



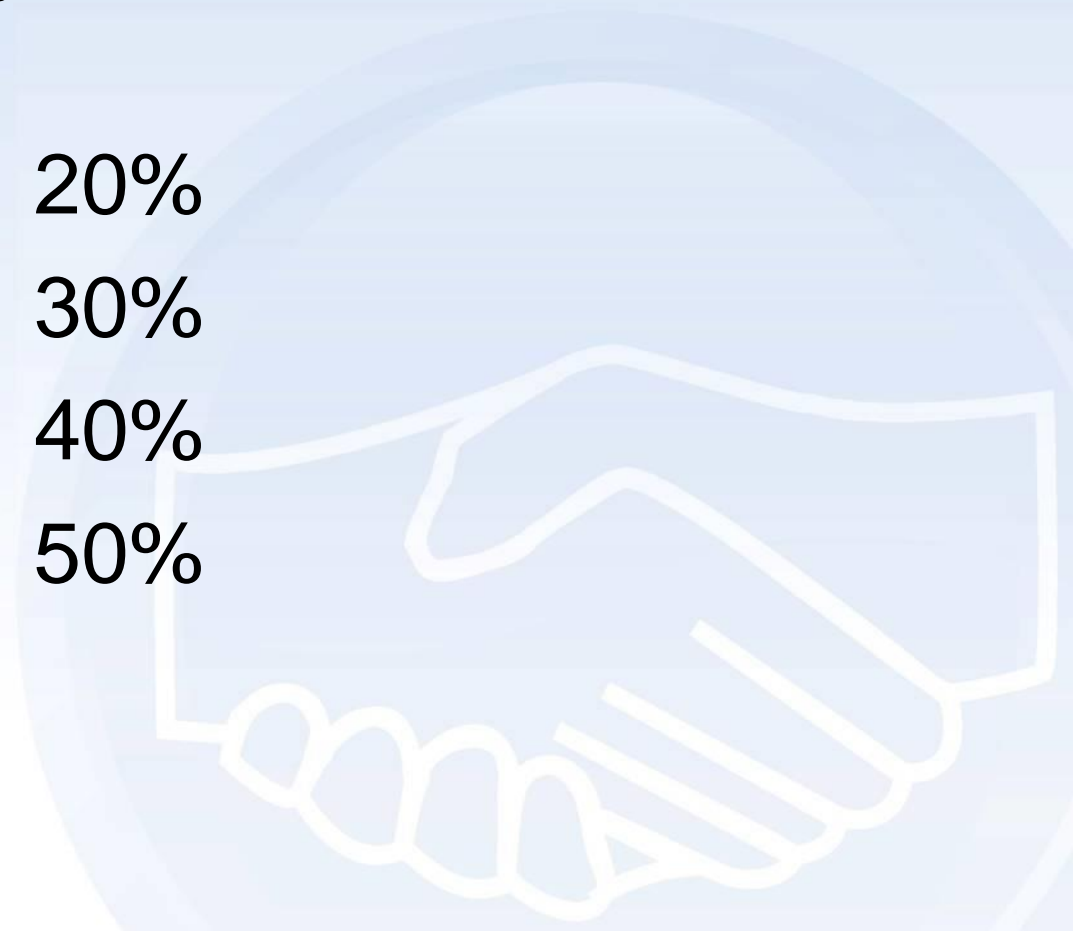
Delivering Person Centred Care through Care and Support Planning

Claire Scott, RGN and Year of Care Trainer



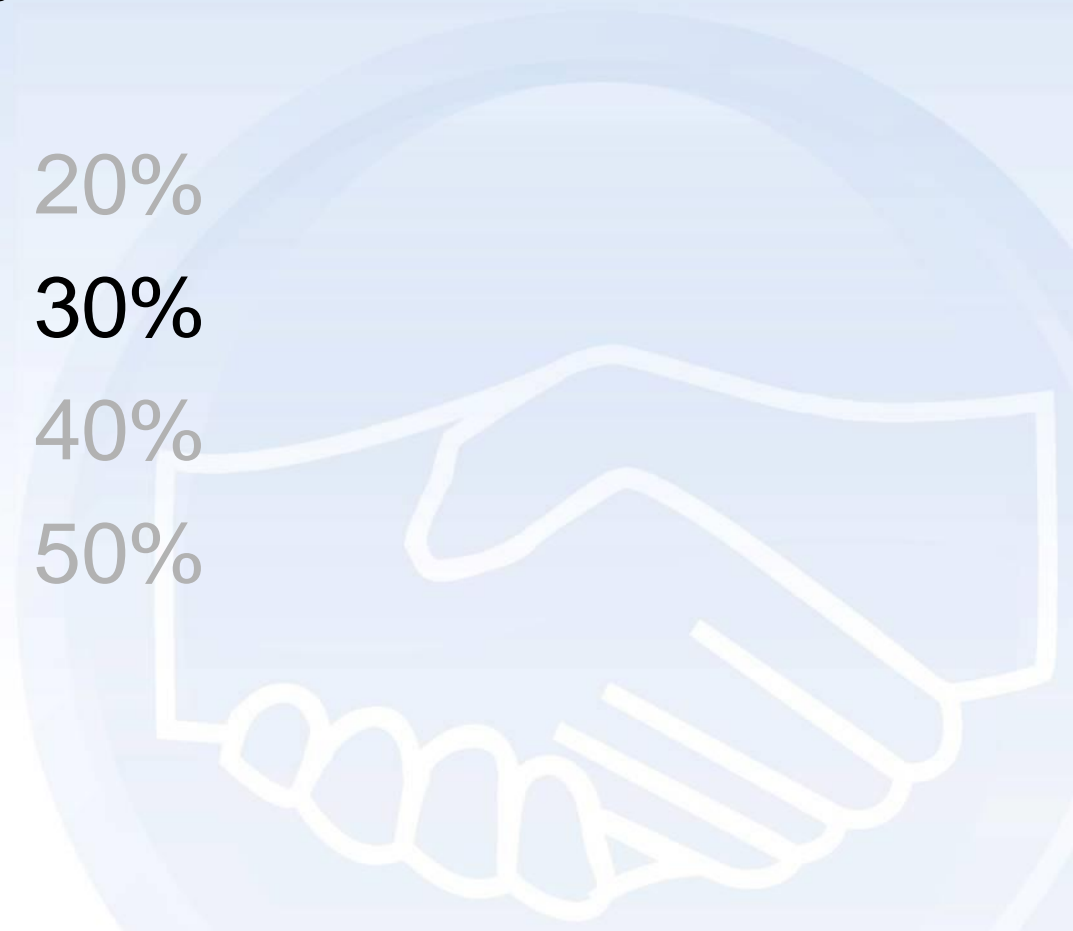
What proportion of the population have one or more long term conditions?

