

Questions from personalised care and support planning (PCSP) webinar 16.07.24 not answered during the session

Recall and inclusion groups

1. Are cancer patients included in the combined approach?

Recognising cancer care reviews should be offered however feedback from patients is that they have reviews for their other conditions and are not always offered support for living with and beyond cancer.

Personalised care and support planning is suitable for any planned care situation and so yes cancer as a condition should be included in the combined reviews. However, it's generally up to practices who they recall to the PCSP process and usually they focus on the conditions they already recall due to capacity issues, and most will focus on the 'QoF' group as that work is incentivised (differently for different conditions) and therefore practices receive funding to do it. Cancer is included in QoF, and we certainly feel that cancer is suitable for PCSP.

It's possible that practices who deliver traditional annual reviews have clinicians who focus mostly on conditions such as diabetes, CVD and respiratory and that clinicians doing these reviews aren't trained in how to support people living with and beyond cancer.

However, as you note this is variable and practice dependant.

2. Are there any differences in this process for supporting people with dementia/cognitive impairment as well as multiple long-term conditions?

Generally, no, however you would expect much more involvement of carers as you would for example for people with learning disabilities. The process would work the same, but as Becky suggested on the webinar you focus the conversation on what matters to the person, so you would expect more focus on how people cope with living with dementia and the practical support they might need, alongside planning future care needs.

Triage and process

3. How much time do you find needs to be allocated for the triage/review of results?

I think we answered this in our Q&A at the end of the session. As an example a 9000-population practice, devotes one hour per week to this/two minutes per patient of a senior nurses time, but it's time well spent ensuring that people get to the right team member and don't then need further reviews.

Preparation

4. Does the process account for sharing test results beforehand that may contain negative information with potential to distress people (e.g. conditions getting worse)?

This process is about being honest and open with people and so people do receive routine results (not new diagnostic information), with an explanation of what it means and a comparison to a previous result. This will include results that are out of target, like a high BP or raised cholesterol, we cannot hide from this reality and it's important that people can see where they are. Results that aren't in target can engage people (like the example of Kathleen we shared on

the webinar). To some extent its easier for people to cognitively process this 'bad news' before a consultation than to try and emotionally digest it and make a decision about it during a consultation.

When we first set up the pilots, we thought people would be ringing up to query results, but they don't because:

- The HCA has told them that if there is anything we are very worried about that we will contact more urgently before their results are sent
- They know that they have a planned review to look at the results

5. What happens if people don't bring their paperwork with them to the appointment?

We all forget our homework from time to time and I wouldn't expect to take my bank statements to the bank as I know they have it online.

So, we really spell out the importance of bringing the forms back and use the process to encourage people to bring the letters with them, the HCA is vital in this. At Glenpark they print the preparation letter on yellow paper, and everyone knows about their yellow letter and what it's for and to bring it with them (and the majority now do).

In the pilots we discovered some people brought their letters with them and weren't asked if they had them with them, so they stopped bringing it along to the review. You really need to lay it out for people and not assume they will know to bring it or get it out during the review.

If they don't bring it, we usually look at the version in the electronic clinical record and emphasis in a nonjudgmental way that it would be good if they could bring it with them next time.

PCSP conversation

6. How do you balance the risk of overwhelming the person with information about each issue after one long appointment?

I think we answered this in the latter part of the presentation. The process allows the team to review all aspects of care by having information collected and reviewed before the care and support planning conversation (second appointment), which means we can focus on the things that need attention during the review. What we noticed with separate disease reviews was the amount of duplication and by combining things everything gets looked at together, providing a good overview of care, which is much better for the person.

Having a robust process often means, for many people there are only a few things to focus on at any given review and this will change each year depending on what is happening in someone's life. As in any conversation, if someone comes with a long list of issues you have to work with them to priorities what can be achieved and if need be, offer a second review, or referred to another clinician/service/activity that helps people with the issues they are most concerned about, but this would be rare.

The idea of a care and support planning review is to sift and sort through issues, priorities and plan care, and focus on what matters and what will make a difference, and of course it's part of ongoing care, so not much will be urgent (and if it is it will be dealt with in the usual way)

What's also interesting is that if you combine the LTC results for people with five conditions for example, it really isn't that long a list (and we only send the most pertinent list of results based on what people can influence and alter for themselves).

7. Might some people prefer single-disease approach. e.g. if having an appointment with a specialist nurse, feeling that they are speaking to someone who 'gets it'?

