Year of Care Partnerships®

Fidelity Toolkit

A supporting guide for teams and practitioners

Year of Care Partnerships
8-24-2022

Purpose of this toolkit

Implementing personalised care and support planning (PCSP) involves changing the way routine care for people with long-term conditions (LTCs) is provided. This involves adapting care processes to enable a 'better conversation'.

This toolkit sets out to help explore issues around fidelity to PCSP in terms of both systems and approaches.

For many, working in this way may require a shift in the **systems and processes** in your practice, your views about your consultations with patients, including the **role and purpose of the consultation** and the language you might employ.

This means we need to consider 'fidelity' across a number of areas including:

- The implementation of the process
- Tools and resources to support 'preparation'
- The PCSP conversation

Ideally this toolkit can be used as a reflective process within your practice team as you start to implement PCSP, or periodically it could be used to revisit the foundations of Year of Care and reflect upon how you are doing, potentially being used for reflective learning/learning sets.

This toolkit complements the ***YOC Quality Mark*** and signposts to other tools which can measure, explore and sustain the quality of PCSP delivery.

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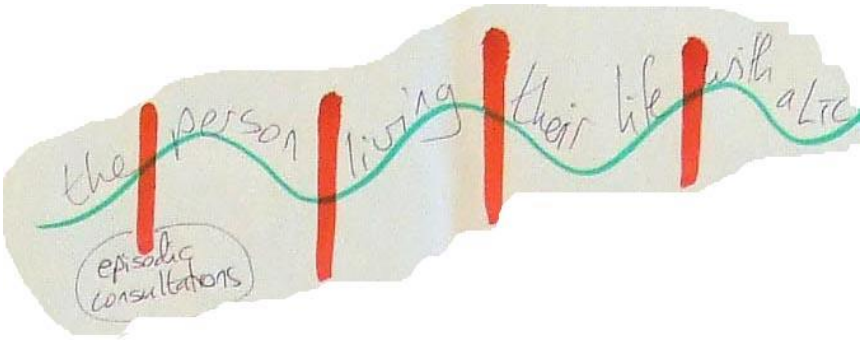
The Year of Care Programme

The Year of Care programme is about providing high quality care for people with long-term conditions through the routine and systematic introduction of personalised care and support planning (PCSP).



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 healthcare practitioner (orange bars in the figure above). The YOC programme seeks to transform this brief contact into a meaningful and useful discussion via systematic PCSP and enable links with activities in a supportive community

PCSP in many conditions such as diabetes and cardiovascular disease has transformed the annual review or routine assessment, which has traditionally often just ticked off the tests that have been done, into a useful dialogue between the healthcare professional and the person with a chronic condition. It involves organisational change to allow systems to develop which maximise the opportunity for people to be involved in making decisions and managing their own condition. It is also a huge cultural change for patients and healthcare professionals alike, involving a shift in philosophy of care and a change in attitudes for both parties to embrace a partnership approach to care.

There is a clear distinction to be made between personalised care and support planning and a care plan. Care plans are the pieces of paper or documentation; personalised care and support planning is what occurs in the consultation and is informed by the theoretical concepts and literature around patient-centred care, enablement and health behaviour change models.

This toolkit sets out to help you to meet the challenge of ensuring PCSP is delivered in a style and according to a philosophy that supports the individual to be in the driving seat of their care.

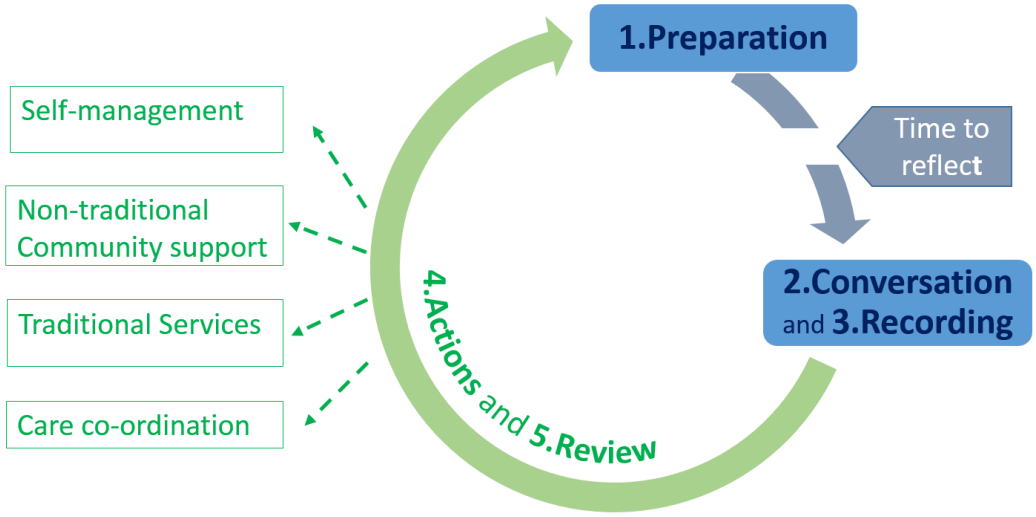
Please use the link below to the Year of Care website to access supplementary materials – www.yearofcare.co.uk.

