Guidance for the Year of Care process and IT template design

Multiple LTCs and frailty

Year of Care Partnerships® is an NHS organisation committed to supporting practitioners to implement personalised care and support planning for people living with long term conditions as routine care, predominantly within the GP practice and primary care setting[1].

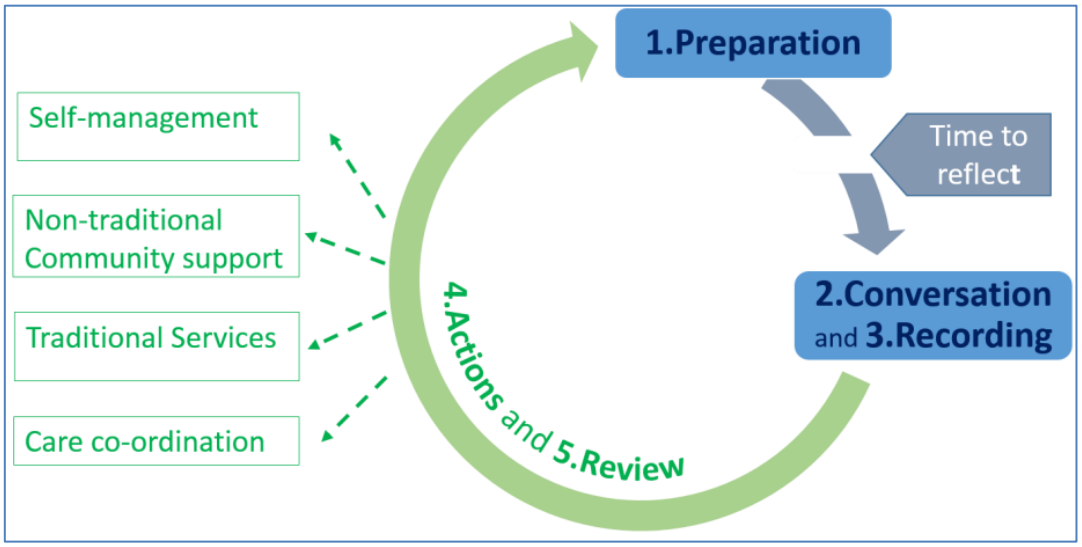
Year of Care pioneered the development and introduction of personalised care and support planning (PCSP). This is a systematic approach designed to deliver more productive conversations (consultations) with healthcare professionals, focussed on what is important to each individual, enabled by preparation.

Our hope is that PCSP becomes the usual approach to routine planned care, being understood as a continuous process rather than one off event, supporting continuity and planning to meet the changing needs of people as they age and progress from living with single to many long term conditions.

Personalised care and support planning – what is it and how does it work?

The essential components of personalised care and support planning are show in Figure 1 below.

Figure 1 – The personalised care and support planning process



Personalised care and support planning - developing a different approach to routine consultations for 'people not conditions'

Personalised care and support planning (PCSP) is a systematic approach to transforming the routine delivery of planned care in general practice (and other healthcare settings) for people living with long term conditions.

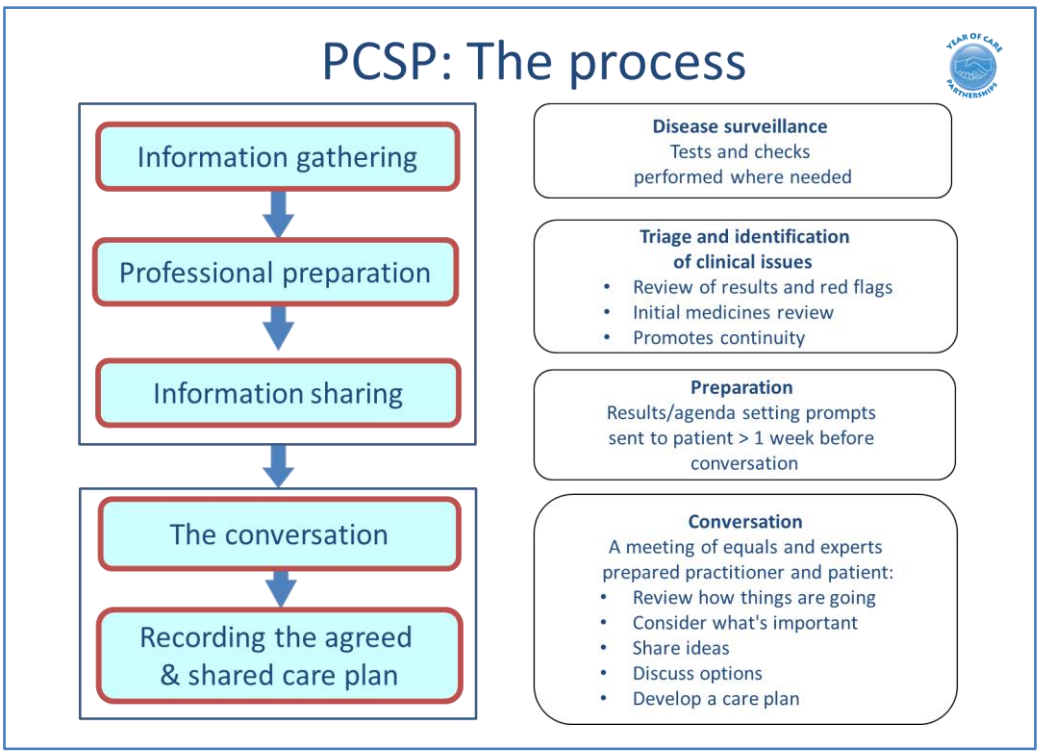
It moves away from a 'tick box approach' promoted by the Quality and Outcomes Framework with its biomedical emphasis, to an approach that recognises what is important to a person based on the reality of their lives.