You can do PCSP as a single disease approach and as this is personalised care there is always an offer that people can have it by single conditions, it's their choice. As you say sometimes people want to speak to people who 'get it', but many people also like to speak with people 'who get them'. We find people rarely want separate reviews and they mostly prefer to speak to someone they know and trust (which of course might be linked to the professional expertise they value the most). Triage is used to offer continuity and if there is a 'dominant issue' for the patient then they will be triaged to the practice expert in that area. In addition, people may still be seeing for example a diabetologist for their type 1 diabetes glucose and insulin management and having all the other general issues/conditions reviewed as part of this process.

8. Re strong emphasis on conversation among equals, as contrasted with consultation (within implied more hierarchy and power in agenda setting) can you say something about whether and how this sometimes requires a shift in professional attitudes and ways of relating to patients? Do you have strategies for supporting HCPs who might not so readily relate to patients as equals, be so open to a patient-prioritised agenda?

A tricky question to answer! This is a values-based approach and getting the culture right is as important as getting the processes in place and getting staff trained in all the generalist issues relevant to long-term conditions. This is often about leadership and role modelling by a senior supporting clinician, and I think perhaps we didn't emphasise the role that Becky plays in supporting and developing others in the team to work in this way.

We spend much time on our training, thinking about the underpinning philosophy of this approach and what the roles of professionals and patients are in supporting people to live with and manage their long-term conditions and how those two things differ. The training is interactive with videos that demonstrate the application of the approach.

The picture of the green wavy line we showed in the session reminds us that the bottom line is that people manage their long-term conditions, we don't! Building trust and rapport, helping people see where they're at, and listening to people's concerns and ideas are important - people don't want to be told what to do and have their own way of doing things and much of their health is determined outside of healthcare itself. We thread these themes into training, but we are aware that this isn't always the way practitioners are trained and perhaps that and how things are incentivised need to change.

9. If people have multiple long-term conditions, how do you cover everything in one conversation? Do you have to refer things to other people?

Please see some of answer six.

The process looks at everything and you can know that there are robust, systematic ways of making sure that nothing gets missed

Preparation – includes all the screening tests and blood tests for the range of conditions people live with and all the drugs they are on. Most of the data entry happens here, freeing up the

second consultation for people to have a conversation rather than collect data/be distracted by an IT template. People are also asked about their concerns and if there is anything that is really bothering them. There are local guidelines in place to raise any urgent issues such as a worryingly high BP, or someone with suicidal thoughts.

Triage - is done by a senior clinician who notices any urgent red flags, reviews bloods and medications etc to ensure people get to the right professional (knowing what the clinical issues are and any early patient concerns identified during information gathering)

This means much is done ahead of the review and sharing results means that you don't spend time telling the patient about each result and what it means (saving time to focus on the issues identified by both you and the patient).

Conversation – this focuses on the most important things for you and the person, and you aren't ticking any boxes or completing lots of templates. You may sometimes have to prioritize the most important issues and arrange for a separate review if there are an overwhelming number of things or if there is a particular issue that need some specific advice such as someone asking about podiatry input or needing further assessment for e.g. falls. But as Becky said you don't cover absolutely everything every year, it's an ongoing process of care and if you do things too superficially to tick off every time, you really achieve very little, and if you don't focus on the patients concerns, you have sort of missed the point.

10. Moving forwards, is there a role for ARRS staff to be more involved e.g. Physio, OT, Health coaches etc

PCSP relates to any planned care setting and so clinicians who work in ARRS roles could apply the principles of PCSP (preparation, conversations, support for self-management including goal setting and action planning) into their routine work. We are happy to offer bespoke training and development programmes.

In terms of this specific example of routine use of PCSP for people with multiple LTCs this depends on the particular ARRS roles in the practice, and how involved and trained they are in long-term conditions care. We note that pharmacists sometimes support this process and with extra training sometimes do the PCSP reviews, particularly where the patient expresses concerns about polypharmacy. Our proactive care programme with focuses on frailty and function has OTs who work with frailty nurses doing the PCSP reviews.

In general, however we note that AHPS and ARRS professionals generally take really meaningful referrals from this process where people have worked through their issues and have actively identified with the clinician what might work well for them, such as access to community activities via a social prescriber or health coach. Care coordinators are often involved in administering the processing and acting as a single point of contact for patients between appointments. This varies as different practices have different provision around ARRS roles.

It's important to remember that there is a lot of clinical content covered within the long-term condition reviews and so whomever does this will need to extend their skill set and be confident in a range of issues such as clinical guidance, interpreting tests, medicines, lifestyle, mental health, contraception, falls, social issues etc.