An overview of personalised care and support planning

Personalised care and support planning (PCSP) 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. PCSP 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 PCSP 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**.



Delivery principles

By changing care processes PCSP provides an opportunity for a good quality conversation, informed by preparation for the person and professional. Practitioners taking part in PCSP conversations should have appropriate training. The PCSP conversation (how the care plan is developed) is a prerequisite for an effective care plan which cannot be produced without it.

The context, place, workforce and responsibility for PCSP for each group of people should be identified in the local care pathway and 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. PCSP does not happen by chance and should therefore be planned to become routine care for people with LTCs.

The personalised care and support planning process

The personalised care and support planning process – fidelity principles and checklist

In order to be consistent with the Year of Care approach to PCSP attention to certain aspects of care delivery are important. This checklist highlights important core elements of fidelity in terms of quality and consistency to PCSP processes and should be used alongside the ***Quality Mark*** tool.

The Year of Care approach to PCSP always ensures:

- Teams receive appropriate **training** and deliver care which has an underpinning philosophy that values and acknowledges the role of the individual in managing their health and their life.
- PCSP is **planned and designed into routine care pathways**

Areas	Checklist	✓
Preparation	Tests, tasks and assessments are separated in time from the PCSP conversation	
	Information (agenda setting prompts/routine results and assessments) are shared at least a week before the PCSP conversation	
	The information and letters that people receive are of good quality and take into account health literacy issues ***(see next section of guide)***	
	There is an opportunity for the patient to reflect on information and prepare by identifying any issues they want to discuss	
Conversation and recording	There is an underpinning philosophy which values and acknowledges the role of the individual in managing their health and their life	
	The conversation acknowledges the expertise and assets of the person and treats them as an equal	
	The discussion includes the person's and professional's agenda	
	Goals and actions and the plan, where appropriate, are based on the person's priorities	
	The focus is on planning care rather than checking or monitoring	
	Production of a plan isn't seen as the entire focus of the conversation (it is a by-product of the conversation)	
Actions and Review	Decisions about referrals, options or care packages are made as a result of the PCSP conversations wherever possible	
	A whole host of support is offered and not all support is delivered in follow up reviews by practitioners	

Monitoring the personalised care and support planning process

The implementation of PCSP can be enhanced by team members meeting and reviewing the process on a regular basis, including looking at process data, and patient/professional feedback.

One element to monitor and review is the proportion of people on your LTCs register who receive the key processes involved in PCSP. SNOMED codes can be used to monitor activity across a number of indicators in the PCSP processes. Whist this is limited in terms of knowing its quality, it does provide useful information around process.

Suggested SNOMED codes (check with your local area in case other codes are being used)

Definition	**SNOMED CT Concept ID**
Information gathering appointment	311791003
Chronic disease initial assessment (as an alternative to above code)	170557005
Long-Term Conditions Summary sent to patient (i.e. information sharing)	862701000000104
Personalised care and support plan agreed (finding)	1187911000000105
Personalised care and support planning declined (situation)	132571000000103
Review of personalised care and support plan	1187921000000104
Referral to social prescribing	871731000000106
Referral to social prescribing declined	871711000000103

Questions to think about

- How comprehensively are we offering PCSP (what proportion of our register are offered this approach) and what other groups could benefit from the approach e.g. people with frailty?
- How robust is our process and how can it be improved?
- What proportion of people attend the first but not the second appointment?
- How does this change over time and what are the implications for how we work?