- a) 20%
- b) 30%
- c) 40%
- d) 50%

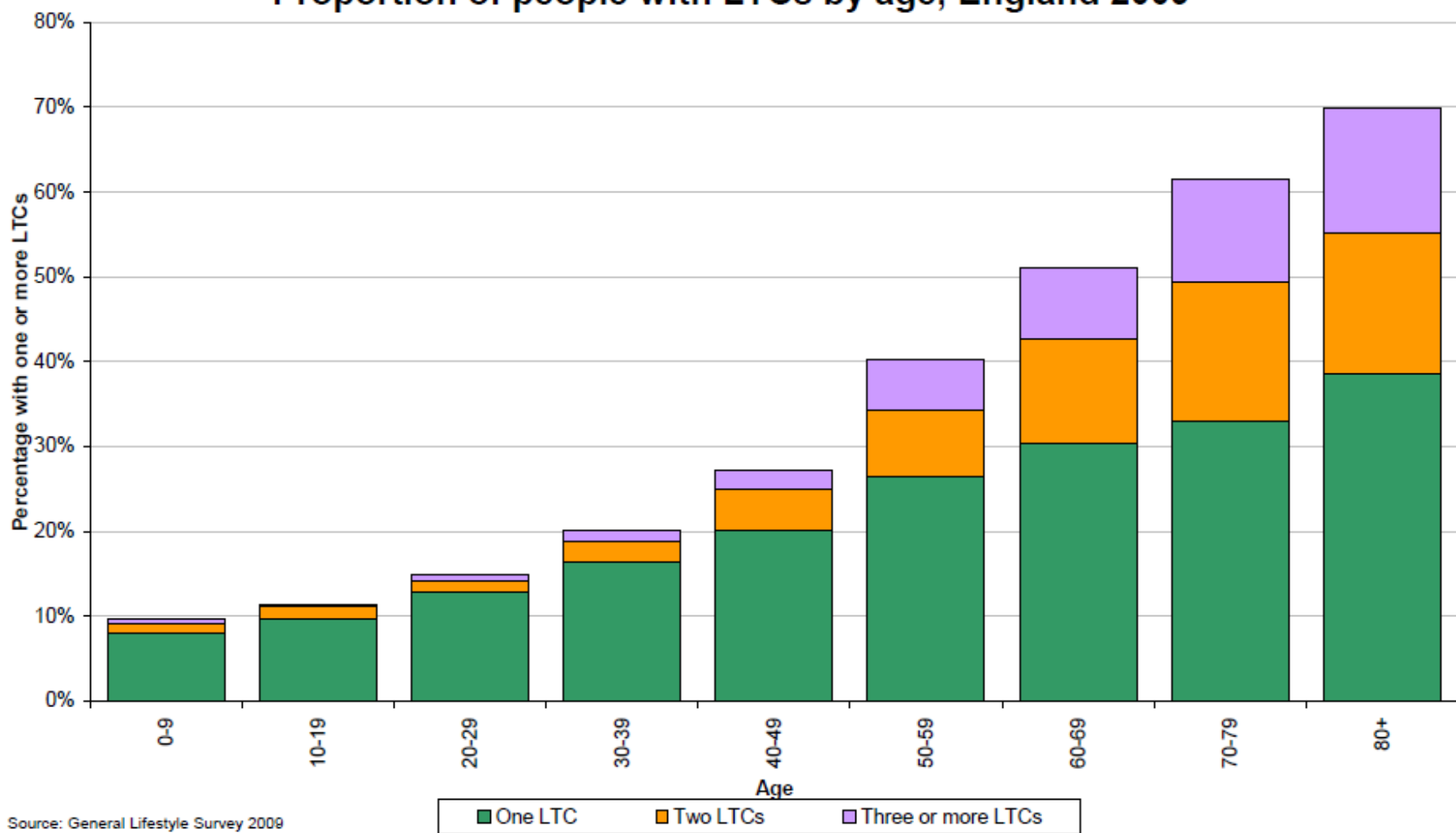


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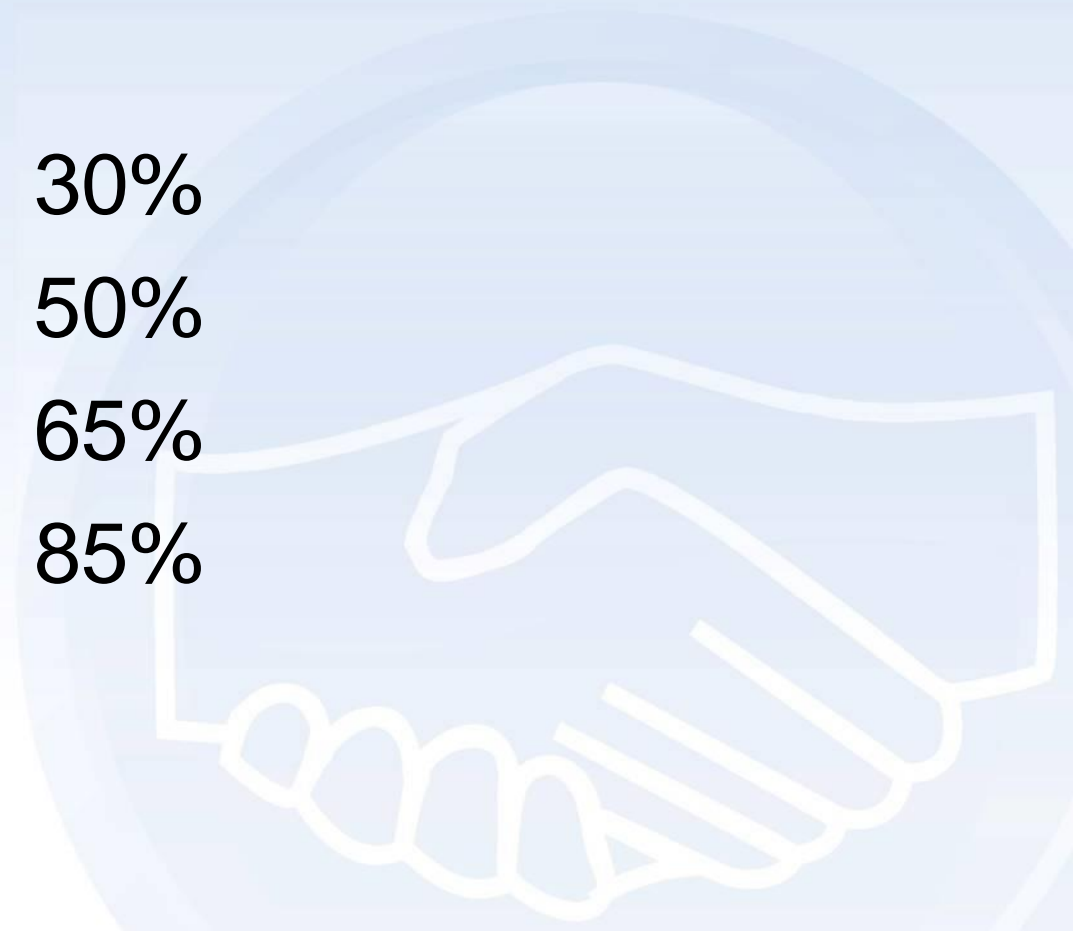


Proportion of people with LTCs by age, England 2009



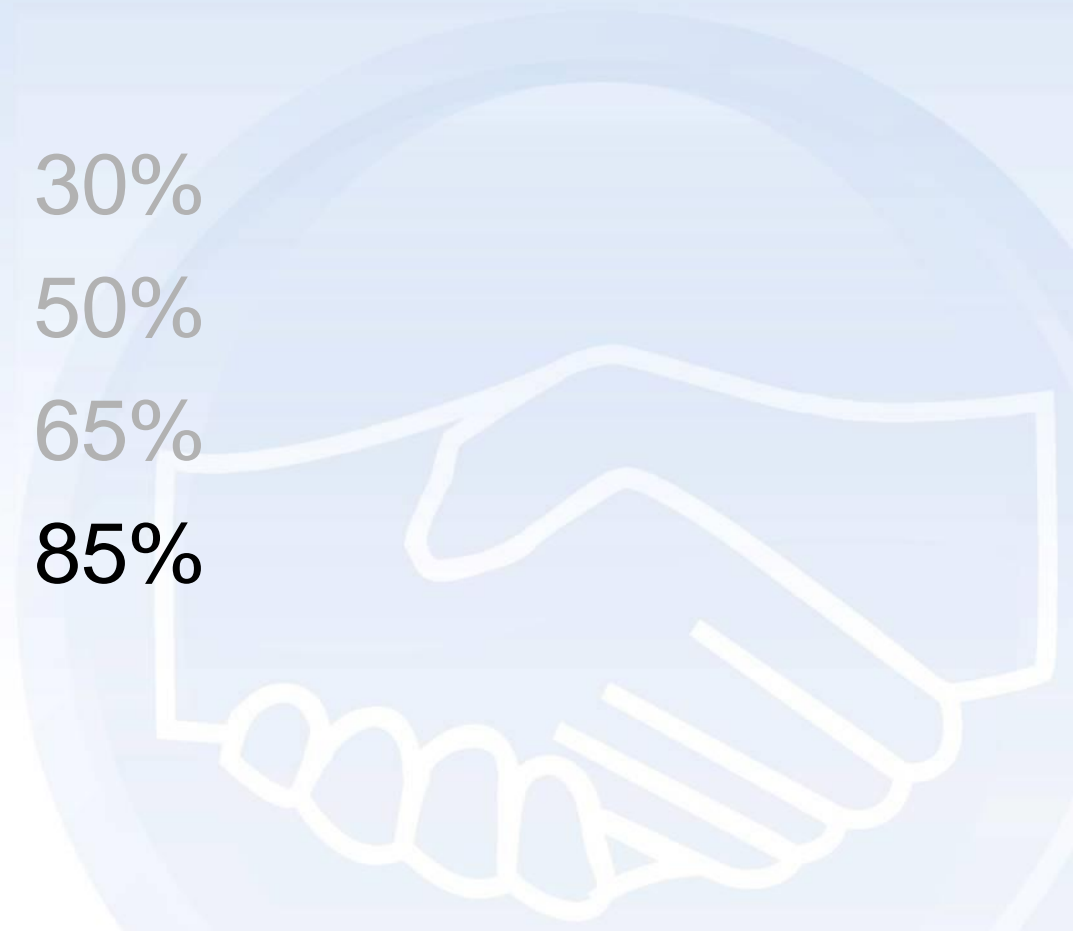
What percentage of clinicians feel they involve patients in decisions about their healthcare?

