**Patient preparation**

Patient preparation documents are sent to patients after their information gathering appointment and before their PCSP conversation appointment. 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 to help them make informed decisions

**Each patient preparation document includes**

* An agenda setting prompt (with space to write what is important and a noticeboard of topics of issues people might like to talk about) – there are 2 type of agenda setting prompt and so 2 versions of each letter
	+ Long term conditions
	+ Frailty
* Results relevant to the combination of conditions people live with, these will need to be merged with the results collected at the information gathering appointment
* Blank care plan so that people can see what will happen at their appointment

**Options for the choice of patient letter**

There are a range of formats of letters listed below

* Colour letters with size 14 font for sharing to mobile devices, or for printing in colour or black and white (limited to conditions in which results sharing is an important part of preparation)
* Black and white letters (used when no option of colour printing/sharing digitally) – please note these letters along with newly developed long term condition templates are also now available for practices using Ardens for both EMIS Web and SystmOne
* Easy Read (pictorial resources specifically designed with people who have learning disabilities)

There are also other versions of colour letters with more detail and space for notes – please contact Year of Care for access to them.

**Administration of preparation documents**

Generating and sending preparation documents is usually completed by the administration team once the results have been returned from the labs and triaged by a clinician.

Dependant on patient preferences you can share these

* In the post
* Via email (with a text to confirm it has been sent and to check junk mail)
* Electronically i.e. a text message with a link to view the document or directing people to the NHS app if they are using it

There are some important considerations:

* Patient details should be on the letter (and double checked) to ensure the right patient gets the right information
* If sending the document electronically ensure it is in a PDF format to ensure the integrity of the formatting and that it cannot be amended
* Preparation prompts should be at minimum of a size 12 font
* SNOMED codes in information gathering templates should match the codes used in the preparation prompt to merge the correct clinical information/results from the clinical record (please check local codes)
* Use SNOMED code to record when the preparation prompts have been sent out for admin/monitoring purposes
	+ Suggested code - Preparation tools sent – ‘long term condition summary sent to patient (862701000000104)