Tools and resources for preparation

Guidance on information sharing tools

Information sharing is a key step in the PCSP process and the quality of the materials used is important as it can 'make or break' the process. Things to consider include how useful it is, how easy it is to understand and how much the words or language engenders a partnership approach. This section of the toolkit contains a checklist of things to consider when drafting tools and a reflective activity on the words used in written material and how that supports or gets in the way of a partnership approach

Information sharing tools

Year of Care has developed a selection of information sharing tools and resources to inform people about the PCSP process and to prepare them for a PCSP conversation. These have been developed with people with long-term conditions and are available in our ***Practice Pack*.**

They are designed based on the following principles:

- **Keep them short in length and structured** so people can easily see their information with short explanations. Where results are included compare these to usual or ideal levels.

- **Include an agenda setting prompt** and a space for the person to write down important issues or questions so that their agenda is included and the focus isn't entirely on biomedical results.

- **Share routine information that is useful to people** (a good rule of thumb is: send results out that people can influence e.g. HbA1c or those which are likely to help them understand the status of their health e.g. foot screening). Don't send information people have themselves; e.g. alcohol and activity.

- Consider the use of **colour coding** to help people interpret results and information.

- **Develop information with patients and practitioners** (this has been done with all YOC material).

- **Use 'Plain English' principles**
    - Use lists of issues
    - Keep your sentences short with one idea per sentence (15-20 words max)
    - Where technical terms are used include an explanation
    - Use active verbs i.e. 'think about your results'
    - Use everyday simple words as much as possible e.g. instead of 'additional' use 'extra'

You may wish to review the letters you send patients, information on your website and the information sharing letters you are using in the practice.

Activity 1 – Mind Your Language! - written materials and statements

Below is a list of 22 statements. These words have been taken from material *currently* available to people with long-term conditions, in use either to support PCSP or as general information about disease management.

You are asked to review these and discuss them with your teams and people with long-term conditions. Consider whether the statements support a partnership approach, might actively undermine this, are neutral or may be a combination of all three?

There are often no right or wrong answers to this, although some do not support individual choices or a partnership approach.

Statement	**Supports Partnership** ✓	**Neutral** ✓	**Undermines Partnership** ✓	**Comments**
Please follow the advice given and look after yourself				
Systolic blood pressure is the highest pressure, when the beats or contractions of the heart force blood around the body				
What aspects of your health would you like to discuss?				
Your HbA1c is an overall measure of glucose control over the last 8-10 weeks. A level of 48–53mmol/mol is associated with the lowest risk of complications				
To help you make decisions it is important that you are prepared for the consultation and have the same information that your doctor, nurse or dietician has access to				
Goal achieved (signed by my health care professional)				
Our aim is to control your COPD and keep you as healthy as possible				
We want to empower you to look after your health as well as possible				

Statement	Supports Partnership ✓	Neutral ✓	Undermines Partnership ✓	Comments
Your nurse, doctor and other members of the practice team are there to advise and help you live with your long-term conditions. However YOU are the most important member of your health team				
It's not just your attendance at the surgery or hospital that makes a difference to your heart disease. It is actually following advice that makes a difference. Be honest and discuss difficulties you face in your healthcare with the carers				
Whatever treatment they recommend you will most likely be able to cope with it. There is a team of healthcare professionals looking after you and your diabetes				
What important things have happened to you since your last appointment?				
During your check you will be able to talk about what is important to you and explore what might be available to help you manage and cope with your health issues				
The team will: • review information about you and assess the care that you need • make sure you receive the services that are most appropriate for you • coordinate and plan a programme of care that is tailored to meet your needs.				
Once we have your results, we will share them with you				

Statement	Supports Partnership ✓	Neutral ✓	Undermines Partnership ✓	Comments
Monitoring your own blood pressure can help make you feel more in charge of your care				
HbA1c is a blood test which tells us how your blood sugar has been controlled over the last 2-3 months. For good control we recommend the HbA1c to be below 53mmol/mol				
You need to see the dietician at least once a year. There is no point going to see the dietician if you do not follow advice given				
Keeping your diabetes under control can reduce your risk of developing health problems, but it is not always easy to manage without help				
It is very important that you fill out the health check forms and bring them along to this appointment				
If you have any symptoms that cause you concern or you need any advice please talk to your GP or practice nurse				
Your sugars are stable at the moment but we have agreed that we will continue to keep a check on them				

Take the opportunity to reflect on your answers either on your own or with colleagues in your team. Consider the differences and reflect on what this might mean about your approach and philosophy towards personalised care and support planning and your thoughts about supporting self-management.