PCSP brings together the technical clinical expertise of the health care practitioner with the lived experience of the individual into a single PCSP process and 'conversation' (no matter how many conditions the person lives with). They coproduce solutions resulting in improved experience and quality of life.

Figure 2 demonstrates the routine way this works in a primary care setting.

[1] https://www.yearofcare.co.uk/

Figure 2 – Personalised care and support planning in primary care



A better conversation is enabled by changes to the ethos and philosophy of practice, skills development and practice/team infrastructure including the length and structure of appointments.

A key component is preparation using reflective prompts for the person and the sharing of personal information including test results by the practice ahead of time. This process actively welcomes and values the person's ideas, recognises their resourcefulness and enables solutions to be coproduced.

How IT supports the personalised care and support planning (PCSP) process

IT templates that support the PCSP process and easily direct the professional to their part seem to be a key enabler for practices to implement the approach. This document lays out the functional requirements of practice IT systems to deliver the Year of Care approach to PCSP.

The key components of IT resources to support each stage of the PCSP process include the elements outlined below (see the page references for further details).

Stage 1 (page 3)

A single **recall system** for individuals, which identifies and combines the recall for all of their LTCs (often running recall in birth month). Practices will begin by running searches in their IT system for people with the LTCs they have chosen to include in PCSP.

Stage 2 (page 4)

An **information gathering** template for the healthcare assistant, which identifies the conditions the person has, the tests which need to be performed, and is laid out in an order and format which makes it easy to navigate during the information gathering appointment.

Stage 3 (page 8)

Professional preparation including medicines review and triage – blood test results from laboratories are sent to a dedicated inbox and reviewed by a GP or nurse practitioner ahead of being sent to the patient. They include information fed in from pharmacist reviews of medicines and identify any prescribing issues. The template for the professional preparation ideally highlights "red flags" and abnormal findings identified during the information gathering consultation. The clinician undertaking the professional preparation stage records notes about important

points for discussion, drawing on all the sources of information (HCA appointment, pharmacist review, red flags) and these notes will be made available in the template for the professional at the PCSP conversation. The most appropriate person for the PCSP conversation is identified at this stage with a view to ensuring the patient sees the most appropriate clinician, creating relational continuity and identifying appointment length.

Stage 4 (page 8)

Preparation materials (Year of Care preparation prompts) have data from the information gathering template and blood test results from laboratories merged onto them, together with questions to prompt the person to think about what's most important to them, and they are sent to the patient before their next appointment.

Stage 5 (page 11)

PCSP Conversation – A template that shows relevant clinical information from the information gathering and professional preparation steps. It allows the clinician to **record the plan** and all the clinical issues covered.

Details for each stage of the PCSP process

Stage 1 - A single **recall system** for individuals which identifies and combines the recall for all of their LTCs (often running recall in birth month)

Recall and appointments

Practices can implement personalised care and support planning using existing recall systems for single conditions; however many now choose to implement the process alongside a move to a multiple long-term conditions approach and to move this to birth month recall.

Practices need to consider which conditions they are going to recall and which conditions they will include in the PCSP process which may not be the same. For example, if a practice chooses to start PCSP for people living with diabetes, CVD and respiratory conditions they need to decide if they will include any of the other conditions the patient lives with as part of that review including both QoF or non-QoF conditions *(example below).*

Recall conditions	**Other conditions reviewed as part of PCSP for those on recall lists**
Diabetes CVD Respiratory conditions	Epilepsy Gout Thyroid Rheumatoid arthritis

Inviting patients to appointments

People will generally need an information gathering appointment (usually with a HCA) followed by a PCSP conversation appointment a few weeks later.

As a guide we allow 20 minutes for each information gathering appointment and add 10 minutes for foot screening (for diabetes). You may need to add 5 minutes for people living with frailty.

There are some single conditions that do not need an information gathering appointment. See Appendix 1 'Flowchart for Appointment Structure'.

The PCSP conversation appointment is held a few weeks later usually with a nurse or GP - this will be determined by the skill mix of the clinician and complexity of the patient. This appointment is usually a minimum of 20 minutes for people with single conditions and 30 minutes for multiple conditions, unless there are issues with complexity or communication which may necessitate a longer appointment (up to 40 mins).

