team have used this approach to introduce care and support planning in a variety of settings including general practice, multidisciplinary community settings including personal health budget teams and specialist outpatients.

The House of Care describes *what* needs to be in place for people living with LTCs to deliver person centred coordinated care but it is up to each local community to decide *how, when, where* and *by whom* this is best provided for their local population. These details form the local 'model of care' which needs to be defined so that local clinical teams have a clear

understanding of their roles and what is expected of them prior to receiving care and support planning training.

The process of 'building the local house of care' is best achieved in three stages which all require active local leadership, accountability and management throughout. **Stage 1 involves 'set up'** by the local leadership team to agree the focus, design the pathways and packages of care and put a local Steering Group in place to oversee all the stages. **Stage 2 is about implementation**. This includes ensuring that grass roots teams receive high quality training and support, that there are mechanisms to sustain this via quality assured local trainers and facilitators, and that all the elements of the house are in place including links with 'more than medicine activities**. Stage 3 is maintenance**. New habits take time to embed, so practitioners and teams need ongoing support and development and continuous improvement which is based on the robust use of data and feedback.