You may also wish to look back and reflect upon things you have written, such as information sheets or clinic letters, or on the things you say in consultations.

Mind Your Language! - reflections and ideas - written materials

There are a number of ways in which a patient can pick up cues to your empathy, enablement and partnership approach in PCSP conversation. This not only includes non-verbal cues such as body language and positioning, but also the words you say and the way you say them.

However, when these words are written down they become more 'black and white' and some of the intonation of how they are said, which might sometimes soften them, are removed. Here are some reflections on some of the statements and the Year of Care perspective on them. Ultimately some words and phrases will feel more comfortable for some of us than others. Some examples of the statements and where our team felt they were are below:

Collaborative approach?	***Statement from the section above***	***Comments and ideas***
Supports partnership	*What important things have happened to you since your last appointment?* *During your check you will be able to talk about what is important to you and explore what might be available to help you manage and cope with your health* *Monitoring your own blood pressure can help make you feel more in charge of your care*	In general these statements show interest in the person's agenda and life and acknowledge the role of the individual in managing their own health, including the importance of having a sense of control – none of these are perfect!
Neutral	*Your HbA1c is an overall measure of glucose control over the last 8-10 weeks. A level of 48–53mmol/mol is associated with the lowest risk of complications* *If you have any symptoms that cause you concern or you need any advice please talk to your GP or practice nurse*	These statements are factual and for information only.
Undermines partnership	*Goal achieved (signed by my healthcare professional)* *Our aim is to control your COPD and keep you as healthy as possible*	One of these statements infers a performance management approach to PCSP with the authoritative stamp of the healthcare professional. The other infers it's the professional role to manage someone's health.

It is important that written material you use in your clinic also reflects the ethos and philosophy of the PCSP processes.

Personalised care and support planning conversations

Personalised care and support planning conversations

This section of the toolkit focuses on the personalised care and support planning (PCSP) conversation. It is made up of a set of reflective activities and self-reflection checklists to use after your consultations to help you to think about your training needs. It also suggests objective measures you could use to gain feedback from colleagues or patients.

Activities

- Activity 2 - Mind Your Language - what's my role within a PCSP conversation? (A tool for practitioners to explore the philosophy, role and attributes of the consultation)
- Activity 3 – Reflecting on a PCSP conversation
- Activity 4 - PCSP consultations - Core Skills
- Measuring the impact of PCSP conversations

Evaluation and Patient measures

The **Year of Care evaluation framework** is available and suggests a range of aspects/tools to use to evaluate PCSP. Tools such as the CARE measure allow you to assess the patient's perspective on the quality of the PCSP conversation. A separate ***briefing for qualitative researchers*** is also available.

Now over to you...

One of the most significant challenges is that, whilst most healthcare professionals will aspire towards person-centred care and supporting self-management, they may not have received much or any feedback about their ability to do this. If you don't know how you are doing, it is hard to ensure you are improving.

Within this toolkit is a series of exercises to help you understand your approach and assess you skills.

Each exercise can be used in isolation, but it is anticipated that the greatest insights and benefits will be achieved when they are used and considered together over time. Furthermore, repeating these exercises from time to time can help ensure you are making the improvements you had hoped for.

Activity 2 - Mind Your Language - what's my role within a personalised care and support planning conversation? (A tool for practitioners)

When we start to consider personalised care and support planning (PCSP) conversations, it is worth spending a little time reflecting on your role as the health care professional within that consultation. This tool will allow you to think through the ***ethos*** of a PCSP consultation, and your ***role***, and consider what difference this then makes to your ***behaviours and communication*** during the consultation.

Please use the reflective tool to consider each of these areas within a PCSP consultation

The ethos or philosophy of personalised care and support planning consultations

How much do you agree or disagree with the following statements?

The person with a long-term condition is in charge of their own life and managing their condition(s)

Strongly disagree — Strongly agree

1 2 3 4 5 6 7 8 9 10

The person with a long-term condition and the health care professional are equals, and experts.

Strongly disagree — Strongly agree

1 2 3 4 5 6 7 8 9 10

The person with a long-term condition is the main decision-maker in terms of how they live with, and manage, their condition(s).

Strongly disagree — Strongly agree

1 2 3 4 5 6 7 8 9 10

Reflections – what does this mean for me?