Practices will need to decide how they want to identify, book and organise these appointments.

Stage 2 - An **information gathering** template for the healthcare assistant which identifies the conditions the person has, the tests which need to be performed, and is laid out in an order and format which makes it easy to navigate during the appointment.

The information gathering appointment is usually completed by a healthcare assistant (HCA) and has 2 key functions:

1. gathering all of the clinical measurements and collecting many of the QOF requirements
2. signposts the person through the PCSP process so they understand what happens next and how it is different from usual care

An IT template for this appointment should gather information in one place and be easy to navigate.

Essential components

- a prompt for the HCA to describe the process and what happens next
- a list of the conditions the person has and any general relevant alerts
- data entry fields for all the information that needs to be collected for the conditions the person lives with, including identifying any 'red flags' that need immediate attention (need to be decided by clinical teams)
- template should be 'intelligent' so that information is not duplicated across conditions and only displays tests and assessments associated with the conditions the person lives with
- identifies/analyses bloods needed for the conditions/drugs that the person has/is taking (and if possible links to blood forms which prepopulate with the tests needed for those conditions)
- prepopulates information that has recently been collected to avoid duplication of tasks (need to define recent-suggest last 2-3 months)
- SNOMED codes correspond to the smart tags in preparation prompts to be sent to patients for easy data merging (see Appendix 2)
- includes a method for the HCA to record any concerns the patient has already raised
- automatically records via SNOMED codes that the process/appointment has been completed for audit/monitoring purposes (see Appendix 2)
- enable recording of patient preferences about how they receive the preparation materials (If there are options such as email/post/collect from practice) and a prompt to check address/email/mobile
- enable recording of patient preferences for mode of PCSP conversation (video/telephone/face to face)
- include prompts to ask questions about carers, need for translator etc.

Desirable components

- the option to print off linked leaflets/prompt for HCA to give if the patient answers positively to a particular question e.g. falls, low mood

The table overleaf lays out the fields required for the conditions that need an information gathering appointment (these should be checked against local guidance and updated according to national and local incentive schemes).

We suggest that this might best be achieved by having a 'generic template' which covers the common tests across all conditions and then separate tabs for the additional tests for specific conditions.

General template: Always completed for : AF, CHD, HF,PAD, Stroke/TIA, DM, RA, hypertension/prevention, CKD, gout, thyroid, coeliac disease, severe mental health ,dementia, learning disabilities	**+ HF**	**+ AF**	**+ stroke/TIA**	**NAFL**	**+CKD**	**Diabetes**	**Respiratory**	**+ frailty**
Height/weight/BMI Blood pressure Pulse rate/pulse rhythm QRisk 2 or 3 (automated) (ASSIGN in Scotland) only for those without established CVD Smoking/Vaping Alcohol consumption Physical activity Flu vaccine (if required) Pneumococcal vaccine (if required) Shingles vaccine (if required) Depression screening Carer status Need for translator Blood tests see below	Exercise grading NYHA classification (swelling, fluid retention, breathing, tiredness) ECG for those with NYHA class III or IV	CHADS2 VASc HAS-BLED	CHADS2 VASc	FIB4 (or alternative)	ACR	Foot screening (circulation and sensation) Check completion of retinal screening ACR	Inhaler technique (optional) ***Asthma*** Peak flow Number of exacerbations ***COPD*** Oxygen sats CAT score MRC Inhaler technique Exacerbations/flare-ups (rescue pack) Hospital admissions Attended pulmonary rehab Is the patient on oxygen therapy?	eFI score indicates degree of frailty available for consultations (potential to verify here with CFS/Rockwood) Screening questions for falls (see page 8)

This information was correct at the time of the date stamp in the footer of this document- please review against local guidelines

	Blood tests needed – aim to link to lab requests that prepopulate for the HCA dependant on conditions									
	FBC	**U&E**	**Lipids**	**TFT**	**LFT**	**HbA1c**	**Bone Profile**	**PTH**	**B12/ Folate**	**Other**
T2 Diabetes Annual		✓	✓		✓	✓				
T1 Diabetes Annual		✓	✓			✓				
Hypertension		✓	✓			✓				
Stroke/TIA/IHD/ Angina/PVD/HF		✓	✓			✓				
CKD G3a		✓								
CKD G3b	✓	✓								
CKD G4/5 6m	✓	✓					✓	✓		
AF (on DOAC)	✓	✓	✓							
LD (Health Check)	*	*		*	*	*			*	
COPD	✓									
Hypothyroidism				✓						
Severe Mental Illness including Bipolar Affective Disorder			✓		✓	✓				
Severe Mental Illness on Antipsychotic Medication	✓	✓	✓		✓	✓				Prolactin-if symptomatic
Severe Mental Illness on Lithium		✓		✓			✓			Lithium Levels

This information was correct at the time of the date stamp in the footer of this document- please review against local guidelines

Depression screening

During the last few months have you been bothered by feeling down, depressed or hopeless?
During the last few months have you often had little interest or pleasure in doing things?
Positive answer can trigger the HCA to give out a preparation prompt for low mood.