- a) 30%
- b) 50%
- c) 65%
- d) 85%



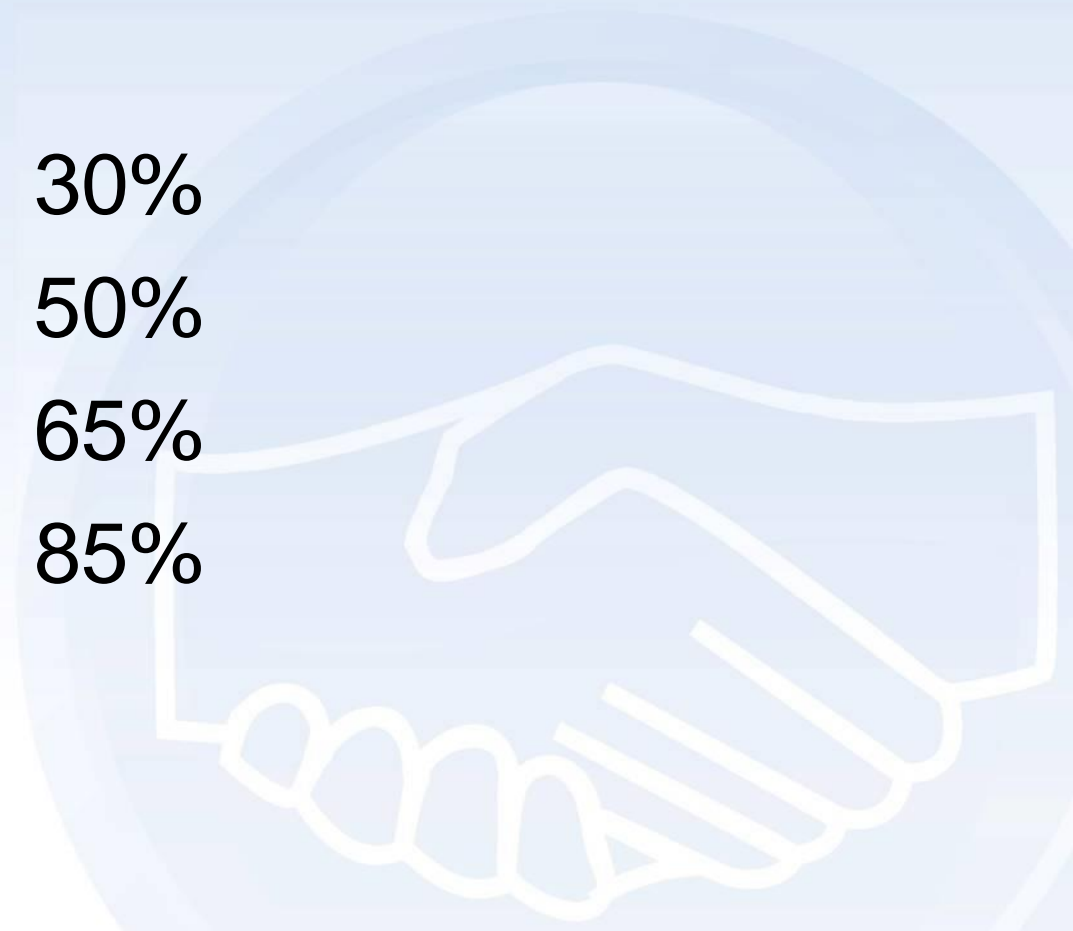
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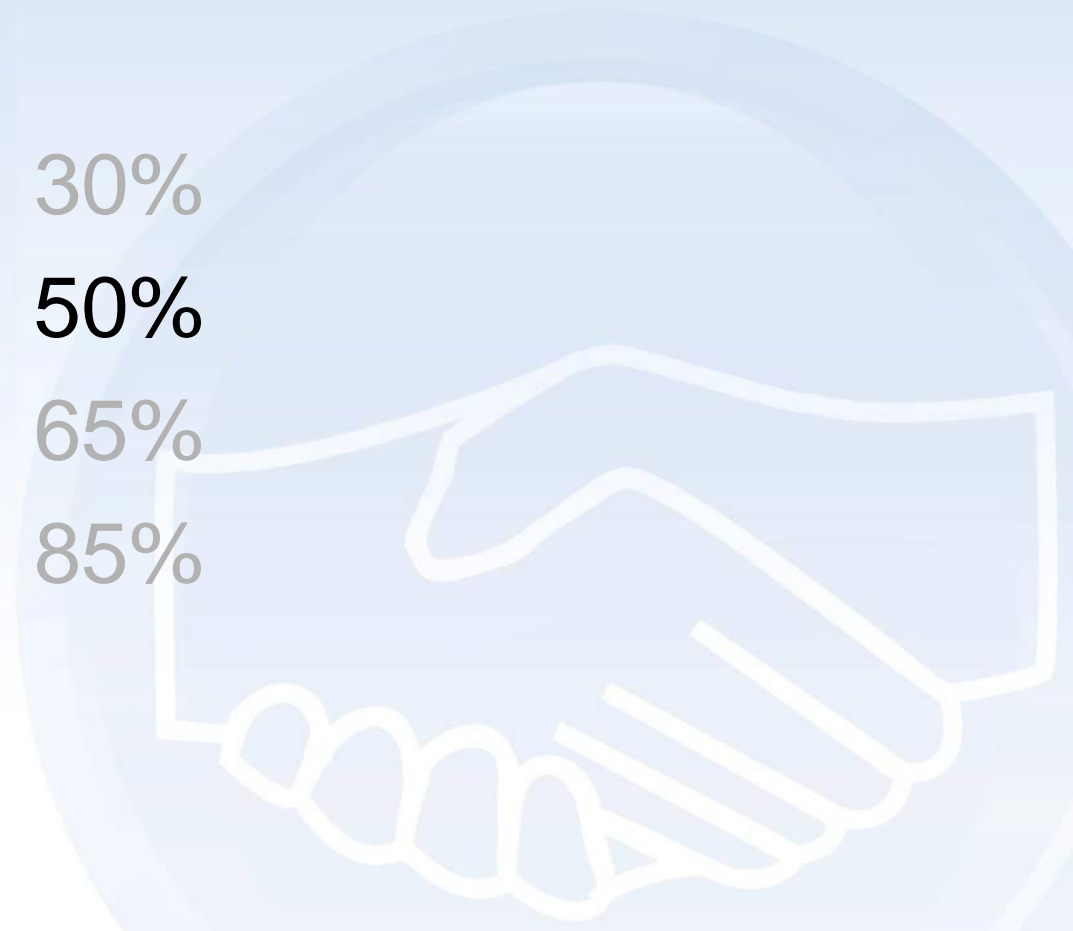
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