The Year of Care approach to personalised care and support planning improving health literacy and tackling health inequalities

Health inequalities and long-term condition care

Health inequalities can be described as unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health and how we think, feel and act, and this shapes our wellbeing and both our physical and mental health.

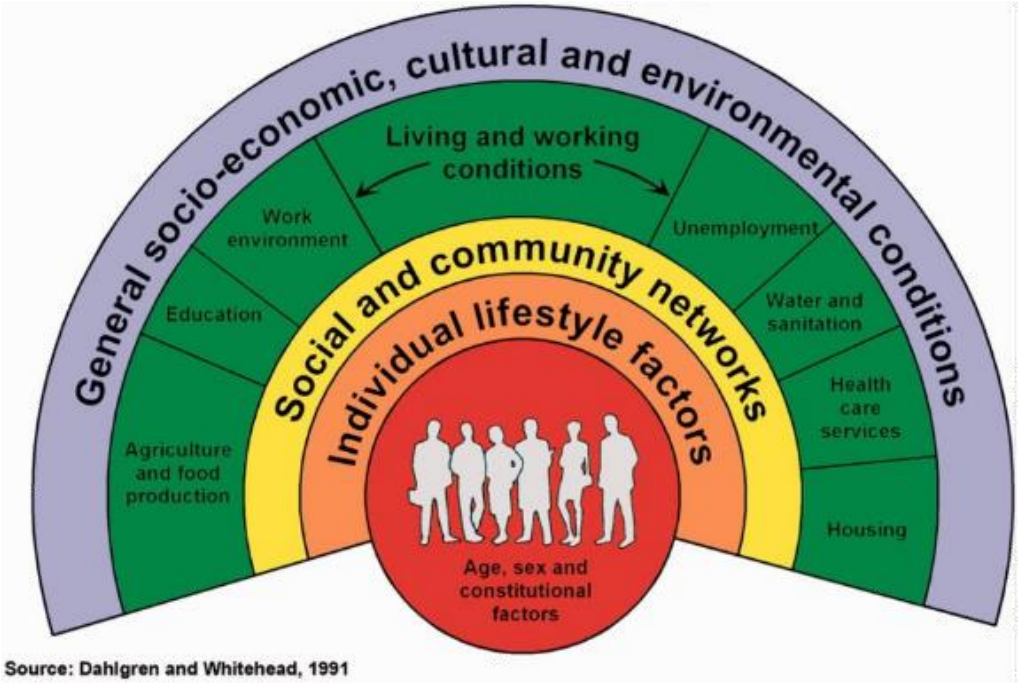
For people with long-term conditions there are added dimensions to the problem:

- People in lower socio-economic groups are more likely to have long-term health conditions, and these conditions tend to be more severe than those of people in higher socio-economic groups.
- Deprivation also increases the likelihood of having multiple long-term conditions; on average people in the most deprived fifth of the population developing multiple long-term conditions ten years earlier than those in the least deprived fifth of the population.

How does the Year of Care approach to personalised care and support planning support health inequalities?

The Year of Care approach puts in place a single personalised care and support planning process which streamlines planned care in general practice and focuses on a person-centred approach to the management of long-term conditions. This recognises the context that people live their lives and includes what is important to them with a focus on mental health and psychological wellbeing.

As such healthcare professionals who implement a personalised approach to long-term conditions care using personalised care and support planning are encouraged to consider the issues affecting someone's life and their health, with a focus on the wider determinants of health. This includes thinking through the ability and barriers to self-manage and to improving health outcomes.



Source: Dahlgren and Whitehead, 1991

The impact of a systematic single personalised care and support planning approach