Screening questions for those who score positively on the frailty score (mild/moderate/severe)

Consider how eFI scores will be clinically validated/updated.

Falls screening

In the last 12 months:

1. *Have you had a fall including a slip or trip?*
2. *Have you had a blackout or found yourself on the floor?*
3. *Have you noticed any problems with your balance (e.g. whilst walking, standing up from a chair or dressing?)*

If positive answer given, then ability to record lying and standing BP and trigger for HCA to give out a preparation prompt for falls.

Stage 3 - Professional preparation including medicines review and triage – this is an important step when implementing PCSP, but it is particularly important when including people with multiple LTCs in the process

This includes a range of activities tailored to the complexity of the patient and the skill mix of the clinical team. It includes:

- Blood test results from laboratories sent to a separate inbox and therefore managed separately from other results for PCSP patients to avoid unnecessary action being taken which disrupts the PCSP process
- The system automatically highlights red-flags on any tests that are out of ideal parameters
- A prescriber identifies any medicines management issues and records these for the PCSP consultation
- The clinician reviews the information gathered by the HCA, laboratory results, pharmacist medication review, other test results and red flags* and can make notes of actions to be taken at the PCSP consultation which are recorded into a single page that displays as the first part of the PCSP conversation
- The most appropriate person for the PCSP conversation is identified at this stage with a view to ensuring the patient sees the most appropriate clinician and creating relational continuity
- A note is sent to the admin team asking them to create and send the preparation prompt with mail merged results, and to offer a care and support planning conversation appointment (duration/clinician identified)

Stage 4 - Preparation materials are mail merged from the information gathering template and from blood test results from laboratories onto Year of Care preparation prompts and sent to the patient

This is usually completed by the administration team once the results have been returned from the labs and triaged by a clinician. The purpose of this part of the process is to:

- give permission to the patient to raise their concerns or questions
- share routine results and information with the patient

The letters are sent to the patient by their preferred method which can be:

- printed and sent in the post
- a link to a PDF file sent via email or text
- a text sent to the patient to access the PDF file in the NHS app

Year of Care letters include an agenda setting prompt, results from the tests performed at information gathering if appropriate for the conditions the person lives with and a care plan summary (see '*core composition of the letter'* table below). We also have a medicines review preparation prompt. Contact us for electronic versions or see secure area of Year of Care website (www.yearofcare.co.uk) sections 5 and 6.

The core composition of the letter includes:

1. Generic/agenda setting prompt (first page)	• A space for the patient to write what's important • Notice board of topics that they might wish to raise - frailty and multi-morbidity version
2. Routine results for the conditions the person lives with (middle pages)	• With explanation of results, recent and previous results • Black and white or colour/RAG rated • SNOMED codes for mail merge
3. Care plan for patient (final page)	• Same format for all patients

Essential components:

- the patient details need to be on the letter to ensure the right patient gets the right information (first page)
- the information gathering templates and codes/smart tags in the letter need to correspond so that the letter draws in the most recent information and auto populates with the most recent result with date and a previous result with date (middle pages)
- people with multiple long term conditions should receive one letter, which only draws in the results and associated explanations for the conditions they live with - results need to be grouped together when printed and be in at least a size 12 font
- the system automatically adds in the appropriate generic agenda setting prompt according to frailty score
- the smart tagged results letter offers a choice of words only (black and white letters) or RAG rated (colour letters)
- includes a separate standardised preparation prompt for prevention groups (health checks, hypertension, high risk of diabetes)
- offers the option to code the record when the preparation prompts have been sent out for audit/monitoring purposes

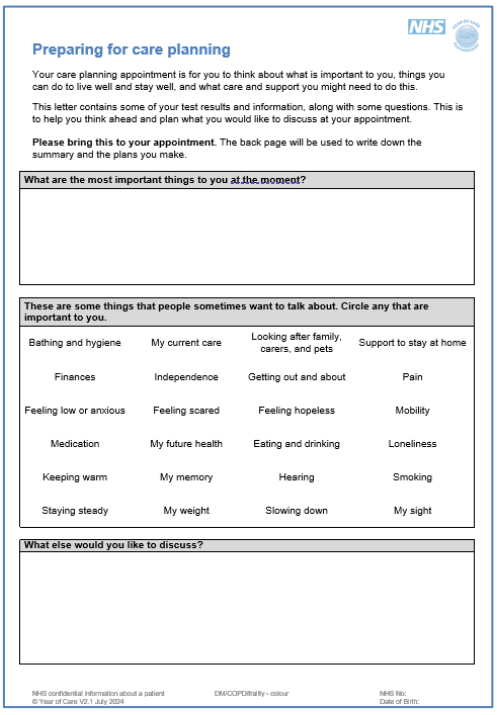
Desirable components:

- if possible, the result is listed against the correct RAG rating based on pre-set limits
- offers the potential to personalise results – e.g. text is altered to show individual target
- offers the potential to modify clinical targets in certain circumstances e.g. HbA1c targets modified for frailty

Building the component parts of the preparation materials – 3 key sections

1. Add the first page – generic prompt – depending on frailty score (moderate/severe)

Frailty generic prompt



Preparing for care planning

Your care planning appointment is for you to think about what is important to you, things you can do to live well and stay well, and what care and support you might need to do this.