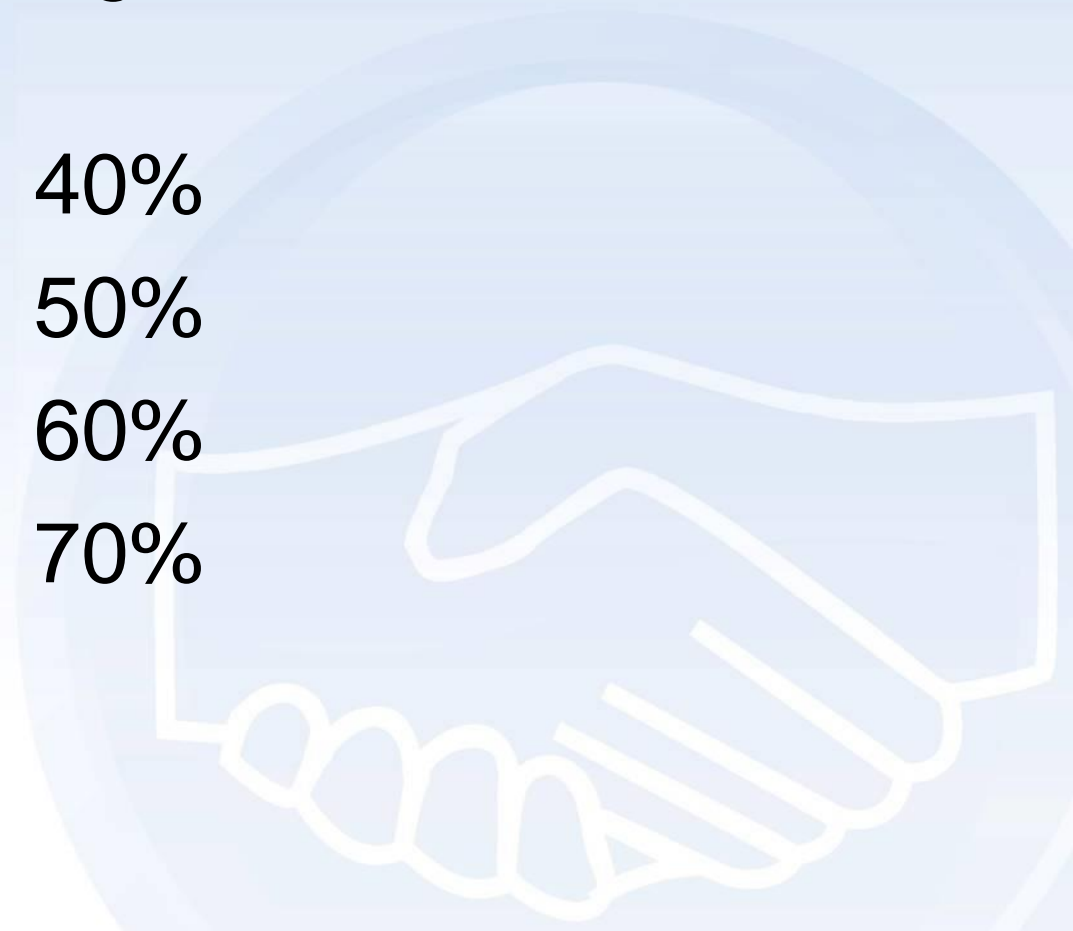
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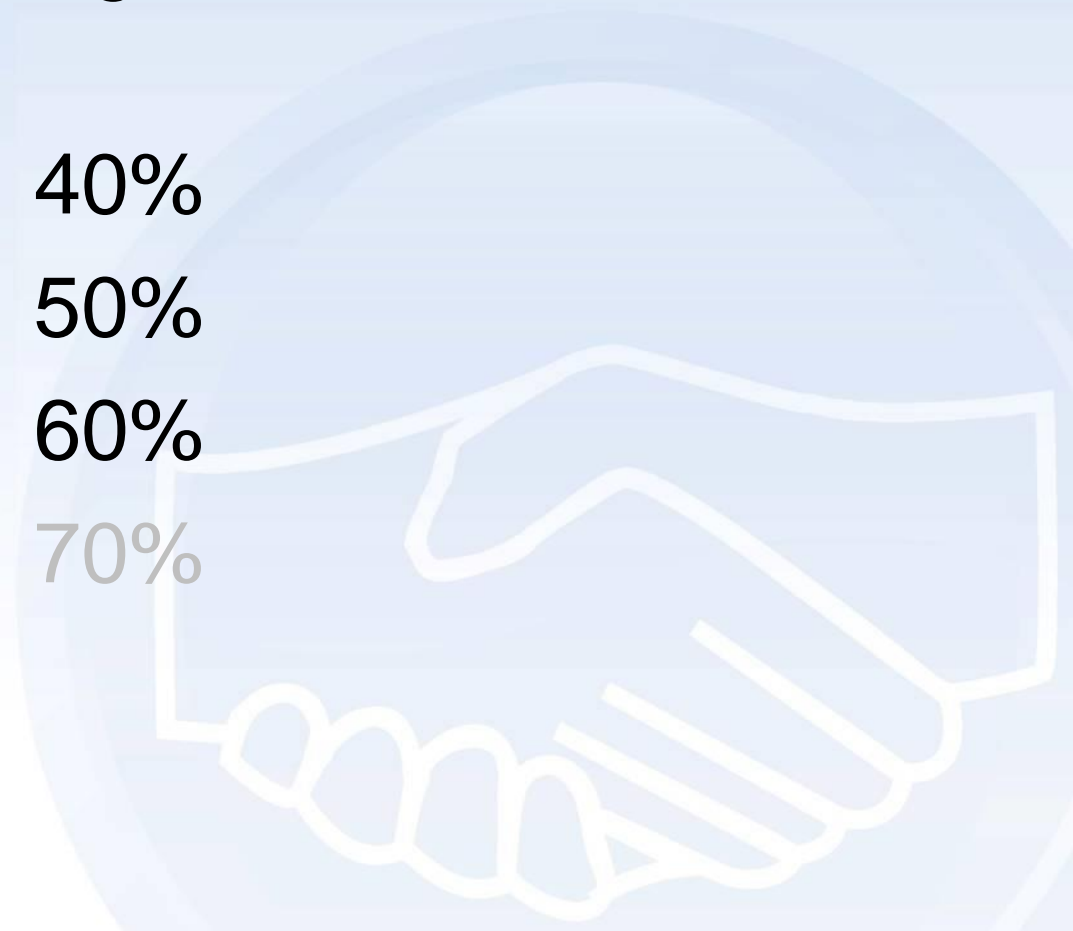
What proportion of people feel confident that they can manage their health?