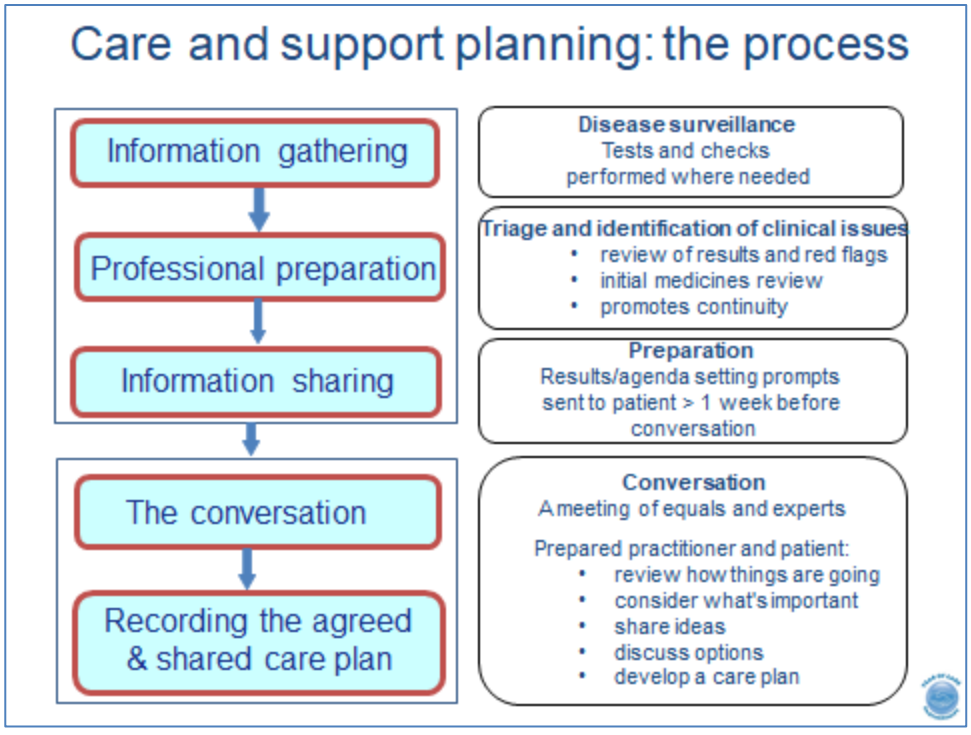
Having a robust and systemised approach to the implementation of personalised care and support planning ensures all of the principles of the approach are embedded into practice pathways. Staff training supports teams to work in a person-centred way, focusing on the issues and priorities of the individual patient. In addition, when implemented as a single process for people with single and multiple long-term conditions this reduces the number of separate appointments people must manage and coordinate.

"It pulls everything together so you're not going to different [appointments] and can speak about anything you're concerned about. You get more time than you used to have. You have already written down what your concerns are."

This can have an immediate impact on reducing treatment burden and providing a more coordinated way of working with people. Systemising long-term condition reviews ensures that **all** patients are invited for reviews and less engaged people are identified as potentially benefiting from a different approach or support from the wider practice team such as social prescribers or link workers.

The Year of Care approach involves:

- A single information gathering appointment with a healthcare assistant where disease surveillance associated with any condition a person lives with is completed
- Structured medication reviews involving the person in how they will manage their medicines
- Patient preparation: sharing information with people ahead of their PCSP conversation (agenda setting prompts and routine results) so they are able to understand and participate more fully in decision making and planning around their self-care
- A holistic personalised care and support planning consultation (conversation) using a person-centred, solution focused approach including the development of a personalised care plan.
  Strong links to social prescribing and 'more than medicine' activities ensuring links to additional PCN roles are effectively integrated with LTC management



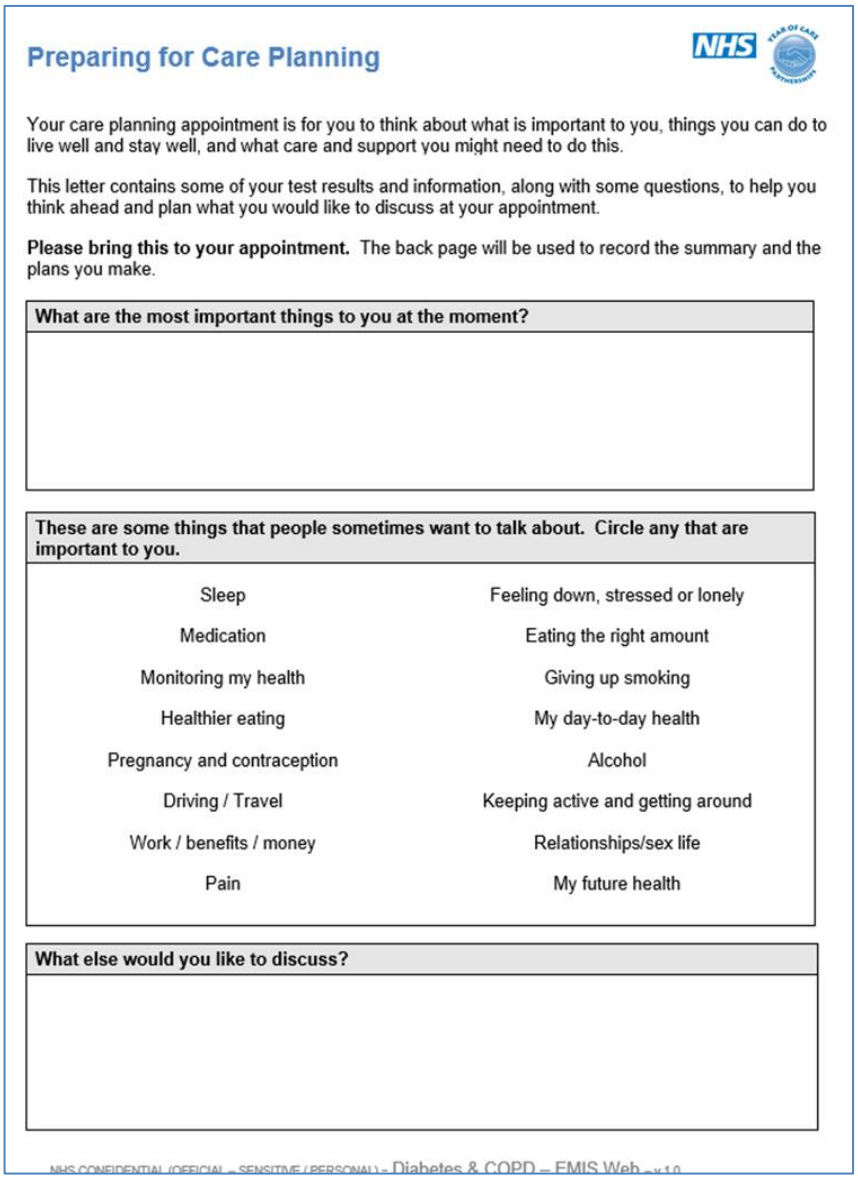
The YOC approach incorporates opportunities to explore and mitigate for health inequalities at all steps of the process.

