Briefing for qualitative researchers – personalised care and support planning

Background

As part of the evaluation of the Year of Care approach to personalised care and support planning (PCSP) organisations often choose to gather qualitative feedback through focus groups, questionnaires, interviews etc. It's important to ensure that the people involved in qualitative feedback about PCSP understand the approach, and also to ensure researchers understand the process of PCSP and the style and constructs of a PCSP conversation.

This document provides an overview of PCSP and suggests how to ensure that people can 'make sense of it' where they understand the purpose, know how it differs from previous practice and can articulate these differences and the value this represents to them.

A suggested suite of interview questions qualitative researchers could choose from is also included.

Part 1

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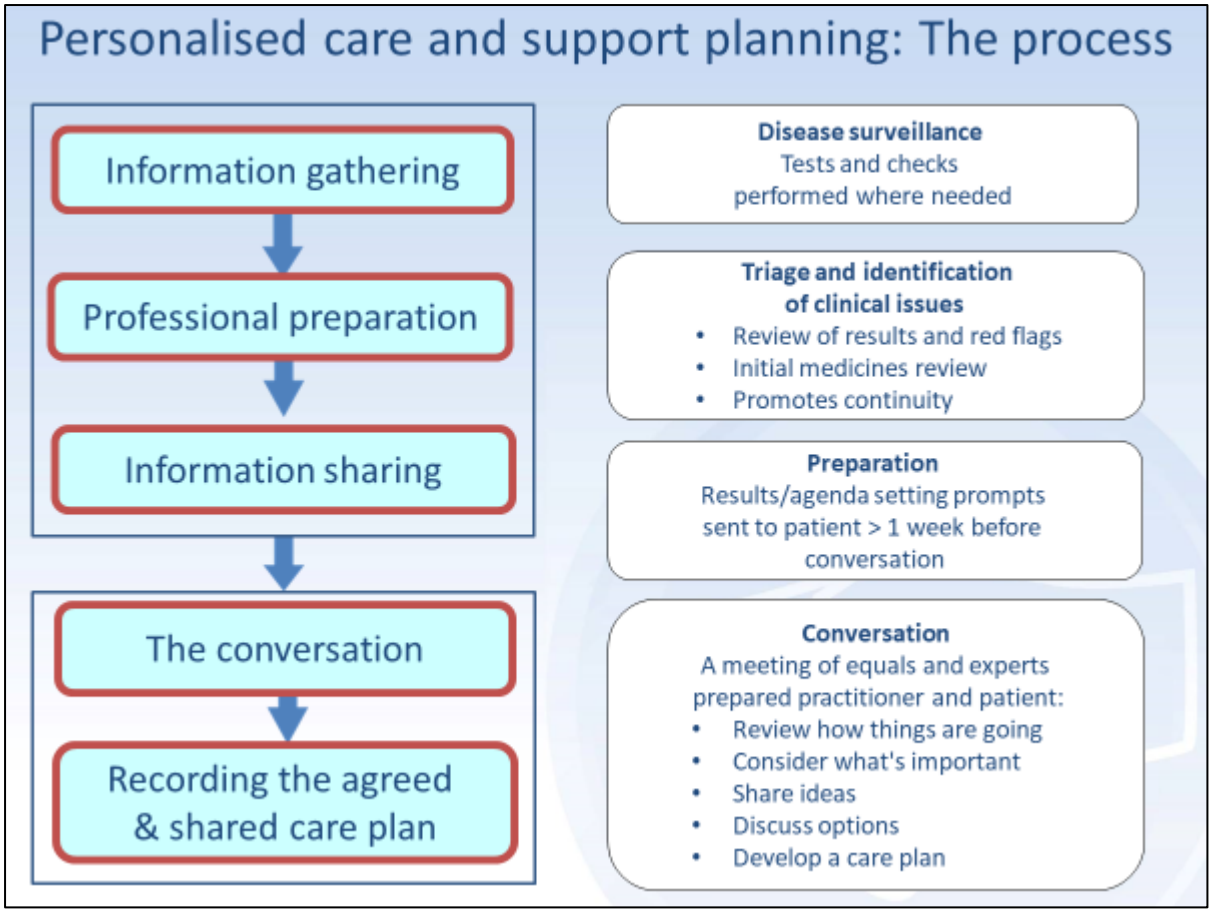
Part 1

What is personalised care and support planning?

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

- PCSP is a lifelong planned and proactive approach to support people living with LTCs and/or disability
- At its centre is a conversation between experts: those with technical expertise and those with lived experience focussed on what matters to each person; jointly exploring, discussing and prioritising issues and making forward plans
- The overarching purpose is to ensure that people can live (and die) well with their conditions which may involve elements of
    - Managing/self-managing the condition well
    - Linking with a supportive community
    - Coordination/referral to specific health and social services
- The process ensures that disease surveillance, health and social care assessments and 'care delivery' are separated in time from the personalised care and support planning conversation



- The process enables
    - Adequate preparation for the person as well as the professional with time for reflection
    - Time for a conversation based on partnership working, which supports both self-management and problem solving and links to support within the local community (where needed)

Consideration for researchers

Service users may have a variety of conditions and be 'under the care' of a host of different healthcare professionals. They need to be clear about which appointments, conversations, people and processes they are being asked to talk about, and be able to 'pick out' these experiences from a range of other plans, appointments and conversations which they may have had.