- a) 40%
- b) 50%
- c) 60%
- d) 70%



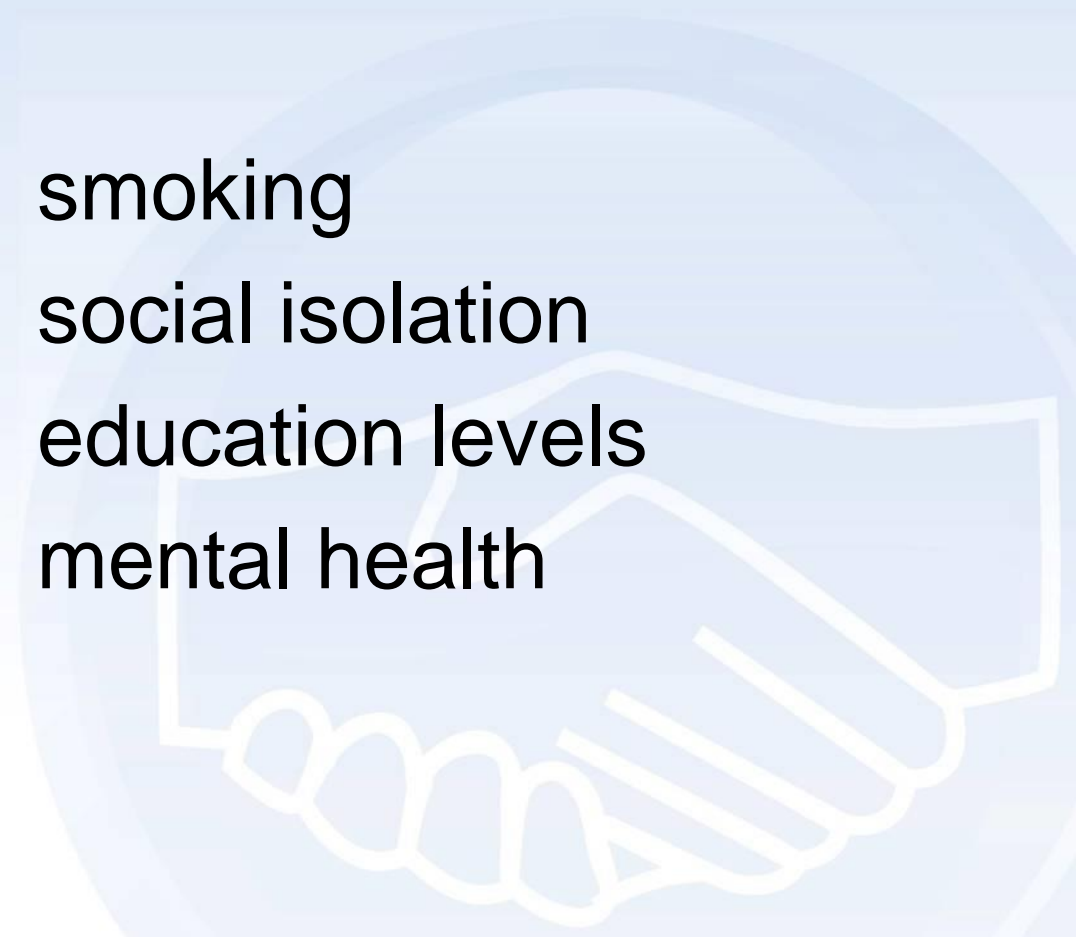
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Which of these has the greatest impact on health?

- a) smoking
- b) social isolation
- c) education levels
- d) mental health



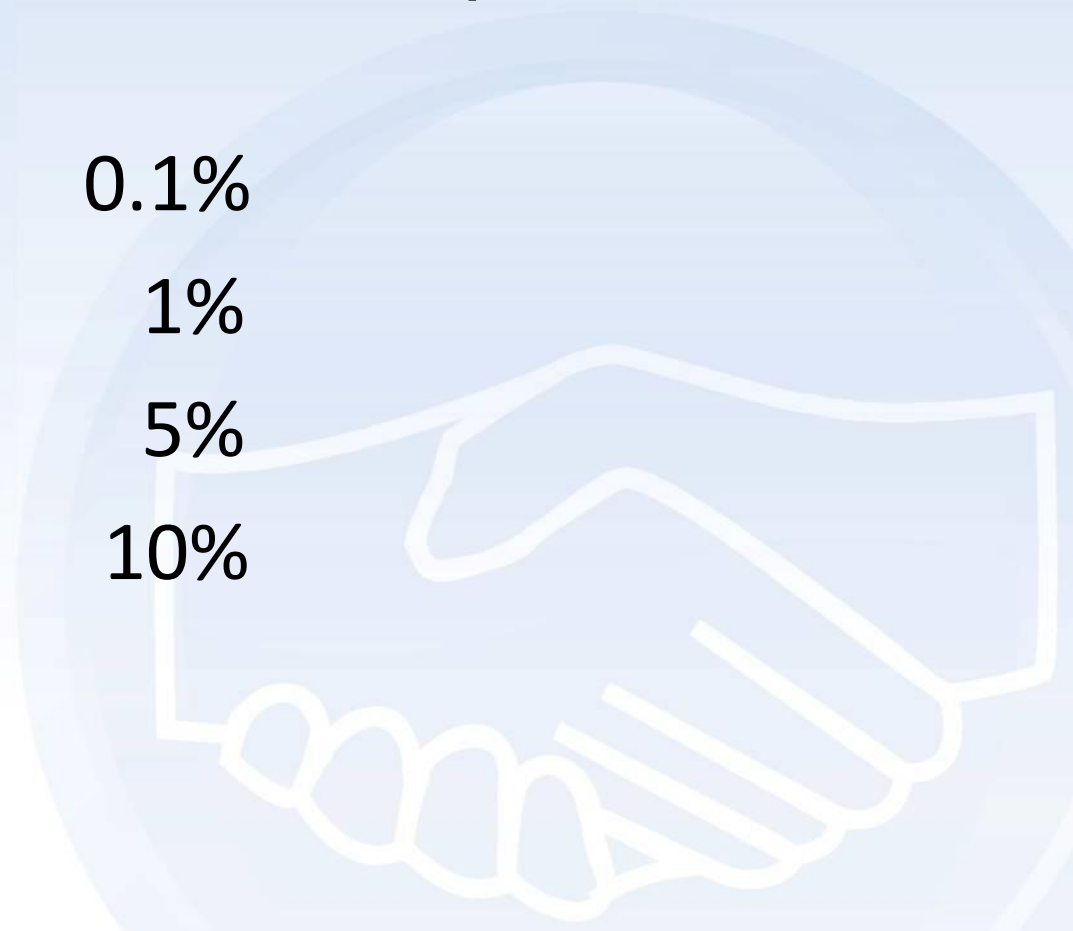
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- c) education levels
- d) mental health

They all have a huge impact on health!

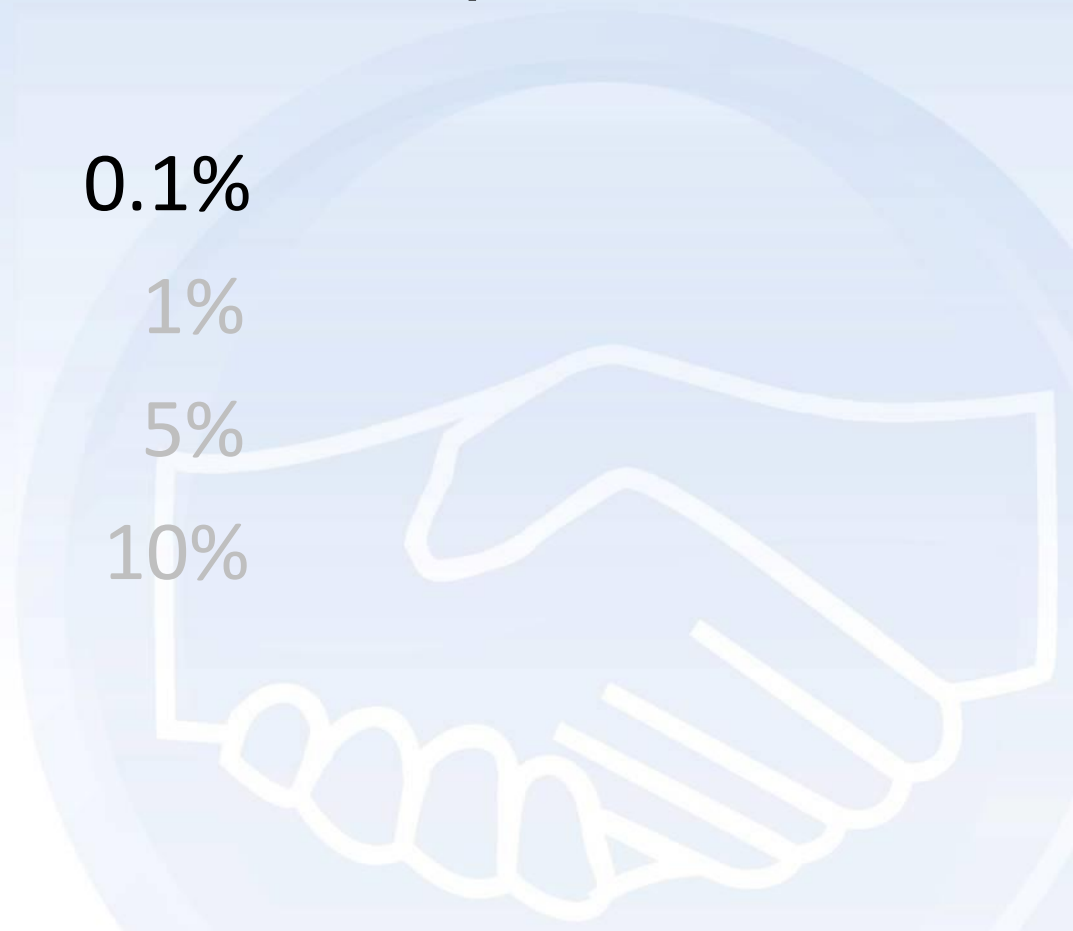
What proportion of their time do most people with LTCs spend with healthcare professionals?