This letter contains some of your test results and information, along with some questions. This is to help you think ahead and plan what you would like to discuss at your appointment.

Please bring this to your appointment. The back page will be used to write down the summary and the plans you make.

What are the most important things to you at the moment?

These are some things that people sometimes want to talk about. Circle any that are important to you.

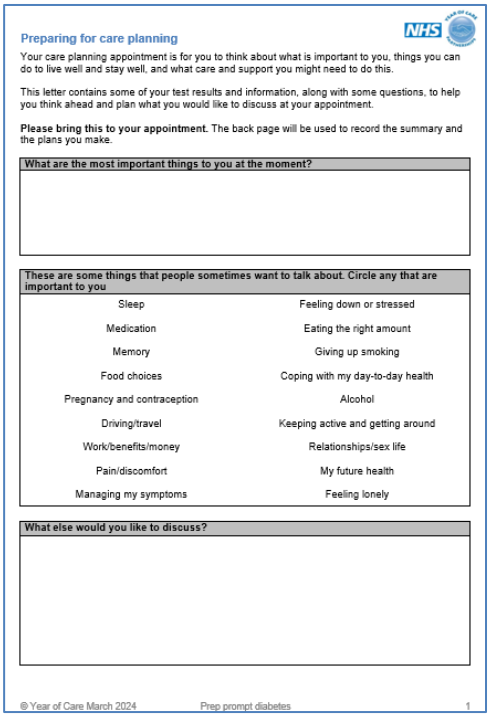
Bathing and hygiene	My current care	Looking after family, carers, and pets	Support to stay at home
Finances	Independence	Getting out and about	Pain
Feeling low or anxious	Feeling scared	Feeling hopeless	Mobility
Medication	My future health	Eating and drinking	Loneliness
Keeping warm	My memory	Hearing	Smoking
Staying steady	My weight	Slowing down	My sight

What else would you like to discuss?

NHS confidential information about a patient DM/COPD/frailty - colour NHS No:
© Year of Care V2.1 July 2024 Date of Birth:

Or

Multi-morbidity (or single condition) generic prompt



Preparing for care planning

Your care planning appointment is for you to think about what is important to you, things you can do to live well and stay well, and what care and support you might need to do this.

This letter contains some of your test results and information, along with some questions, to help you think ahead and plan what you would like to discuss at your appointment.

Please bring this to your appointment. The back page will be used to record the summary and the plans you make.

What are the most important things to you at the moment?

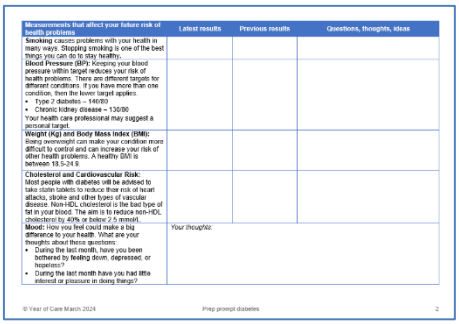
These are some things that people sometimes want to talk about. Circle any that are important to you

Sleep	Feeling down or stressed
Medication	Eating the right amount
Memory	Giving up smoking
Food choices	Coping with my day-to-day health
Pregnancy and contraception	Alcohol
Driving/travel	Keeping active and getting around
Work/benefits/money	Relationships/sex life
Pain/discomfort	My future health
Managing my symptoms	Feeling lonely

What else would you like to discuss?

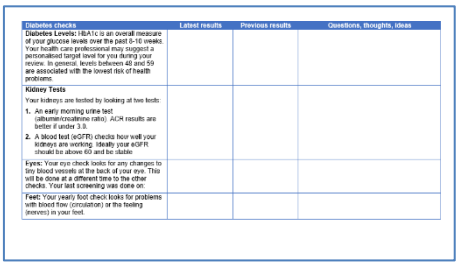
© Year of Care March 2024 Prep prompt diabetes 1

2. Choose a black and white *or* colour/RAG rated version of the letter with results into the middle section (only relevant results will show in the letter)

