From fixer to facilitator

Evaluation of the House of Care Programme in Scotland

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Matter of Focus

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Matter of Focus
Evidence. Action. Change.

About Matter of Focus

Matter of Focus is a mission-led company based in Edinburgh, Scotland.
We work with organisations, projects and programmes to explore, map, analyse and assess the outcomes that matter to them, the people and populations they care about, and their funders.

We provide tools and techniques to bring together evidence, data and evaluation to ensure that projects and programmes work successfully towards outcomes, are successful and adaptable, and can demonstrate that success to funders, service-users and other stakeholders.
We have created an innovative and easy to use software tool, OutNav, which enables public service organisations and funders to make effective use of their data and information to learn, improve and tell the story about the difference they make.

Matter of Focus is led by Dr Ailsa Cook and Dr Sarah Morton. Ailsa and Sarah are internationally renowned academics, both well known for their ability to develop practical tools backed by robust evidence-based approaches, with extensive experience of delivering practicable approaches for public service organisations.

Contents

1. Executive summary

Background

Shifting the focus of support away from *what is the matter with the patient* to *what matters to the person* is a key priority for health and social care services. Care and Support Planning (CSP) using the House of Care Framework (simply referred to as The House of Care), established by the Year of Care Partnerships® is an evidence-based and tried and tested approach to achieving this. The approach brings together five elements that make up the House of Care and enable meaningful conversations to happen in primary care in the context of health and social care integration. These elements include; engaged, informed and empowered individuals with long term conditions (LTCs) (left wall) working with health care professionals committed to working in partnership (right wall) and supported by robust organisational processes and arrangements (roof) with access to 'More than Medicine' (floor).

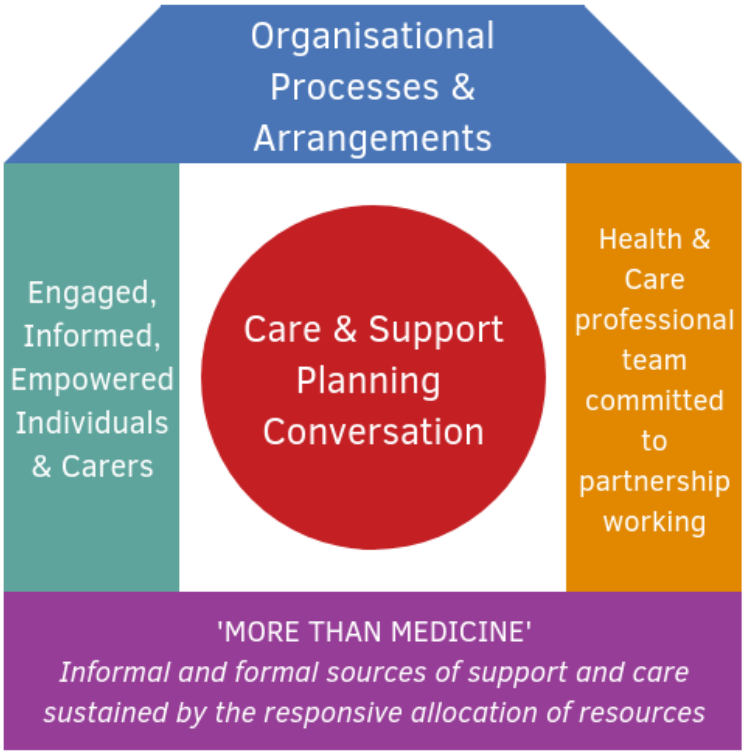


Figure 1 The House of Care model

Over the past seven years, the House of Care approach has been implemented to varying extents across eleven health boards in Scotland with support from the House of Care core team, made up of the Scottish Government, the Health and Social Care Alliance Scotland (the ALLIANCE), the Clinical Lead, and the Year of Care Partnerships. Since late 2019, Matter of Focus has been working with the House of Care core team and local sites to reflect on the evidence that they have gathered over the course of the programme. This has formed the basis for this evaluation of the contribution of the House of Care programme to improving outcomes for people with LTCs, as well as staff and the primary care system during the lifetime of the programme. This report summarises the findings from national and local evaluation of the implementation of the approach in Scotland.

Approach to the evaluation

The evaluation was carried out from July 2019 to July 2020 using the Matter of Focus approach[1]. This practical and robust, theory-based approach to evaluation is informed by contribution analysis[2] and works with organisations to develop a clear understanding of:

- the theory of change underpinning their approach
- the data and evidence required to assess programme progress
- the contribution of the programme to intended outcomes
- what more can be done.