- a) 0.1%
- b) 1%
- c) 5%
- d) 10%

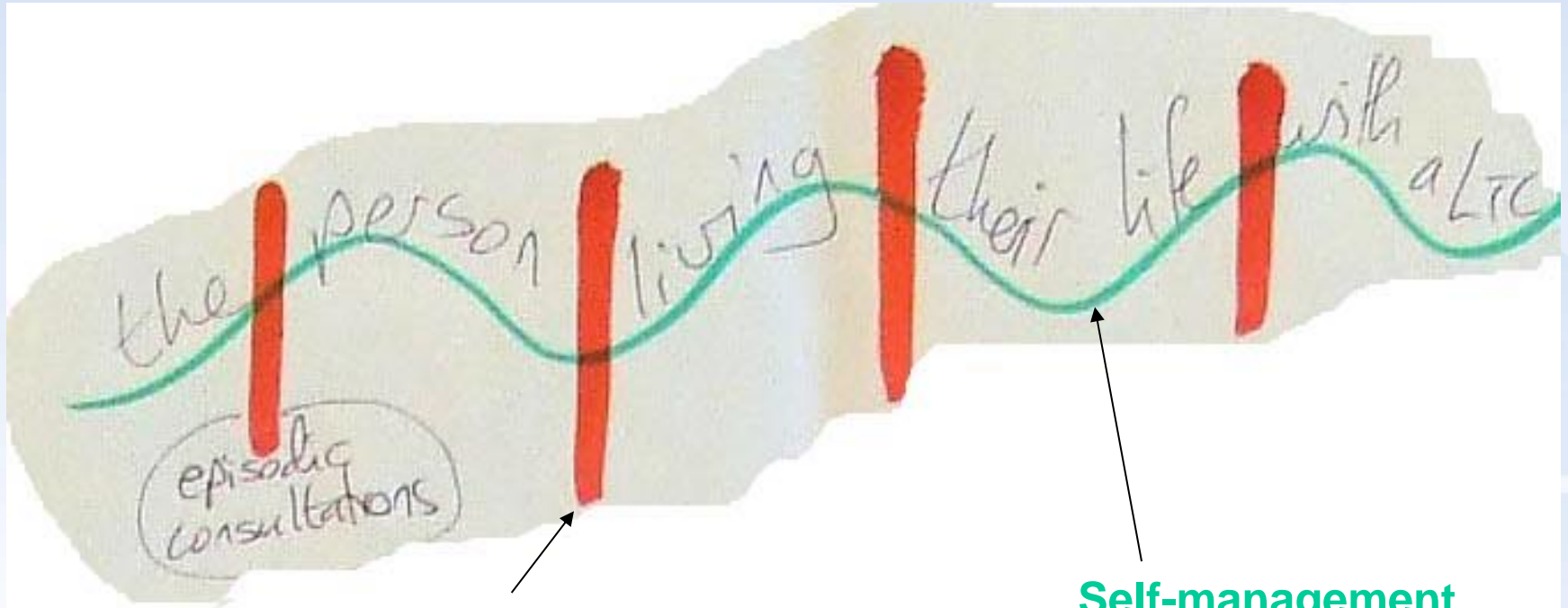


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Long term conditions are different