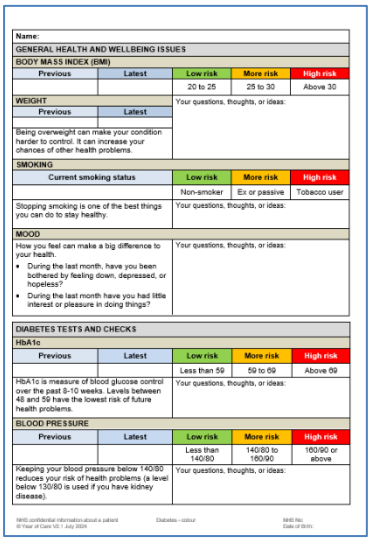


Measurements that affect your future risk of health problems	Latest results	Previous results	Questions, thoughts, ideas
Smoking causes problems with your health in many ways. Stopping smoking is one of the best things you can do to stay healthy.			
Blood Pressure (BP): Keeping your blood pressure within target reduces your risk of health problems. There are different targets for different conditions. If you have more than one condition, then the lower target applies. • Type 2 diabetes – 140/80 • Chronic kidney disease – 130/80 Your health care professional may suggest a personal target.			
Weight (Kg) and Body Mass Index (BMI): Being overweight can make your condition more difficult to control and can increase your risk of other health problems. A healthy BMI is between 18.5–24.9.			
Cholesterol and Cardiovascular Risk: Most people with diabetes will be advised to take statin tablets to reduce their risk of heart attacks, stroke and other types of vascular disease. Non-HDL cholesterol is the bad type of fat in your blood. The aim is to reduce non-HDL cholesterol by 40% or below 2.5 mmol/L.			
Mood: How you feel could make a big difference to your health. What are your thoughts about these questions: • During the last month, have you been bothered by feeling down, depressed, or hopeless? • During the last month have you had little interest or pleasure in doing things?	*Your thoughts:*		

© Year of Care March 2024 Prep prompt diabetes 2

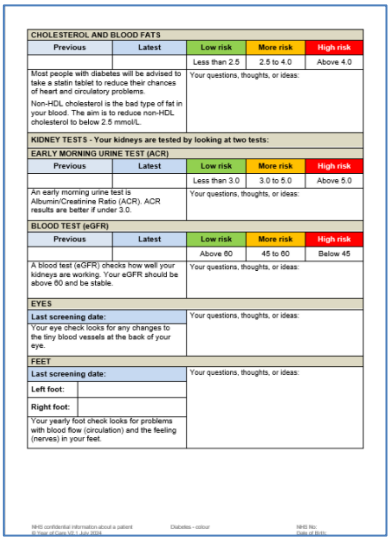


Diabetes checks	Latest results	Previous results	Questions, thoughts, ideas
Diabetes Levels: HbA1c is an overall measure of your glucose levels over the past 8-10 weeks. Your health care professional may suggest a personalised target level for you during your review. In general, levels between 48 and 59 are associated with the lowest risk of health problems.			
Kidney Tests Your kidneys are tested by looking at two tests: 1. An early morning urine test (albumin/creatinine ratio). ACR results are better if under 3.0. 2. A blood test (eGFR) checks how well your kidneys are working. Ideally your eGFR should be above 60 and be stable			
Eyes: Your eye check looks for any changes to tiny blood vessels at the back of your eye. This will be done at a different time to the other checks. Your last screening was done on:			
Feet: Your yearly foot check looks for problems with blood flow (circulation) or the feeling (nerves) in your feet.			



Name:				
GENERAL HEALTH AND WELLBEING ISSUES				
BODY MASS INDEX (BMI)				
Previous	Latest	Low risk	More risk	High risk
		20 to 25	25 to 30	Above 30
WEIGHT		Your questions, thoughts, or ideas:		
Previous	Latest			
Being overweight can make your condition harder to control. It can increase your chances of other health problems.				
SMOKING				
Current smoking status		Low risk	More risk	High risk
		Non-smoker	Ex or passive	Tobacco user
Stopping smoking is one of the best things you can do to stay healthy.		Your questions, thoughts, or ideas:		
MOOD				
How you feel can make a big difference to your health. • During the last month, have you been bothered by feeling down, depressed, or hopeless? • During the last month have you had little interest or pleasure in doing things?		Your questions, thoughts, or ideas:		
DIABETES TESTS AND CHECKS				
HbA1c				
Previous	Latest	Low risk	More risk	High risk
		Less than 59	59 to 69	Above 69
HBA1c is measure of blood glucose control over the past 8-10 weeks. Levels between 48 and 59 have the lowest risk of future health problems.		Your questions, thoughts, or ideas:		
BLOOD PRESSURE				
Previous	Latest	Low risk	More risk	High risk
		Less than 140/80	140/80 to 160/90	160/90 or above
Keeping your blood pressure below 140/80 reduces your risk of health problems (a level below 130/80 is used if you have kidney disease).		Your questions, thoughts, or ideas:		

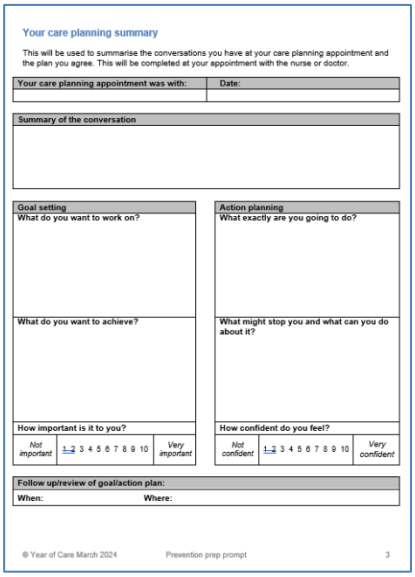
NHS confidential information about a patient © Year of Care V2.1 July 2024 Diabetes – colour NHS No: Date of Birth:



CHOLESTEROL AND BLOOD FATS				
Previous	Latest	Low risk	More risk	High risk
		Less than 2.5	2.5 to 4.0	Above 4.0
Most people with diabetes will be advised to take a statin tablet to reduce their chances of heart and circulatory problems. Non-HDL cholesterol is the bad type of fat in your blood. The aim is to reduce non-HDL cholesterol to below 2.5 mmol/L.		Your questions, thoughts, or ideas:		
KIDNEY TESTS - Your kidneys are tested by looking at two tests:				
EARLY MORNING URINE TEST (ACR)				
Previous	Latest	Low risk	More risk	High risk
		Less than 3.0	3.0 to 5.0	Above 5.0
An early morning urine test is Albumin/Creatinine Ratio (ACR). ACR results are better if under 3.0.		Your questions, thoughts, or ideas:		
BLOOD TEST (eGFR)				
Previous	Latest	Low risk	More risk	High risk
		Above 60	45 to 60	Below 45
A blood test (eGFR) checks how well your kidneys are working. Your eGFR should be above 60 and be stable.		Your questions, thoughts, or ideas:		
EYES				
Last screening date:		Your questions, thoughts, or ideas:		
Your eye check looks for any changes to the tiny blood vessels at the back of your eye.				
FEET				
Last screening date:		Your questions, thoughts, or ideas:		
Left foot:				
Right foot:				
Your yearly foot check looks for problems with blood flow (circulation) and the feeling (nerves) in your feet.				

NHS confidential information about a patient © Year of Care V2.1 July 2024 Diabetes – colour NHS No: Date of Birth:

3. Add the final page – care and support plan



Your care planning summary

This will be used to summarise the conversations you have at your care planning appointment and the plan you agree. This will be completed at your appointment with the nurse or doctor.

Your care planning appointment was with:	Date:

Summary of the conversation

Goal setting	Action planning
What do you want to work on?	**What exactly are you going to do?**
What do you want to achieve?	**What might stop you and what can you do about it?**

How important is it to you?			How confident do you feel?		
Not important	1 2 3 4 5 6 7 8 9 10	*Very important*	*Not confident*	1 2 3 4 5 6 7 8 9 10	*Very confident*

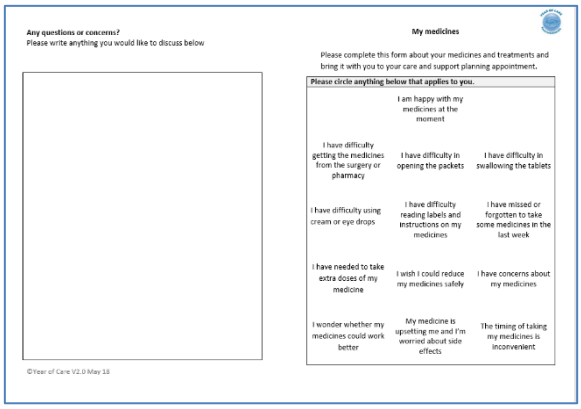
Follow up/review of goal/action plan:

When: **Where:**

© Year of Care March 2024 Prevention prep prompt 3

Medicines review preparation prompt

A medicines review preparation prompt is available and can be used in several ways across the process to support the person to identify issues around the medicines they take or/and polypharmacy. This would need to be smart tagged to draw in the patients details and drugs.



Any questions or concerns?
Please write anything you would like to discuss below.

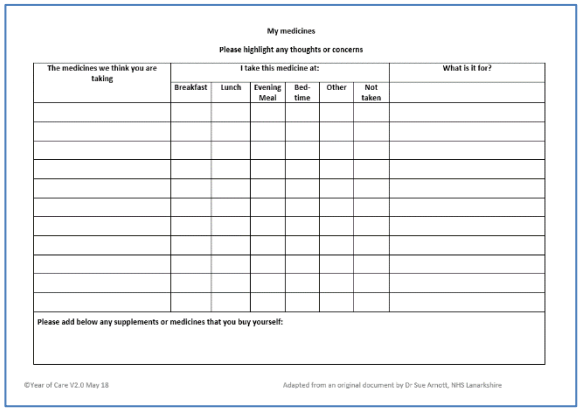
My medicines

Please complete this form about your medicines and treatments and bring it with you to your care and support planning appointment.

Please circle anything below that applies to you.

