Our vision for the future
People living with long-term conditions are the biggest users of NHS services and the largest part of the health services budget is spent on their support. The care and support needed to live well with a long-term condition is fundamentally different to that for acute health conditions. People with long-term conditions often spend just a few hours a year with health and care professionals, yet they live with their conditions and manage them on a daily basis themselves.

The health and care system must support individuals to have the knowledge, skills and confidence to design and manage their own health and care, and to support one another in the context of their wider families and communities. We therefore need a major re-design of current approaches. This will require many changes across the health and care system: from the way professionals and people interact in face-to-face consultations, to how professionals are trained and what support people can tap into, including provision for carers and family members.

Big change is needed.

People with long-term conditions need a better deal from the health and care system - changing the way that they are supported is long overdue.
The Coalition for Collaborative Care (C4CC) believes people are in charge of their own lives and should be the main decision makers about the actions they take in designing their support and managing their conditions. They have vital experience, knowledge and skills and therefore the relationship between a person and a professional should be one of equals; where each is seen as having expertise.

We need to build a powerful movement for change to make this a reality for people with long-term conditions. This means enabling people to express their own needs and decide on their own priorities in partnership with professionals, who recognise people’s assets, strengths and abilities, not just their needs. People are interested in their lives, rather than just their conditions and help should be coordinated around the whole person to reflect this.

As well as being the right way to support people, we know that this approach works. People are more likely to follow through on decisions they make in partnership, helping them to better manage their conditions and stay well and independent. This applies to people at all stages of life.

What do we stand for?

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How can person-centred collaborative care be achieved?

Over a number of years now, a range of practical, effective and evidence-based approaches aimed to help make the shift we want to see have been developed and tested. Some of these are focused on people being fully engaged as partners in decisions and planning of their care, with support for self-management and emotional, psychological and practical support – beyond tests and treatment. Many involve enabling people to connect with and be fully included and supported within their communities.

This includes asset-based approaches to community development, peer support and tackling the wider determinants of ill health, increasingly referred to as ‘more than medicine’.

Personalised care and support planning is a key means by which people can be full partners with health and care professionals. It is focused on ‘better conversations’, enabling each person to articulate their own issues, develop solutions and access or design the right support at the right time from the many options available.

We know that this all requires leadership by people and professionals to build momentum for change, as well as practical support and training for teams to give everyone the confidence to make the change happen in their lives and practice.

To realise the full potential of these approaches will require going beyond putting single elements in place.

For me, person-centred care is about two things. First, it means healthcare professionals seeing me as a whole person with a productive and complex life rather than a series of single conditions. Most of the time I manage my own care myself and while I truly value the expertise of healthcare professionals they need to make the most of, and value, my expertise and experience.

Second, systems and budgets need to be much more joined-up. Explaining repeatedly, and ‘dealing’ with disparate services, wastes everybody’s time and resources and doesn’t help anyone.

Fiona Carey
Member of the Co-Production Group for the Coalition for Collaborative Care
The House of Care

The House of Care was developed by the Year of Care Partnerships to show what needs to be in place to ensure the benefits of care and support planning and ‘more than medicine’ activities are available to each person living with long-term conditions.

The House of Care provides a framework for thinking about the full set of interdependent changes that are needed. Using the House of Care helps local teams work out which elements are missing and those areas that are priorities for improvement so that person-centred collaborative care can become the norm.

The House of Care emphasises that achieving person-centred, coordinated care based on effective care planning relies on four key elements across the local system:

• individuals should be engaged in decisions about their treatment, care and support and able to act on these decisions;
• professionals being committed to working in partnership with people;
• systems being in place to support this new way of working;
• having a whole-system approach to commissioning, making sure the resources are in the right place at the right time and that there is a thriving set of community activities in place.

More than Medicine

In People Powered Health, Nesta coined the phrase ‘More than Medicine’ to recognise a range of social interventions that build on and complement clinical care. More than Medicine connects the clinical consultation with interventions such as peer support groups, debt counselling, walking groups, befriending, one-to-one coaching and community cooking classes. More than Medicine solutions are aimed at behaviour change, building social networks and addressing the social determinants of health.