People may also use different language to describe the stages (e.g. some people call the information gathering appointment an 'MOT', some refer to the preparation part as 'test results' or just the 'letter', some call care and support planning a 'catch up'). A simple diagram of the stages showing the terms which might be used can be helpful (see Part 2). In addition, if comparisons are being made, patients need to have enough experience of the previous way of working to be able to say how it is different.

Terminology may vary across different practices. Some people may be invited to an 'information gathering' appointment, whereas some people may be invited for a 'pre-assessment' – these may be the same thing – see Part 2.

Definition of 'review appointments' A person with a LTC generally will have a regular (annual/6 monthly) personalised care and support planning appointment. These appointments may have been referred to by a particular name (annual check-up, regular review, health-check etc.). During the PCSP appointment, there may occasionally be an agreement for additional 'review' appointments before the next PCSP appointment is due, e.g. if a person's goal included reducing cholesterol, they may agree 3 monthly repeat cholesterol tests. These 'review' stages might also consist of a short discussion with a HCP. These reviews however don't constitute the main PCSP appointment.

People may not understand the difference between personalised care and support planning and a care and support plan. Personalised care and support planning is a collaborative conversation between the person and their healthcare professional and a care and support plan is a physical plan which records the actions/outcomes agreed during the PCSP conversation.

People may already have a number of different documents called 'care plans' which they have received following a discussion with a healthcare professional (e.g. anticipatory care plans, crisis care plans, exacerbation care plans, diabetes care plans). The personalised care and support plan is created in partnership with healthcare professionals during the personalised care and support planning conversation.

Part 2

Terminology of personalised care and support planning

PCSP step	May also be called
Information gathering	Test appointment - bloods/feet/blood pressure etc. MOT Check up 1st appointment
Professional preparation	Triage Bloods coming back/reviewing bloods Review results and red flags
Information sharing: (results/agenda setting prompt)	Appointment letter Results sheet
Personalised care and support planning conversation	Catch up appointment Annual review My (condition) health check Care planning discussion 2nd appointment Appointment with the doctor or nurse

Part 3

What is the House of Care?

The Year of Care (YOC) programme developed the House of Care (HOC) to show what needed to be in place to enable local teams to introduce PCSP.

The original Year of Care pilot sites assigned all the 'issues' to four groupings which became the two walls, roof and foundation of the 'House of Care'. This is a metaphor as well as a checklist emphasising that effective PCSP consultations rely on four elements working together in the local healthcare system: an engaged, empowered person working with healthcare professionals (HCPs) committed to a partnership approach (the walls), supported by appropriate/robust organisational systems (the roof) and underpinned by responsive whole system commissioning.

Consideration for researchers

People's interpretation of 'House of Care' varies widely and their understanding of what it is can be difficult to articulate particularly at the early stages of adoption. The House of Care represents the components which need to be in place to ensure effective PCSP happens however it is often easier for people to relate to and talk about their experience of PCSP, rather than their experience of House of Care.

Part 4

What's different about the approach?

PCSP often has immediate benefits in terms of people's experience however some people may have to experience a number of PCSP cycles to fully feel the benefits such as:

- Impact on their own awareness of their condition
- Understanding of what they can do to influence condition
- Increase person's ability to self-manage
- Allow them to contribute as an equal in the conversation

The conversation between HCP and service user should change with the service user taking a more active role, working collaboratively with the HCP to identify and plan goals which are important to them.

Consideration for researchers

Understand what is meant by self-management. Working within the health service, the term self-management is often used. Self-management relates to the tasks that an individual undertakes to live well with one or more conditions. This includes gaining the knowledge, skills and confidence to manage their own health.

Accessing community assets/more than medicine. People have personal 'assets' e.g. their families, social groups etc. and there are also community assets such as walking groups, women's institute meetings etc. These may not at first seem to be directly related to people's health condition, but relate to some of the wider determinants of health such as social isolation and wellbeing which can impact on how well people live with their long-term condition(s).

Part 5

Fidelity to the approach

Effective personalised care and support planning is achieved by initially ensuring fidelity to the Year of Care approach. If all elements of the approach (represented by the House of Care) have not been addressed, service users may not see the true benefits.

Consideration for researchers

It's important for researchers to understand where feedback may suggest a lack of fidelity to the approach, rather than all elements being implemented but without the desired effect.

Fidelity in the preparation step - the preparation step can be an example of this with feedback around usefulness of information a reflection of the process rather than the information itself.