Three core principles of the Year of Care approach that support involvement and health literacy

The three key principles which underpin the Year of Care approach to personalised care and support planning aim to support the person, in the context of their life, this includes:

1. The prepared patient

Providing people with relevant information about their health and an agenda setting prompt ahead of their personalised care and support planning appointment enables people to think things through, find out more and speak to trusted friends and family as well as making it easier to raise broader factors impacting on their ability to manage their heath. This includes social and psychosocial issues.



Preparing for Care Planning

NHS

Your care planning appointment is for you to think about what is important to you, things you can do to live well and stay well, and what care and support you might need to do this.

This letter contains some of your test results and information, along with some questions, to help you think ahead and plan what you would like to discuss at your appointment.

Please bring this to your appointment. The back page will be used to record the summary and the plans you make.

What are the most important things to you at the moment?

These are some things that people sometimes want to talk about. Circle any that are important to you.

Sleep	Feeling down, stressed or lonely
Medication	Eating the right amount
Monitoring my health	Giving up smoking
Healthier eating	My day-to-day health
Pregnancy and contraception	Alcohol
Driving / Travel	Keeping active and getting around
Work / benefits / money	Relationships/sex life
Pain	My future health

What else would you like to discuss?

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This process creates the space for more meaningful conversations by:

- Promoting curiosity and understanding
- Supporting agency
- Clarifying peoples' understanding of their health
- Ensuring a patient-led conversation which focuses on what is important to the person

This process can highlight hidden health literacy needs or compelling psychosocial problems which are then more likely to be discussed.

"I liked the fact that the record [preparation information] was very straightforward so I could understand it – it was in layman's terms."

2. A meaningful and productive conversation

Evidence suggests empathy and enablement have been harder to achieve in low income groups in the traditional health care model[1].

The personalised care and support planning approach offers people dedicated time to talk about what is most important to them; to share their concerns, consider options and make decisions and is a key recommendation of the RCGP.

> *"Enabling practices in deprived areas to provide longer and more patient-centred care for multimorbid patients may protect quality of life in a cost-effective way."* - CARE Plus Study[2]

The personalised care and support planning consultation model includes a more person-centred enabling and empathic approach which begins by hearing the person's story. This includes talking about what matters to the person including their wider non-medical concerns – social and psychosocial issues; seeking to build the knowledge, skills and confidence to manage their own health and wellbeing.

The structured consultation model supports the professional to involve people in setting their own goals and actions to achieve these, it explores barriers and enables professionals to understand a person's readiness to change and how to understand and work with the person from where they are at and at a pace that suits them.

Evidence[3] suggests that this approach can improve how involved people feel in their care and increase engagement with care. Following the implementation of the approach in the multicultural borough of Tower Hamlets:

- 92% of practice patients with Type 2 diabetes took part in care and support planning
- Patient 'Perceived involvement in care' rose from 52% to 82% in Tower Hamlets CCG after implementing YOC
- Care processes and intermediate health measures improved

3. Support for self-management to live well and a 'more than medicine' approach to support

By focusing on a meaningful conversation that identifies what would make a difference to the individual, the output of the personalised care and support planning conversation is often focused on supporting people by linking them into local community activities alongside exploring the individual's own resourcefulness and support systems with the aim to sustain health improvements.

One of the key outcomes of PCSP is to identify people's needs and ensure those needs are met. With the right allocation of resources, areas with the highest identified need should benefit the most.

For more information please contact enquiries@yearofcare.co.uk or see our website www.yearofcare.co.uk.

[1] https://www.ncbi.nlm.nih.gov/pubmed/26951586

[2] https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-016-0634-2

[3] Report of Findings from the pilot programme https://www.yearofcare.co.uk/sites/default/files/images/YOC_Report%20-%20correct.pdf page 95