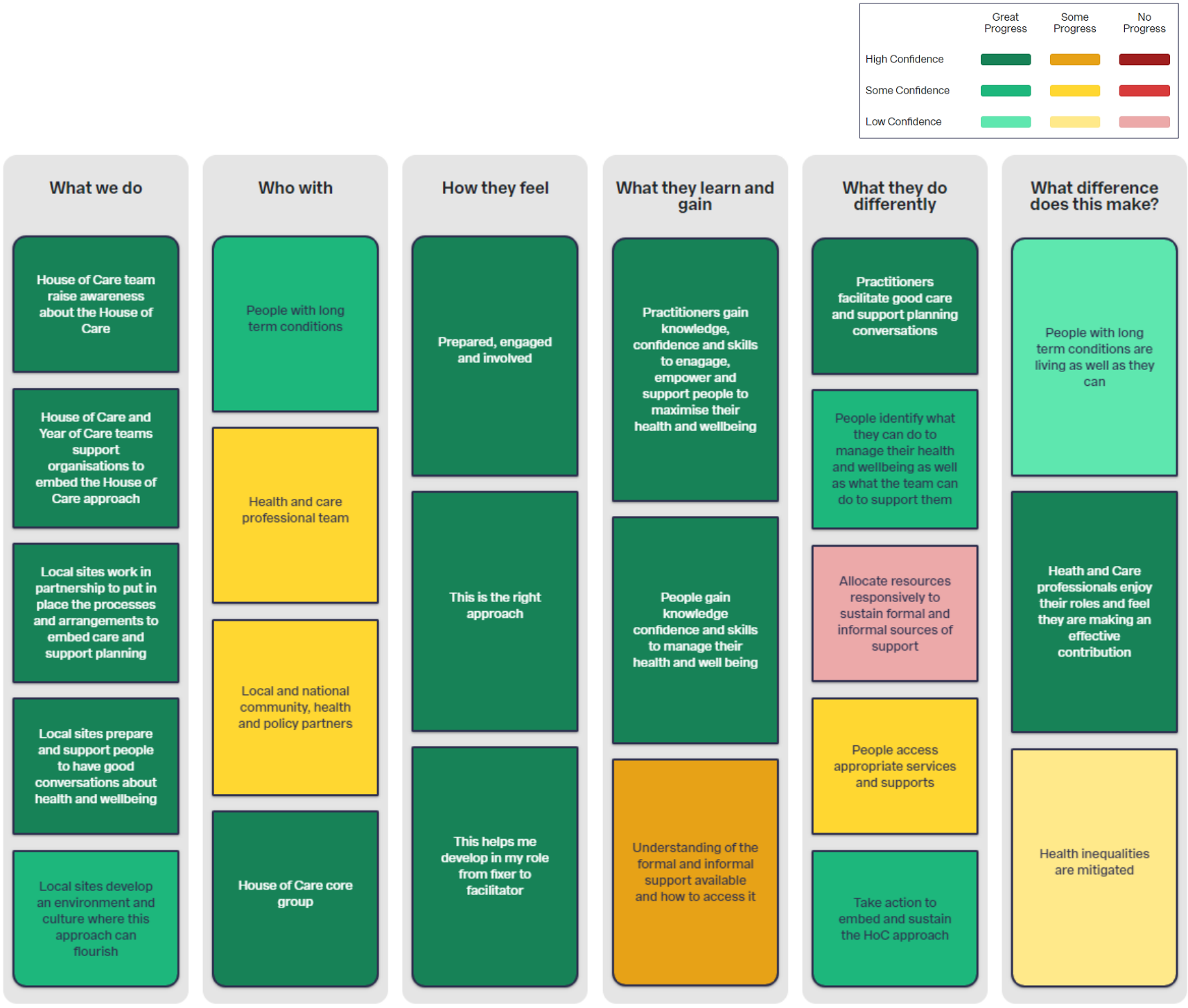
The intention for this evaluation was that each of the health board sites would put this approach into practice to tell their own stories of their contribution to outcomes. To this end, we ran a series of face-to-face and virtual workshops with representatives from the sites and the House of Care core team. Through these workshops we developed an outcome map that showed how the House of Care approach contributes improved outcomes (shown page 6).

Unfortunately, the COVID-19 response meant that none of the sites had the capacity to continue with involvement in the evaluation through to the data analysis stage. The analysis presented in this report has been carried out by the Matter of Focus team drawing on documents shared by the sites and core team.

Findings

The outcome map on page 6 shows the contribution of the House of Care to improving outcomes. Each stepping stone (box) has been colour coded to summarise what the evidence said about how much **progress** had been made for each step in the process and also how **confident** we could be in the evidence. The meaning of the colours is shown in the key.