**Hours with healthcare professional
= 4 hours in a year**

**Self-management
= 8756 hours in a year**

The Year of Care Approach



The evidence base in *all* long term conditions

**Engaged
empowered
patient**



Partnership

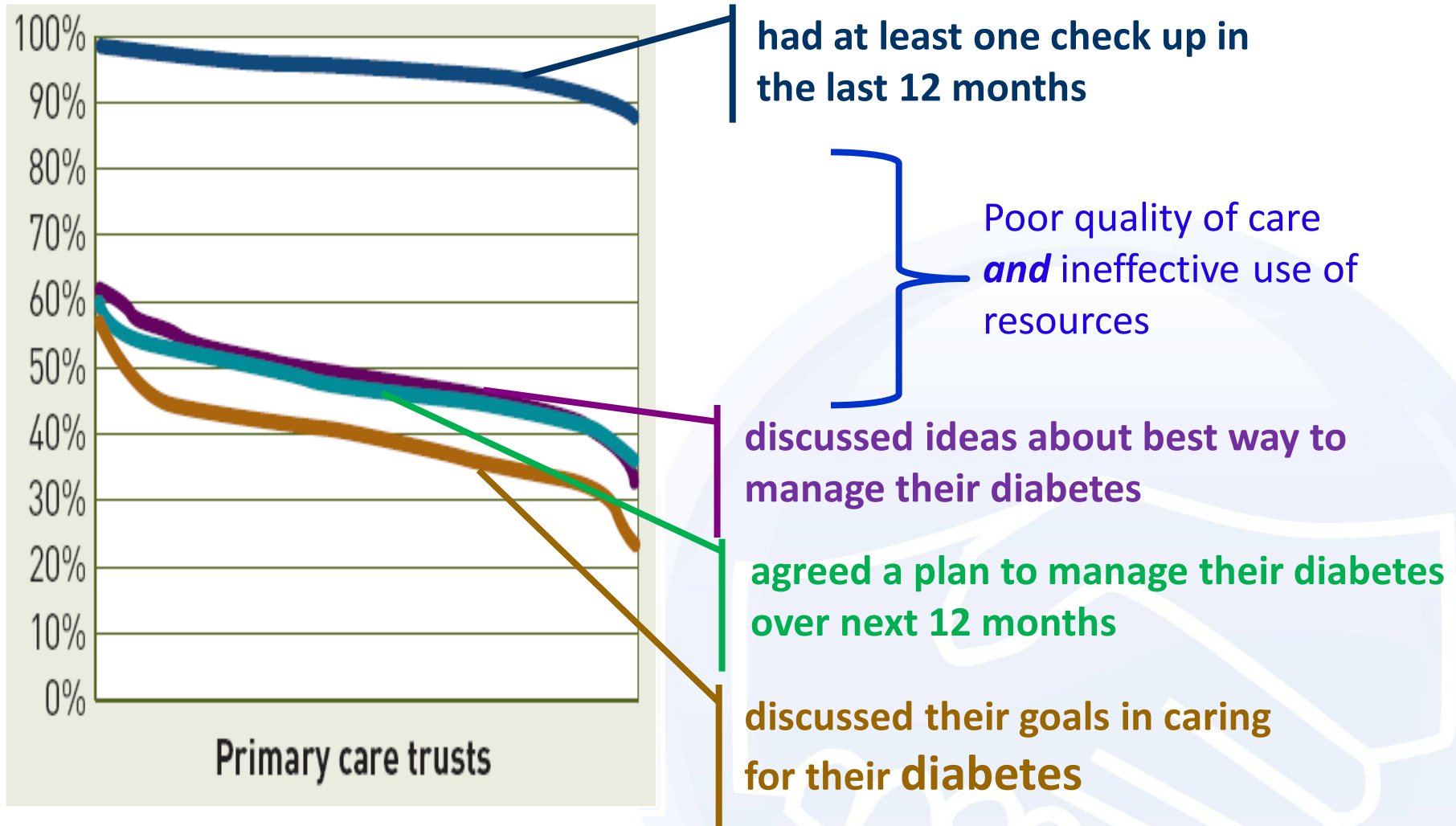
**Organised
proactive
system**

= Better outcomes

In England : The Diabetes NSF

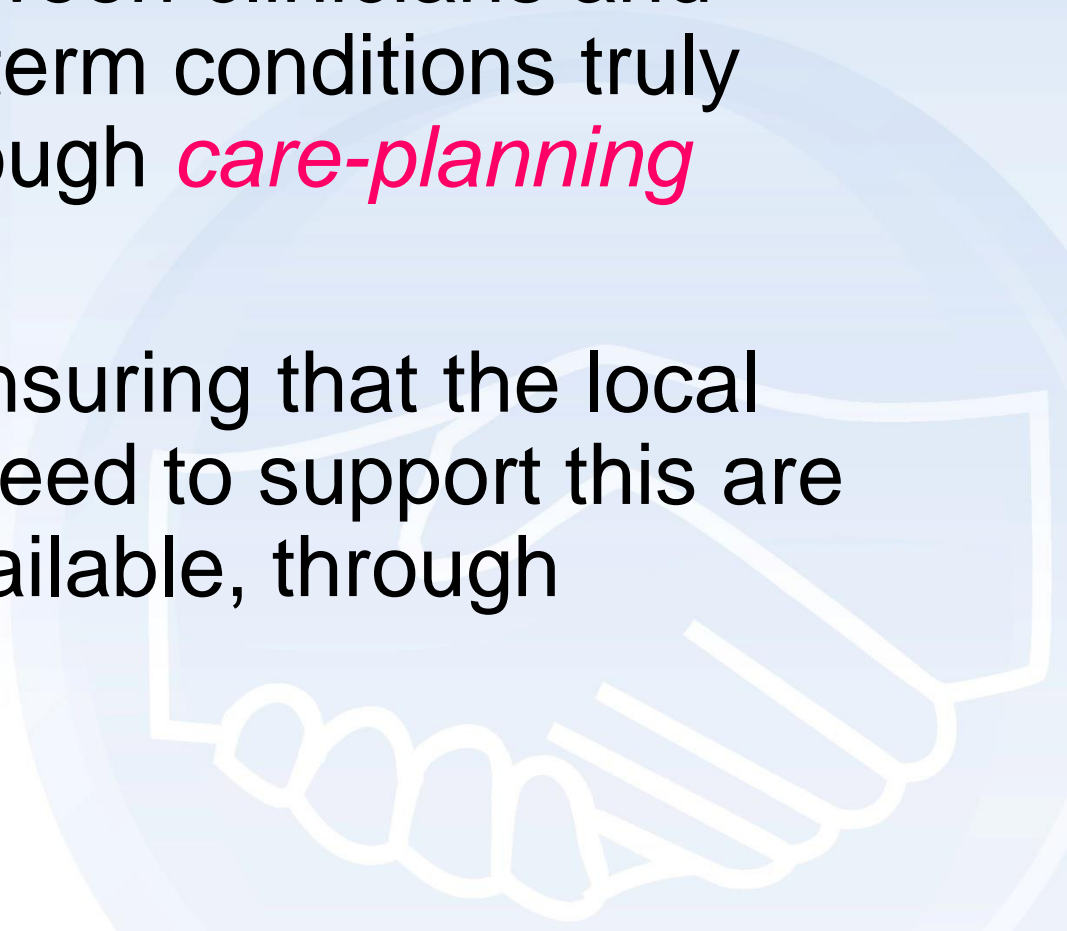
Internationally: The Chronic Care Model - Wagner

Year of Care : addressing the problem (diabetes)



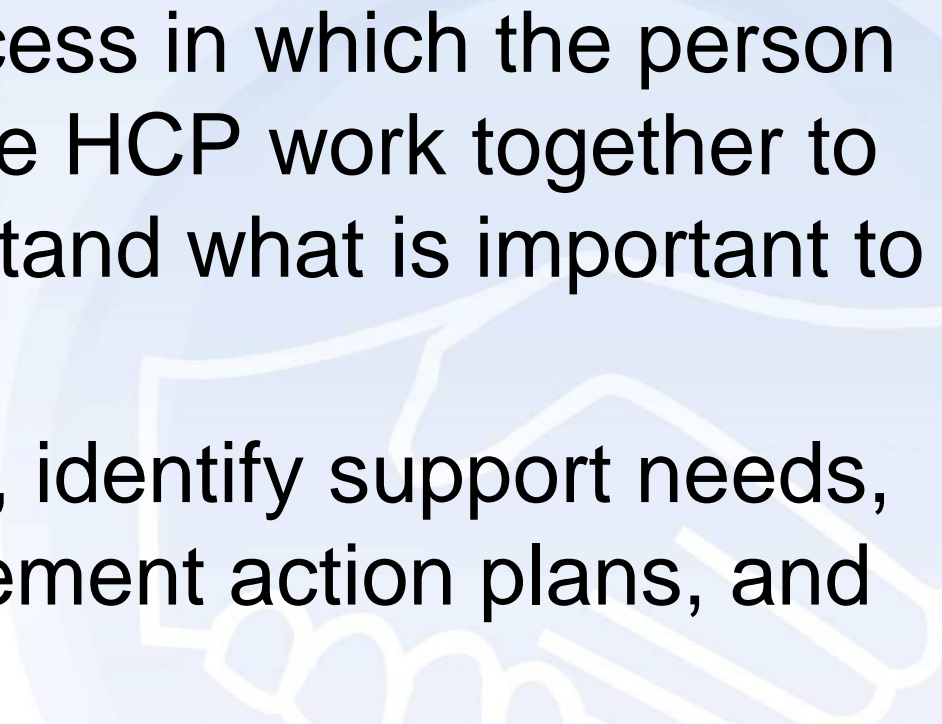
The Key Aims of Year of Care

- It is *firstly* about making routine consultations between clinicians and people with long-term conditions truly collaborative, through *care-planning*
- and *then* about ensuring that the local services people need to support this are identified and available, through *commissioning*



