**Training and development needs for personalised care and support planning conversations**

This tool is for healthcare assistants and nurses involved in delivering the Year of Care (YOC) approach to personalised care and support planning who are keen to identify their ongoing support needs in 3 key areas:

* Topics raised by people during personalised care and support planning conversations
* Confidence in core skills for personalised care and support planning
* Personalised care and support planning for people with more than one long term condition

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| **Name:** | **Role:** |
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| 1. **Topics raised as concerns by people within a care and support planning conversation**
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| **Topic** (these reflect topics on the YOC agenda setting prompt)  | **Please rate your confidence on a scale of 1 (not very) to 5 (very)** | **Do you feel you need training on this topic?**(Yes/No)  | **Any comments**  |
| Sleep |  |  |  |
| Low mood and anxiety |  |  |  |
| Social isolation/feeling lonely |  |  |  |
| Driving regulations |  |  |  |
| Work/Benefits/Money |  |  |  |
| Pregnancy and contraception |  |  |  |
| Healthier eating |  |  |  |
| Eating the right amount |  |  |  |
| Giving up smoking |  |  |  |
| Alcohol |  |  |  |
| Physical activity |  |  |  |
| Relationships/sex life  |  |  |  |
| Bereavement  |  |  |  |
| My future health – discussing risk |  |  |  |
| My future health – end of life  |  |  |  |
| Pain and discomfort  |  |  |  |
| Memory  |  |  |  |
| Falls and unsteadiness. |  |  |  |
| Medication  |  |  |  |
| Activities of daily living  |  |  |  |
| 1. **Strengths and development needs for care planning 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 care planning consultation |  |  |  |  |  |
| Establish a collaborative relationship with the person |  |  |  |  |  |
| Elicit thoughts, ideas, and health beliefs from the 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 care planning consultation** |
| I have a clear understanding of the purpose of care planning and the overall structure of the care planning consultation and how it differs from usual care |  |  |  |  |  |
| I feel confident to set the scene with a patient about the overall care planning 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 |  |  |  |  |  |

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| **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 |  |  |  |  |  |

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| 1. **Disease specific issues around multi-morbidity**
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| **Clinical considerations** | **Low****1** | **2** | **3** | **4** | **High****5** |
| How confident do you feel that your clinical skills can support care and support planning conversations with patients with multiple long-term conditions? |  |  |  |  |  |
| How confident do you feel in managing all clinical aspects of a multi morbidity care and support planning conversation? |  |  |  |  |  |
| How confident do you feel that your practice protocols support you in recognising and escalating clinical issues arising during care and support planning conversations where required? |  |  |  |  |  |

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| **Additional comments** |
| **Are there any other areas you would like to develop over the next 12 months?** |
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| **Are there any challenges or training needs arising from having personalised care and support planning conversations with people with many long-term conditions, rather than a single long-term condition?** |
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| **Other thoughts or reflections** |
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