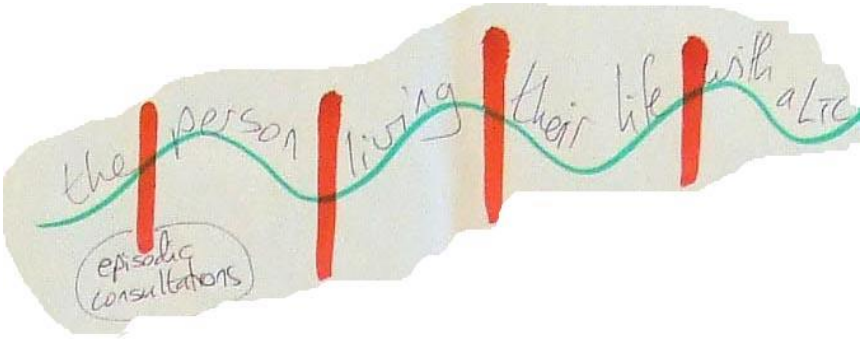
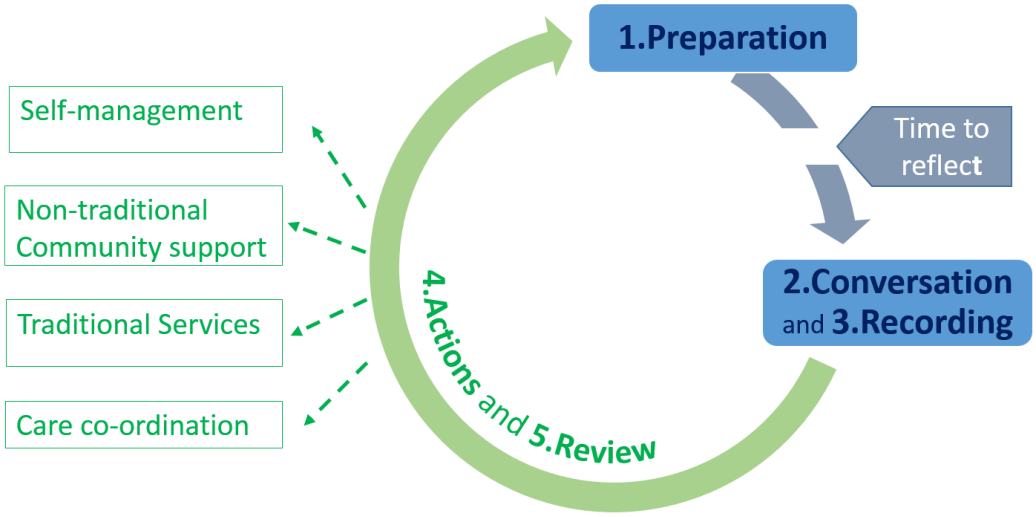
The Year of Care Programme



The Year of Care (YOC) programme recognises that people who live with long term conditions (LTCs) make the majority of the decisions that affect their lives day by day (green line in the figure above), spending only a few hours each year with a health care practitioner (orange bars in the figure above). The YOC programme seeks to transform this brief contact into a meaningful and useful discussion via systematic **care and support planning** and **enable links** with **activities in a supportive community.**

Care and support planning



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

The aim is for CSP to become **normal care**, replacing what is currently often a fragmented way of working. It is a continuous process, not a one off event, and involves a number of **specific, observable steps**.

Care and support planning: Philosophy

There is a strong programme philosophy which underpins all elements and activities.

- People with LTCs are in charge of their own lives and self-management of their conditions and are the primary decision makers about the actions they take to manage these.
- People with LTCs bring personal assets, strengths and abilities to develop solutions. The CSP process supports them to articulate their own needs and decide their own priorities.
- The care and support planning conversation is a meeting 'between experts' which brings together the lived experience of each person and the technical expertise of the practitioner.
- People are much more likely to take action from decisions they make themselves rather than decisions that are made for them.

Care and support planning: Delivery principles

- The CSP conversation (how the care plan is developed) is a prerequisite for an effective care plan which cannot be produced without it. (It's the verb!)
- No major allocation of resources or actions (including 'assessments') should be made until the person's view of 'what matters to them' has been identified and recorded.
- Tasks, tests and assessments should be separated in time from the discussion about what is important to them.
- Practitioners taking part in CSP conversations should have appropriate training.
- The context, place, workforce and responsibility for CSP for each group of people should be identified in the local care pathway.
- Using the generic approach and common language for CSP supports a consistent approach for an individual and economies of scale for service providers. CSP is suitable for routine planned care for people with single or multiple LTCs and frailty including physical, mental health and social care issues. It has been used with or mapped to the recommended approaches to personal health budgets, prevention (e.g. ageing, health checks), end of life care, enduring mental health, learning disabilities and special educational needs.

The Year of Care Partnership programme was set up to bring together and develop the learning and resources developed by grass roots teams with the aim of making CSP linked to community activities the norm for everyone living with one or more LTCs or multi-morbidity. It is an NHS organisation, based within Northumbria Healthcare NHS Foundation Trust, set up to offer commissioners and providers expertise, practical support and training to put collaborative CSP into routine practice as part of a whole system approach.

Acknowledgements

The YOCP acknowledges the learning and experience of all those working every day to make routine CSP a reality. The steps and terminology of CSP have been refined to recognise the contribution of

http://www.nationalvoices.org.uk/sites/default/files/public/publications/guide_to_care_and_support_planning_0.pdf

http://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/

Coulter A, Entwistle VA, Eccles A, Ryan S, Shepperd S, Perera R. **Personalised care planning for adults with chronic or long term health conditions.** Cochrane Database Syst Rev 2015; **3**CD010523. doi: 10.1002/14651858.DC010523.pub2. http://www.ncbi.nlm.nih.gov/pubmed/25733495

Further information: http://www.yearofcare.co.uk : enquiries@yearofcare.co.uk