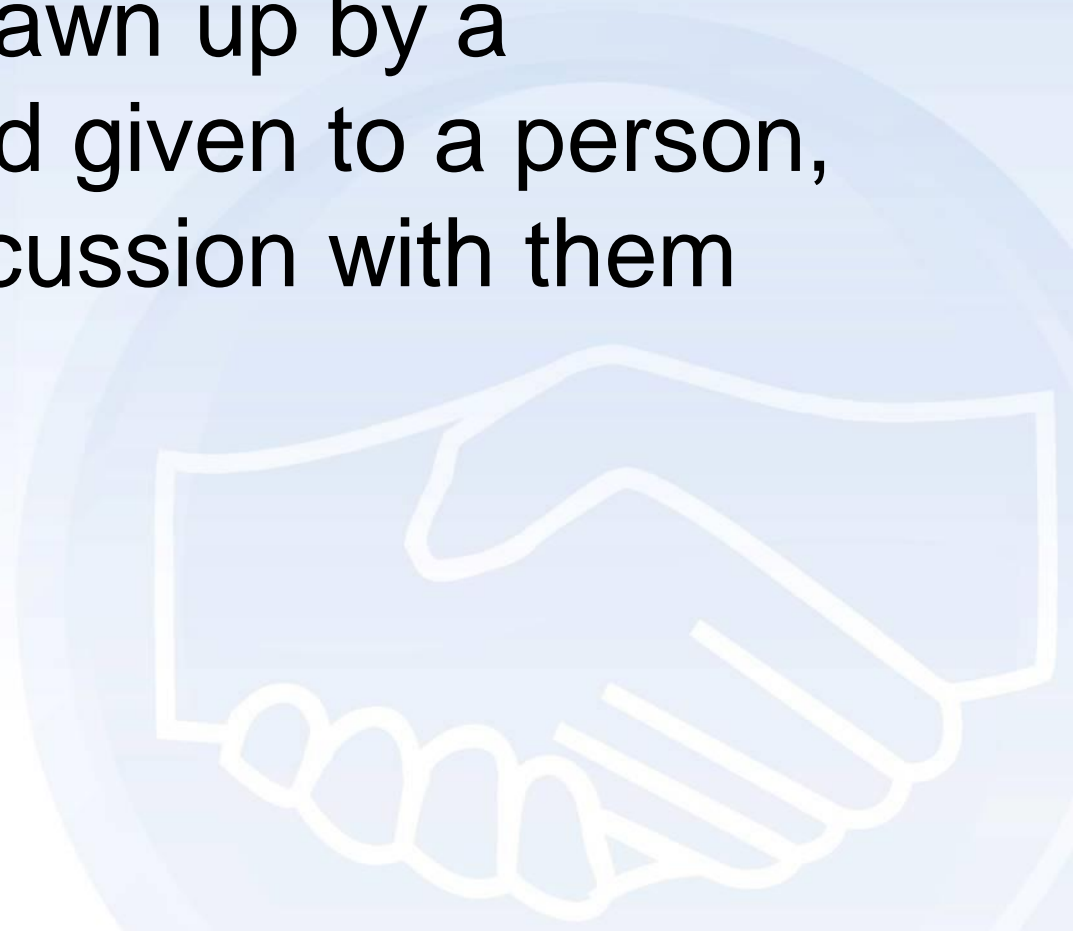
Person centred care and support planning

What is it?

- A continuous process in which the person with a LTC and the HCP work together to clarify and understand what is important to that individual.
 - Then agree goals, identify support needs, develop and implement action plans, and monitor progress.
- 

What it isn't

- A document, drawn up by a professional and given to a person, without any discussion with them



Care plans v. Care planning

Medical Treatment Plan Template

_____ [Name of the medical centre / hospital / nursing home]

Address: _____

State: _____ City: _____ Zip code: _____

Contact number: _____ E-mail address: _____

Date: _____

Name of the patient: _____ [First name followed by last name]

Subject: _____ [Give the appropriate subject of the topic
E.g., The medical plan for the patient _____ (mention the name of the patient)]

Case under the supervision of: _____ [Mention the full name of the supervising doctor]

Medical Treatment plan for _____ [mention the name of the patient]

1. Date admitted in the hospital: _____

Date of treatment: _____

Treatment₁ done by doctor: _____ [Mention the full name of the doctor]

Date of treatment₂: _____

Treatment₂ done by doctor: _____ [Mention the full name of the doctor]

Period of patient care in the hospital: [From] _____ [To] _____

Name of the nurse or nurses to take care of the patient: _____

Patient admitted in department: _____

The given treatment plan for the patient is to be carried out as per the planned schedule. For any queries or complaints, you can contact _____ [give the name of the representative to be contacted] or call at the contact number _____ [mention the contact number of the representative]

_____ [Signature of the medical treatment planner]

More templates at - Sampletemplates.org

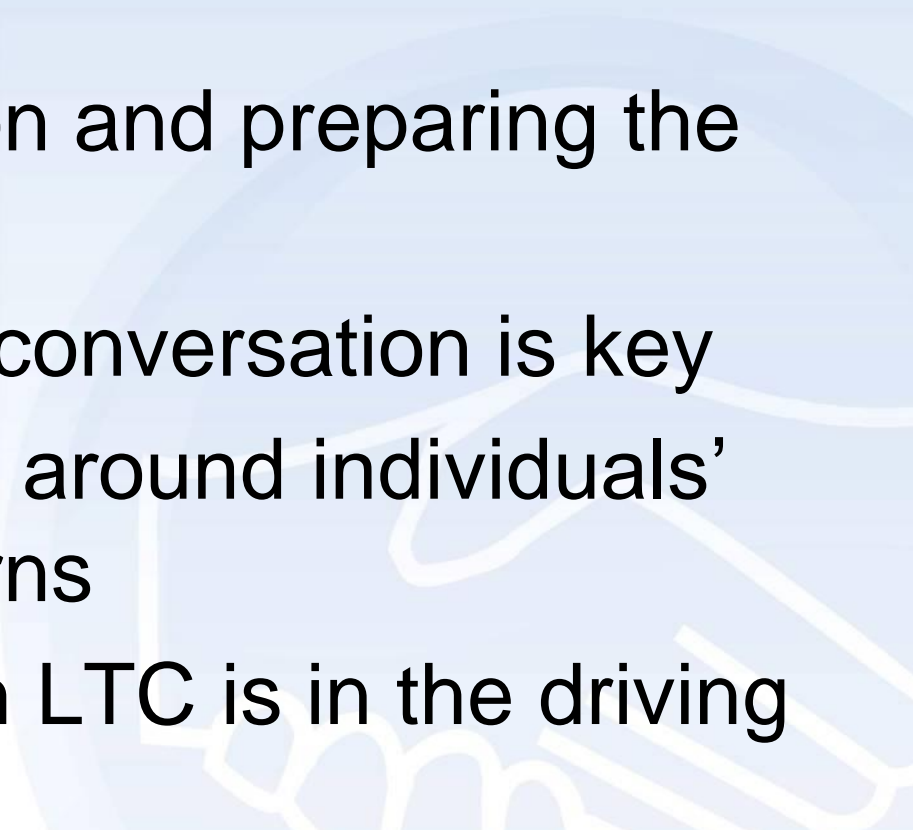


Having better Conversations

- How we make decisions?



Principles

- It is a meeting of equals and a partnership of expertise
 - Sharing information and preparing the individual.
 - The quality of the conversation is key
 - Support is shaped around individuals' values and concerns
 - The individual with LTC is in the driving seat
- 

Four Key Steps



1st visit

Information gathering

HCA performs annual review tests

Between visits

Information sharing

Sent to patient > 1 week before consultation;
with agenda setting prompts

2nd visit

Consultation and joint decision making

Prepared HCP and patient

Agreed and shared goals and actions (care plan)

Resultant care plan shared with patient, immediately or by post

Impact of Year of Care



Improving satisfaction & effectiveness

'I enjoy doing the clinic a lot more now... working with them rather than at them'

'We have used the YoC as a template for other care packages.'

'It's absolutely 100% better for me and for the patients'

Care planning has made me look at patients differently. I have to invest more time but it will get easieras people get more used to it.'

Better practice organisation and support for self management.

Practice organisation and resources

'In primary care you always feel you are chasing your tail and fire fighting - this makes you feel you have achieved something—like a proper job' (HCA - Holmside)

'The new pathway more efficient in time for both patients and health care professionals.' (Practice team member)

Cost neutral at practice level
Pre Year of Care : £21
Post Year of Care : £21

Clinical care..... Improving too!

Tower Hamlets

92% of registered population (Type 2 diabetes) taking part in care planning

Patient perceived 'involvement in care' **rose from 52-82%**



72% received all 9 processes in National Diabetes Audit: **Best in England** (Average 49%)

Any
Questions?



www.yearofcare.co.uk