	I am happy with my medicines at the moment	
I have difficulty getting the medicines from the surgery or pharmacy	I have difficulty in opening the packets	I have difficulty in swallowing the tablets
I have difficulty using cream or eye drops	I have difficulty reading labels and instructions on my medicines	I have missed or forgotten to take some medicines in the last week
I have needed to take extra doses of my medicine	I wish I could reduce my medicines safely	I have concerns about my medicines
I wonder whether my medicines could work better	My medicine is upsetting me and I'm worried about side effects	The timing of taking my medicines is inconvenient

©Year of Care V2.0 May 18



My medicines

Please highlight any thoughts or concerns

The medicines we think you are taking	I take this medicine at:						What is it for?
	Breakfast	Lunch	Evening Meal	Bed-time	Other	Not taken	

Please add below any supplements or medicines that you buy yourself:

©Year of Care V2.0 May 18 Adapted from an original document by Dr Sue Arnott, NHS Lanarkshire

This could be shared with the patient prior to the medicines review by the pharmacist, prior to a PCSP consultation or if drugs are identified as a significant issue in the PCSP consultation and a more detailed face to face medicines review is deemed helpful.

Stage 5 - Conversation – shows relevant clinical information for the clinician and identifies any red flags in terms of 'medical musts'/'prescribing issues'. Allows the clinician to **record the plan** and all the clinical issues covered.

Local clinical teams will need to consider how they handle the clinical checklists that the clinician who performs the care planning review uses. Every effort should be made to move as much routine data collection away from the care and support planning review as possible to enhance the opportunity for a patient centred conversation. If an organisation is developing clinical templates consideration should be given so that they do not drive the PCSP consultation into a box ticking activity by having multiple fields on the template. Ideally it should flag and direct the clinician to the important medical musts.

Ideally the PCSP conversation (second) template should include the items in clusters below.

Section 1: For the professional to be prepared a section that displays all of the professional clinical issues identified earlier:

- A summary of the conditions the person has
- The notes from professional preparation to be visible with a place to bring forward any issues identified by triage/medication review/from the HCA/clinical red flags
- Any results or tests which are out of range (as professional issues – e.g. if depression screening is positive etc.)
- A link to the preparation prompt and results document the patient has been sent

Section 2: To summarise the conversation within the clinical record including:
What are the most important issues for the patient?

Summary of discussion

- Patient story
- Professional issues discussed

Section 3: The care plan: (this is the section that can either be printed off and given to the patient or allows the professional to record in the patient's words what they plan to do as a summary)

It is important that completing the 'plan' does not consume a high proportion of the consultation, in most instances it is merely a summary of the key decisions made and aide memoire for the patient.

Year of Care has a Word template available for this with headings that include:

- Date/who the plan was made with
- Goals (what do you want to work on/how important is the goal)
- Action plan (what exactly are you going to do/how confident do you feel)
- Plan for review

Section 4: For any SNOMED codes to be completed

- Disease review codes
- Local CQUINS or enhanced services (determined locally if needed)
- Link to and record the completion of medicines review, exemption report

Section 5: For the professional to record any topics discussed (and potential to link to referral forms)

Dropdown box/picklist across conditions including:

- Smoking cessation
- Physical activity
- Alcohol
- Substance misuse
- Nutrition
- Weight management
- Contraception
- Low mood
- Bereavement
- Driving
- Travel
- Erectile Dysfunction
- Pain
- Falls
- Mobility
- Sleep
- Activities of daily living
- Foot care
- Hearing
- Vision
- Social isolation
- Continence
- Memory/cognitive decline
- Exacerbation/sick day rules
- Work
- Benefits
- Free prescriptions
- Carers support
- Medication adherence

For patients with multimorbidity or polypharmacy, the following prompt questions would appear:

- When people are on lots of medicines, they sometimes forget to take them all, how often does this happen to you?
- Some people miss out a dose of their prescribed medications to adjust it to suit their own needs, how often do you do this?
- Are there any of your drugs that you don't take or don't like?
- Medication review completed

Suggestions about additional topics for disease specific reviews are available but need to be developed locally.

Appendix 1

PCSP appointments structure flowchart

Prevention: hypertension/ health checks	NAFLD/ high risk of diabetes	CHD and PAD/TIA Stroke/AF/ IHD and angina	Diabetes/ CKD	HF	MSK RA/Gout	Coeliac disease **	Thyroid disease **	Frailty	COPD	Mental health

Epilepsy **	Asthma	IBS **	MSK OA/OP & fragility **

Always require information gathering with the healthcare assistant (HCA) and initial disease surveillance

Allow 20 minutes and add 10 minutes for feet
(Suggested tests and tasks listed in separate document – ensure HCA sufficiently trained)
HCA also supports patient prepare for the PCSP conversation

Only involved in an information gathering appointment when have other conditions

Safety netting of test results and triage in terms of most appropriate person to see patient

Preparation materials:

- Generic agenda setting prompt
- Sharing of routine test results
- Specific condition self-assessment tools

Preparation materials:

- Generic agenda setting prompt
- Specific condition self-assessment tools

Personalised care and support planning conversation

(Usually 20-30 minutes)
No specific assessments/examinations to be completed during discussion

**May not require PCSP conversation

PCSP conversation may be remote by agreement with practice and patient especially for those who are less complex

Appendix 2

Monitoring the personalised care and support planning process

Practices can monitor and review the proportion of people on LTC registers who receive the key processes involved in PCSP via SNOMED codes. Whilst this does not evaluate 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