The People Powered Health approach offers a vision for a health service in which the health and social care system mobilises people and recognises their assets, strengths and abilities, not just their needs. The ability to live well with long-term conditions is powered by a redefined relationship, a partnership of equals between people and health care professionals and the health and care system organises care around the patient in ways that blur the multiple boundaries between health, public health, social care and community and voluntary organisations.

See www.nesta.org.uk/project/people-powered-health for further information.
To speed up progress, we have set up the Coalition because not enough is happening to make person-centred, collaborative care the norm.

We know that a major change in our approach is necessary. We know how to make it happen and we have the evidence that it works, but the pace of change is too slow. It has become increasingly clear that the cultural, practice and system changes needed cannot be brought about by people and organisations working on their own. We need to bring together people with the range of experiences, skills and influence to have a major impact on how things work at all levels — practice, system and policy — guided by the experience of people with long-term conditions themselves. We will build and support a movement to bring about the change that is needed.

The Coalition brings together a growing number of people and organisations. These include those wanting to introduce person-centred, collaborative care to their lives and work, as well as those responsible for NHS delivery and development at a national level.

There are also major charities and voluntary organisations supporting people with long-term conditions; professional and leadership bodies in health and social care and leading development agencies involved. Crucially, people with long-term conditions will play a central role in our decision-making and the work we do. Our partners will all make direct contributions and take action to make person-centred care the norm. We want to encourage many more organisations and individuals to join us.

For a list of our current national partners visit: www.coalitionforcollaborativecare.org.uk
How will we work?

Put simply we will do two things:

1. We will actively promote a new way of doing things in local areas – using professional champions, experts and leaders, along with groups of people with long-term conditions, who want to see change. We will work to make practical support available to help communities embarking on this journey by providing information and networking groups for support, learning and training. We will also work with major initiatives and programmes to demonstrate how person-centred, collaborative care can be achieved.

2. We will work to ‘create the conditions’ to allow person-centred care to flourish. This will include using the evidence and building the case for change needed to influence and support systems and practice, working with leaders at all levels to develop new workforce approaches and strategies, and identifying and helping to pull the system and financial levers that will remove barriers and incentivise the changes we seek.

In doing these things we aim to model co-production, including through the establishment and support of a group of experts by experience – people with long-term conditions and family carers – who will sit at the heart of the Coalition’s work, both in design and delivery.

The core actions of the Coalition will be taken by its partners and members, aligning our work towards shared goals. We will also work with other key partnerships including Think Local Act Personal, who have been driving and supporting personalisation in social care and integrated provision.
How can you join us?

We are developing our plans for action and over the next few months will be launching our first resources and activities. If you are interested in joining our movement to transform the experience of people with long-term conditions you can be involved in different ways:

Members
Membership of the Coalition is free and open to any individual or organisation with an interest in and commitment to achieving person-centred, co-ordinated care. They will be operating in different ways and at different levels.

We would expect members to declare their commitment through agreement with the Coalition's vision and to champion this in their lives and work. Our offer to support them will include:

• for some members, significant and targeted support using the resources of the C4CC team and partners. This may range from identifying and activating champions, support networks, action learning, training and mentoring with topic focussed or geographical groups - to more significant initiatives at regional and local levels. We will look for and take all available opportunities to support members.

• access to our web-based materials and an opportunity to advise on their content and on the wider work of C4CC.

• a regular e-newsletter and social media updates on relevant developments (where possible targeted to specific interests).

• an advice line, including the facility to link people to relevant activity of C4CC partners.

Partners
Partners will typically be groups and organisations with national coverage which are committed and relevant to achieving the goal of collaborative, person-centred care and support. They may offer:

• expertise through experience of using care and support;

• professional, policy and organisational leadership across health, and social care;

• workforce and leadership support;

• development, innovation and academic expertise and capacity;

• charity, third sector and provider knowledge and capacity.

Partnership will be open to these types of organisations and groups who are strongly committed to the vision and goals of C4CC and willing to make an active and direct contribution to the work of the Coalition.

For more information, or to join us, please visit: www.coalitionforcollaborativecare.org.uk
email: info@coalitionforcollaborativecare.org.uk or telephone: 0113 825 0719