Fidelity in the conversation - it is unusual for patients not to feel that they had a chance to talk about their issues and have more of an opportunity to ask questions as a result of PCSP. This culture shift can be more difficult for some people to adapt to than others however.

Fidelity in more than medicine (MTM) - if a person indicates that MTM wasn't adequate this may be because it was not appropriate, the HCP was not fully aware of relevant community support, or because the need for support was identified but there were not relevant assets/services available to meet the persons' needs.

Part 6

Qualitative interview questions – for use with patients who have experienced personalised care and support planning

These questions are to be used as part of qualitative interviews with people who have experienced personalised care and support planning. They explore two key areas:

- Questions which ascertain if the individual has experienced personalised care and support planning (aided by a simple explanation below)
- Questions which explore the person's experience of personalised care and support planning

Explanation of personalised care and support planning

We suggest you talk through the personalised care and support planning process to ensure you gain feedback on this aspect of care and to confirm the individual has received PCSP. Note any aspects of the process the person does not seem to recognise.

Your practice has recently started a new way of working which we are calling personalised care and support planning. We hope it will improve care for people with long-term conditions. This approach changes the way your annual check is organised.

You should have been invited into the surgery for your annual checks which may have included blood, urine and foot checks, breathing checks, blood pressure and weight. This should all have been completed at the same appointment even if you have a number of different conditions.

You should have then received a letter with your results and a place to write down things you wanted to ask or talk about.

You would then have been asked to come to an appointment with the nurse or doctor. During this appointment you and your GP/nurse should have had the opportunity to talk about the things that concern or interest you, and discuss any issues that have arisen. Starting with what was most important to you; you would have focused on one or two key issues and together developed a written plan.

The plan might have included ideas for helping you stay healthy and might have identified any support you needed to look after your health and stay well.

Questions to consider asking

1. **General**
    a. Does this sound like something you have experienced?
    b. Can you tell me how you think this was different to your usual appointments?
    c. What do you think the impact of this way of working was for you?
    d. How did it make you feel?
    e. How did it help you manage your health?
    f. Do you think you had the right amount of information to be able to talk about what was important to you?
    g. What do you feel was most useful?
    h. How could it be improved?

2. **Information gathering appointment**
    a. How much was the process explained by the person who did the first appointment?
    b. In what way did this help you think about what you wanted to discuss at the second appointment?

3. **Getting results and information before your second appointment**
    a. Did you get your results at least a week before your personalised care and support planning conversation? *(This question is about checking if this happened)*
    b. How useful do you think the layout was in helping you think about what you wanted to talk about?
    c. What did you think about getting the information?
    d. How useful did you find this information?
    e. In what ways did this affect the discussion you had at your second visit?

4. **Personalised care and support planning conversation**
    a. How did this feel different from other appointments?
    b. To what extent did you feel valued and involved?
    c. How much did the conversation help you think through how you were going to look after your health?
    d. To what extent did it help you think through how to live with/manage your health?
    e. How much did the conversation help you think about what support you would need?
    f. Did you did you come away from your appointment with a plan?
    g. To what extent did you feel it was your plan rather than the nurse or GP's?
    h. What support have you been able to/expect to access following the conversation?
    i. What difference has this made to you?

Part 7

Qualitative interview questions – for use with staff who are delivering personalised care and support planning

These questions are suggested to be used as part of qualitative interviews with staff who support the delivery of or who are the professionals delivering personalised care and support planning. They explore two key areas:

- Questions which explore the professional's views of what personalised care and support planning is and what is it trying to achieve
- Questions which explore the persons experience of personalised care and support planning and its impact on them

Explanation of personalised care and support planning

We suggest you ask the interviewee to talk through personalised care and support planning to check understanding. The 'general' questions are likely to be applicable to all, although the 'process' and 'consultation' questions will be more applicable to some staff groups rather than others.

1. **General**
   a. What training have you received to help you and your practice implement personalised care and support planning?
   b. What involvement have you had in the implementation of personalised care and support planning in your practice?
   c. What do you think are the differences between this approach and usual routine reviews for long-term conditions?
   d. What do you think the value is of this way of working?
   e. How is what you do now different to what you were doing before:
   i. In terms of the process?
   ii. In the conversation with the patient?

2. **Personalised care and support planning process**
   a. What feedback have you had from patients about the personalised care and support planning process?
   b. What has been the impact on the practice of implementing this way of working?
   c. What has been the impact on you on implementing this process?
   d. What resources, training or support would enable you to better support the process?

3. **Personalised care and support planning conversation**
   a. What do you think are the main differences between personalised care and support planning conversations and other types of long-term condition review?
   b. What in your view is your role in a personalised care and support planning conversation? And how does this differ from previous care?
   c. What difference has personalised care and support planning made to you?
   d. What is still difficult about delivering a personalised care and support planning conversation?
   e. What additional support do you need to be able to develop your skills in personalised care and support planning conversations?
   f. What has the impact been on patients?
   g. How easy or difficult is it to offer other solutions/other types of support other than repeat appointments? (And what makes it easy or difficult?)