Applying psychological principles to help people with long-term physical health problems in the context of primary care

(Implementing shared care planning and decision-making)

The competences set out in this section are intended for healthcare workers in primary care usually (but not exclusively) general practitioners or practice nurses. They need to be read in conjunction with other sections of this competence framework, in particular those included in the domain of "core knowledge and competences for work with people with physical health conditions"

Basic stance for implementing shared care planning and decision making

An ability to draw on knowledge of the importance of moving from the position of an 'expert' to one of a collaborator	
An ability to place a priority on identifying and working with a 'shared understanding' of the patient's illness and its management, and hence to encourage the patient to convey:	
	their understanding of their illness
	their understanding of the treatment and management options open to them
	the knowledge, values and assumptions that influence their perceptions of their illness
	the goals that are important to the patient (the outcomes that they would like to achieve)
An ability to draw on knowledge of the role of the healthcare worker in coordinating the patient's care across health and social care contexts and acting to advocate for their interests where this is indicated	

Knowledge of principles of shared decision-making and supported self-management

An ability to draw on knowledge that shared care aims to help patients:	
	feel confident about managing the challenges of living with their condition
	develop the skills of self-management
An ability to draw on knowledge that shared decision-making means that patients:	
	need to be the primary decision makers regarding the actions they take to managing their condition
	need the knowledge, skills and confidence to manage their own health and healthcare
	need to be appropriately empowered so as to have a sense of themselves as taking an active role in their own healthcare
An ability to draw on knowledge that (with the support of the health practitioner) in shared decision-making the patient should be able to:	
	identify their 'agenda' for change
	identify what they wish to change
	identify how they would like changes to be achieved
	identify how they would like progress to be reviewed
An ability to draw on knowledge of the components of care planning, and its role in supporting self-management:	
	helping patients to understand the condition itself
	supporting patients identify and manage the consequences of living with their health condition (including its impact on their roles and responsibilities and the way they think and feel about themselves and their relationships)

Working as part of a system

An ability to draw on knowledge that, because care planning and implementation of a care plan requires a consistency of approach across the whole team, it is important that the healthcare 'system' (including both clinical and administrative teams) is appropriately co-ordinated and informed, and works as one
An ability to draw on knowledge that repeated referrals for investigations that are not clinically indicated has the potential to cause:
psychological harm (e.g. by increasing anxiety about the likelihood of an underlying medical cause, and hence promoting an unhelpful relationship to illness)
physical harm (e.g. through polypharmacology or increased risk consequent on repeated radiological investigations)

Background knowledge

Understanding factors that promote adjustment*

An ability to draw on knowledge that adjustment is not an end-point but a process of assimilation that takes place over time and which can be expected to vary in response to changes in the person's physical condition
An ability to draw on knowledge that adjustment to a health condition can be understood as the patient's capacity to maintain, restore or renew their sense of emotional equilibrium, their identity and quality of life

*As detailed in the domain of "core knowledge and competences for work with people with physical health conditions"

Understanding factors that promote behavioural change*

An ability to draw on knowledge of generic models of behaviour change and strategies that promote this

*As detailed in the domain of "core knowledge and competences for work with people with physical health conditions"

Understanding self-management*

An ability to draw on knowledge of strategies that promote the patient's capacity for self-management of their physical health condition

*As detailed in the domain of "core knowledge and competences for work with people with physical health conditions"

Engaging patients and developing a shared agenda

Discussing the patient's 'account' of their presenting condition(s)

An ability to use active listening skills to help the patient convey their "global" experience of their presenting problem(s) and their history
An ability to develop a clear sense of the patient's perceptions of their condition(s) by helping them to discuss the ways in which they account for:
the onset and development of their health problems
the ways in which the condition and symptoms are maintained

Discussing the impact of living with the condition

An ability to help the patient discuss the impact of the condition on daily life (e.g. on their social life, ability to work, family issues, or its impact on physical activity)
An ability to help the patient discuss the impact of medical interventions for their condition
An ability to help the patient discuss the emotional and physical burden of living with their condition

Assessing psychological functioning

An ability to gain an overview of the impact of physical health problems on the patient's psychological functioning (e.g. their mood, or their level of worry and anxiety)
An ability to gain an overview of any past history of mental health difficulties (including any help the patient has received to manage these, and their experience of this help)
where relevant, an ability to reassure the patient that the purpose of asking about psychological difficulties is not to 'explain away' physical symptoms
An ability to identify and (where there are indications of its relevance to the intervention) discuss any significant issues in the patient's history (e.g. childhood sexual or physical abuse or neglect, significant loses or separations, exposure to trauma)