My role in a personalised care and support planning consultation

How much do you agree or disagree with the following statements?

My role is about coming up with solutions to the person's problems

Strongly disagree Strongly agree

1 2 3 4 5 6 7 8 9 10

My role is to facilitate a discussion - we don't always come away with a goal and a clear plan

Strongly disagree Strongly agree

1 2 3 4 5 6 7 8 9 10

My role is about giving advice; it's up to people if they follow it

Strongly disagree Strongly agree

1 2 3 4 5 6 7 8 9 10

My role is to help people work out what matters to them and how they can live well with their condition/s

Strongly disagree Strongly agree

1 2 3 4 5 6 7 8 9 10

My role is to persuade people to make the right decisions to manage their health, even if they want to do something different

Strongly disagree Strongly agree

1 2 3 4 5 6 7 8 9 10

Reflections – what does this mean for me?

The attributes and style of a personalised care and support planning consultation

How much do you agree or disagree with the following statements?

It's important to show genuine interest in people – using specific consultation techniques alone won't be enough

Strongly disagree Strongly agree

1 2 3 4 5 6 7 8 9 10

Building relationships with people is key to personalised care and support planning: continuity and building rapport are essential

Strongly disagree Strongly agree

1 2 3 4 5 6 7 8 9 10

A non-judgmental approach is mostly achieved by the use of positive non-verbal's and this will make a difference to how the patient's relationship with the health care professional is maintained

Strongly disagree Strongly agree

1 2 3 4 5 6 7 8 9 10

It's useful and possible to challenge people

Strongly disagree Strongly agree

1 2 3 4 5 6 7 8 9 10

Reflections – what does this mean for me?

What is so important about how we communicate?

In both health and social care, communication is usually at the heart of the intervention or the treatment. It may even be the intervention or treatment itself. The relationship that is formed between the practitioner and client is essential to successful outcomes and this is shaped by our communication with that person - both verbal and non-verbal. Working in partnership with patients requires a number of organisational factors to be in place, but within the consultation it can only be delivered through the use of 'person-centred language' and positive non-verbal behaviours.

Ethos and philosophy

The language used within consultations is a key part of delivering person-centred care. The words and language you use reflect your values and philosophy.

If you have a long-term condition; the reality is that you live with it every day. Most of the day to day decisions and on-going management are down to you. People with long-term conditions gain experience from living with their condition, and ultimately know what will work for them. They bring this experience to the conversation, but can then benefit from the opportunity to talk things through and from a collaborative approach which brings in the technical expertise of the professional (personalised care and support planning).

Roles within a personalised care and support planning (PCSP) conversation

Traditionally the roles of health services are viewed as cure or care, with the healthcare professionals being the key 'actor' in a 'fix it' role. Long-term conditions are different - by definition they are incurable. Most of the care delivery in long-term conditions done by the patient and is self-management with or without support. This means that the role of the healthcare professional, who ultimately may only spend a few hours a year with a person, is about sharing technical ideas and expertise, allowing people to work out what solutions work for them and sometimes challenging ambivalence or health beliefs. Ultimately, individuals will only do things if they are important to them and if they have the support, abilities and skills to do so. A good PCSP conversation in itself can be therapeutic and may contribute to supporting people to live well with their condition.

The attributes and style of a PCSP conversation

PCSP conversations, use a style and core skills common to many consultation 'techniques' (open questions/reflections/positive non-verbal communication). However, this is enabled by a process of preparation, ensuring the person's agenda is at the centre, as well as providing an opportunity for the professional to facilitate a discussion which might challenge the individual's ideas. It is only possible to effectively challenge people in a trusting relationship with a high level of rapport and respect. Demonstrating empathy (genuine interest/understanding of a person's feelings) is also critical to enable change in behaviour and improved outcomes.

The Year of Care team have a number of tools you can use to consider the individual behaviours/competencies (of the healthcare professional) during a PCSP conversation **(including activity 4).** You may wish to use these tools to reflect and develop in your own consultations.

Activity 3 – Reflecting on a personalised care and support planning (PCSP) conversation

The checklist below has been developed to help you to structure your reflections following a consultation. This can be completed after any consultation but was specifically developed for PCSP consultations.

You could simply reflect on these questions shortly after a consultation. Ideally, you could audio or videotape your consultation and use this checklist whilst listening or watching it back. Alternatively, it could be used by a colleague sitting in and observing your consultation.