Discussing other health and social issues

An ability to help the patient discuss any other health and social issues that may impact on the overall care (e.g. other long-term conditions or health conditions that the patient sees as salient)

Helping patients to learn about their condition

An ability to provide information to the patient about their condition, for example by:
giving information about the reasons for, and expected outcomes from, tests and special investigations prior to their implementation
giving test results in a form and format that can be easily understood (e.g. using a visual scale to explain the meaning and implications of laboratory results)
answering their questions and checking their understanding of the issues raised (e.g. by inviting them to summarise the points being covered)
helping them identify and access relevant and appropriate sources of information
An ability to adapt information content so that this is cognisant of, and builds on, the patients current level of knowledge
An ability to adapt the way information is conveyed in relation to the patient's cognitive and educational capacity

Providing a 'rational' explanation for negative test results/ investigations

An ability to draw on knowledge that in discussing negative test results or investigations it is usually unhelpful:
to offer simple reassurance (and so fail to offer a coherent explanation that accounts for a null result)
to reattribute symptoms to 'stress' or to psychological issues (implying direct causality between psychological issues and physical symptoms)
An ability to work collaboratively with patients in order to provide an explanation that accounts for (and spells out the implications of) negative test results/ investigations, ensuring that explanations:
are coherent, and congruent with the patient's ways of understanding their condition (and so plausible both to them and to the health professional)
are phrased in a way that links bodily function and normal psychology (and does not imply weakness or fault on the part of the patient)
help to initiate movement towards a new perspective and to alternative ways of approaching the problem

Helping patients develop a 'shared agenda'

An ability to begin working with the patient to arrive at a joint framework that integrates their understanding of their condition and their concerns with that of the health care professional by helping them:
discuss their experience and understanding of their condition (including their ideas, concerns, expectations, feelings and thoughts about the condition)
identify and discuss their concerns
prioritise their concerns
explore the options available to them
make mutually agreed informed decisions about ongoing care
An ability to take a flexible and responsive approach to discussion in order to accommodate the different approaches to care planning that patients choose (e.g. recognising that patients will vary in the degree to which they wish to take control over their care)
For patients with multi-morbidities, an ability to use the care planning model to provide a single, comprehensive and patient-centred review (rather than multiple reviews for each individual condition)

An ability to accept patient autonomy in decision making, for example:
making an informed choice to continue engaging in potentially risky or harmful behaviours (such as smoking or an unhealthy diet)
deciding not to self-manage their condition

An ability to accept that (after discussion) not all patients will wish to engage in shared decision making, and that this can be an informed choice
An ability to identify when patients do not have the capacity to engage in shared decision making

Summarising discussions

An ability to summarise discussion with the patient in a manner which:
demonstrates an understanding of the subjective distress experienced by the patient and the patient's perspective on the issues
brings a coherence to their symptoms and disparate experiences (e.g. by linking any account to examples from their own experience and history)
helps the patient to reflect on the relevance of, and their reactions to, the account that emerges from the assessment
engenders hope (through indicating the possibility that an intervention can bring about change)

Agreeing action points

An ability to help the patient acknowledge the condition and its impact on themselves and significant others in the present, and its possible impact in the future
An ability to help the patient plan changes in a manner that enhances their control of the process of change
An ability to help patients evaluate their current situation, contemplate change, take action and continue to adapt and change
An ability to employ strategies such as Motivational Interviewing to help patients to identify both the costs and benefits of any changes

An ability to work with the patient to agree a detailed and specific set of action points:	
	that the patient is reasonably confident they have the ability to complete
	that will lead to outcomes that the patient values
	that are congruent with the patient's understanding of their condition
	that are congruent with the patient's personal and cultural values
	that are likely to be achievable given the personal/ interpersonal and practical resources available to the patient
An ability to ensure that plans identify who will be responsible for achieving each of the actions (e.g. for the patient, specifying actions in relation to self-management, for the health care professional arranging further investigation)	

Documenting action planning

An ability to document the outcomes of the care planning consultation in collaboration with the patient, clearly setting out the patient's choices, preferences and action plans	
	an ability to ensure that this documentation is made available both to the patient and to all members of the health care team