Please consider the statements below and circle how much you agree with each (0 - not at all; 5 - very much so). It would probably be best to use a separate sheet for each consultation and collate the results of several to then inform the next step in the exercise.

	Statement		**Agree (please circle)**					
1.	The person with a long-term condition talked more than I did		0	1	2	3	4	5
2.	We developed a good working alliance/rapport		0	1	2	3	4	5
3.	We developed a collaborative agreed agenda/focus for the consultation		0	1	2	3	4	5
4.	The person was exploring things for themselves, possibly thinking about some things for the first time or in a different way		0	1	2	3	4	5
5.	The person was taking the lead, making suggestions and asking me for information.		0	1	2	3	4	5
6.	We explored and discussed their results and assessments		0	1	2	3	4	5
7.	I asked the person for their permission before I raised my concerns/views/worries		0	1	2	3	4	5
8.	We identified a goal that was important to the patient and progressed through action planning		0	1	2	3	4	5
9.	The person had an opportunity to raise their concerns, worries and views		0	1	2	3	4	5
10.	When I asked, the person reported having more confidence in managing their condition by the end of the consultation		0	1	2	3	4	5

When you have completed the above checklist several times it may be that you begin to notice a pattern emerging of the areas that you feel are stronger and weaker in your PCSP consultations with people. These might help you identify areas for development.

You can also compare your self-assessments with some patient surveys to see whether there are any differences.

Identifying my skills and areas for development

After reviewing your reflections of your consultations please identify on a scale of 0 - 5 how confident you rate yourself regarding the following statements (a score of 0 indicating 'not confident at all' and 5 indicating 'very confident').

	Statement		**Confidence rating (please circle appropriate number)**					
1.	I can elicit the person's views and feelings about their condition		0	1	2	3	4	5
2.	I can elicit the person's knowledge and beliefs about their condition		0	1	2	3	4	5
3.	I can develop a collaborative and agreed agenda with a patient		0	1	2	3	4	5
4.	I can provide emotional support to a person with a long-term condition		0	1	2	3	4	5
5.	I can elicit the person's own personal goals for self-management		0	1	2	3	4	5
6.	I know the steps in helping support someone to identify personally important goals and to develop an action plan, and I can manage it in practice		0	1	2	3	4	5
7.	I can assess through discussion the person's emotional and psychological needs in relation to their condition		0	1	2	3	4	5
8.	I can tell when I am starting to try to persuade the person to do what I think is right for them.		0	1	2	3	4	5
9.	I can check with the person how they feel our conversation is going.		0	1	2	3	4	5
10.	I am comfortable with the person taking the lead in the consultation and managing an equal power dynamic		0	1	2	3	4	5
11.	I know when I have developed a good rapport with someone and we working well together.		0	1	2	3	4	5
12.	I am able to express my concerns and challenge people in a manner that preserves our rapport and is not lecturing or telling		0	1	2	3	4	5
13.	I can elicit the person beliefs, values and goals in life i.e. what is important to them		0	1	2	3	4	5

Activity 4 - Personalised care and support planning (PCSP) consultations - core skills

I feel confident to… **Confidence Score**

Core communication skills	**Low 1**	**2**	**3**	**4**	**High 5**
Explain the concept and philosophy of a PCSP consultation					
Establish a collaborative relationship with the person					
Elicit thoughts, ideas and health beliefs from individuals					
Give clear, jargon free explanations which will include challenging misconceptions					
Ensure information provision is timely and appropriate and doesn't interrupt the consultation dialogue					
Support a patient to funnel and sift through information and make decisions which are right for them					
Use open questions to explore issues and elicit ideas					
Use active listening skills, reflections and summarising					
Take corrective action if I begin to try to persuade the person to do what I think is right for them					
Express my concerns and challenge people without telling/lecturing					
Recognise when formal goal setting and action planning might not be appropriate					
Setting up a PCSP consultation					
I have a clear understanding of the purpose of PCSP and the overall structure of the consultation and how it differs from usual care					
I feel confident to set the scene with a patient about the overall PCSP consultation					
Sharing stories					
Elicit a person's thoughts and beliefs about their health condition					
Ensure the key medical issues are discussed clearly, including creating a common understanding of results, targets, risks and potential treatment options					
Ensure all the person's issues and concerns, as well as my own, are identified					

Exploring and discussing					
Ensure any important concerns are explored and discussed as fully as possible					
Gain a common understanding of the priorities from both professional and individuals perspectives					
Support the individual to prioritise a person-centred goal					
Goal setting					
Support the person to identify personally important goals					
Ensure the goals are specific, measurable and have a review date					
Ensure the goal has been assessed in terms of its importance and relevance to the individual					
Action planning					
Support the individual to generate and arrive at their own solutions					
Explore self - efficacy (confidence), barriers and support mechanisms					
Use my knowledge of community based support (more than medicine) to signpost to support					
Ensure where appropriate contingency planning is included in the plan					
Set a plan for self- monitoring, self- assessment or review					
Ensure a recorded plan which details the specific actions and behaviours which are agreed and set by the individual					
Review					
I feel confident about including a range of follow up options other than repeat face to face visits behaviours					
I feel able to review a care plan, building on successes and reviewing relapse, ambivalence and maintenance of behaviour					

Measuring the impact of personalised care and support planning conversations

The **Year of Care evaluation framework** is available and suggests a range of aspects/tools to use to evaluate personalised care and support planning (PCSP) however most of these tools were not designed to specifically assess this.

Tools which can be used to gain feedback on the PCSP conversation include (minimum of 30 per clinician):

1. Patient Enablement Index
2. CARE measure (Stewart Mercer)
3. A tool called CQI which combines these tools with a specific long-term condition questionnaire (available from YOC)
4. In addition, you could add some specific questions about the PCSP process, including preparation, to this tool – see below

1 - Patient Enablement Index

As a result of your consultation today, do you feel you are…?
(please tick one box in each row)

		Much better	Better	Same or less	Not applicable
a	**Able to cope with life…**	☐	☐	☐	☐
b	**Able to understand your condition(s)…**	☐	☐	☐	☐
c	**Able to cope with your condition…**	☐	☐	☐	☐
d	**Able to keep yourself healthy…**				
		Much more	**More**	**Same or less**	**Not applicable**
e	**Confident about your health…**	☐	☐	☐	☐
f	**Able to help yourself…**	☐	☐	☐	☐

2 - CARE measure

Please rate the following statements about today's consultation
Please tick one box for each statement and answer every statement

	How was the person you saw at…?	Poor	Fair	Good	Very Good	Excellent	N/A
a	**Making you feel at ease…** *(being friendly and warm towards you, treating you with respect; not cold or abrupt)*	☐	☐	☐	☐	☐	☐
b	**Letting you tell your 'story'…** *(giving you time to fully describe your illness in your own words; not interrupting or diverting you)*	☐	☐	☐	☐	☐	☐
c	**Really listening…** *(paying close attention to what you were saying; not looking at the notes or computer as you were talking)*	☐	☐	☐	☐	☐	☐
d	**Being interested in you as a whole person…** *(asking/knowing relevant details about your life, your situation; not treating you as 'just a number')*	☐	☐	☐	☐	☐	☐
e	**Fully understanding your concerns…** *(communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything)*	☐	☐	☐	☐	☐	☐
f	**Showing care and compassion…** *(seeming genuinely concerned, connecting with you on a human level; not being indifferent or 'detached')*	☐	☐	☐	☐	☐	☐
g	**Being positive…** *(having a positive approach and a positive attitude; being honest but not negative about your problems)*	☐	☐	☐	☐	☐	☐
h	**Explaining things clearly…** *(fully answering your questions, explaining clearly, giving you adequate information; not being vague)*	☐	☐	☐	☐	☐	☐
i	**Helping you to take control**… *(exploring with you what you can do to improve your health yourself; encouraging rather than 'lecturing' you)*	☐	☐	☐	☐	☐	☐
j	**Making a plan of action with you…** *(discussing the options, involving you in decisions as much as you want to be involved; not ignoring your views)*	☐	☐	☐	☐	☐	☐

4 - Additional questions

Do you remember getting a letter asking you to think about your health (including your test results) before you talked with your nurse or doctor?

Yes ☐

No ☐

How useful was this letter in helping you to prepare for the care planning conversation?

Not at all useful ☐

Not very useful ☐

Somewhat useful ☐

Very useful ☐

Did not read ☐

During your care planning conversation today, did you discuss services and supports based in your local community (for example, support groups, or patient organisations)?

Yes ☐

No ☐

If yes, how useful was this for you?

Not at all useful ☐

Not very useful ☐

Somewhat useful ☐

Very useful ☐