[1] www.matter-of-focus.com/our-approach
[2] Mayne, J. The Institutional Learning and Change (ILAC) Initiative, (2008). Contribution analysis: An approach to exploring cause and effect.https://www.betterevaluation.org/resources/guides/contribution_analysis/ilac_brief


Great Progress
Some Progress
No Progress
High Confidence
Some Confidence
Low Confidence
What we do
House of Care team raise awareness about the House of Care
House of Care and Year of Care teams support organisations to embed the House of Care approach
Local sites work in partnership to put in place the processes and arrangements to embed care and support planning
Local sites prepare and support people to have good conversations about health and wellbeing
Local sites develop an environment and culture where this approach can flourish
Who with
People with long term conditions
Health and care professional team
Local and national community, health and policy partners
House of Care core group
How they feel
Prepared, engaged and involved
This is the right approach
This helps me develop in my role from fixer to facilitator
What they learn and gain
Practitioners gain knowledge, confidence and skills to enagage, empower and support people to maximise their health and wellbeing
People gain knowledge confidence and skills to manage their health and well being
Understanding of the formal and informal support available and how to access it
What they do differently
Practitioners facilitate good care and support planning conversations
People identify what they can do to manage their health and wellbeing as well as what the team can do to support them
Allocate resources responsively to sustain formal and informal sources of support
People access appropriate services and supports
Take action to embed and sustain the HoC approach
What difference does this make?
People with long term conditions are living as well as they can
Heath and Care professionals enjoy their roles and feel they are making an effective contribution
Health inequalities are mitigated

As the outcome map on page 6 shows, overall, the House of Care Programme has made a meaningful contribution to improving outcomes. There is evidence that the approach has contributed to people with LTCs living as well as they can be and staff feeling satisfied in their roles. There is some evidence that implementing the approach has mitigated health inequalities, though further evidence is required to substantiate this claim which will be a focus of future work.

Review of the data gathered by the sites and the core team led us to identify key aspects of the process that enabled these outcomes to happen. They are summarised below.

Activities / what we did: The core team have raised awareness about the approach and supported implementation through: attending and organising events and meetings; running training sessions; direct in practice support; and sharing resources and tools through their websites, blog, Twitter feed, publications and reports. This work has been complemented by that taken forward in the local sites. Local leadership and facilitation, as well as the creation of local capacity for training and facilitation, has been important to support implementation of the approach and to spread the approach within health board areas.

Engagement / who with: To date the House of Care approach has had substantial reach, with more than 1 in 10 GP practices across 11 health board areas in Scotland adopting the approach to some extent. The approach has also been adopted in some secondary care and community care settings. The approach has been used with people with a wide range of LTCs across those practices. The core team have experienced some barriers to engaging practices, in particular limited capacity, competing pressures and workforce instability.

How people felt about the approach: The response of people involved in this work has been very positive. Managers and practitioners alike have reported that this is a way of working that they enjoy, is in line with their values, and is effective. The training and facilitation was reported to be well constructed and designed. Qualitative feedback from the sites shows that people living with LTCs also enjoy the approach and feel more prepared and empowered.

What was learnt and gained: Practitioners found the training and support they received very beneficial. Analysis of post training feedback shows that the majority of practitioners gained confidence in engaging with people with LTCs around their goals and plans. Feedback from people with LTCs was also very positive. In NHS Grampian, 91% of people living with LTCs who took part in an evaluation agreed that receiving the results letter prior to their appointment was beneficial. 64% of people with LTCs rated the care and support planning (CSP) conversations as excellent or very good in 'helping them to take control'.

What people did differently: There is very strong evidence from across sites that many practitioners trained in the approach continued to embed the approach in their practice. This is evidenced through qualitative and quantitative feedback from practitioners and people living with LTCs. There is also strong evidence that the approach helps people take control of their health and wellbeing. 72% of people living with LTCs involved in the NHS Grampian interim evaluation felt the CSP conversation had enabled to keep themselves healthy compared to traditional consultation methods.

There is evidence of House of Care sites investing time and resources to build local capacity and supports for people with LTCs, with a particular focus on Link Workers.

Conclusions

The findings from this evaluation show that there are many places in Scotland where the House of Care approach has been successfully implemented, and that people with LTCs are leading better lives as a result. This is a significant achievement for local adopter sites and the core team who have made these changes during a challenging period for primary care, with austerity, changes to the GP contract and structural reorganisation all providing barriers to change. Local leadership, the quality of the training and ongoing support to the practices have all been highlighted as factors important to this success.

Recommendations

Based on the findings from this work we make the following recommendations:

1. Relational, enabling and preventative approaches such as CSP are central to local and national policy responses to improving outcomes for people living with LTCs. These need to be supported by a continued shift towards community supports.

2. The House of Care approach should continue to be promoted as an effective approach to primary care transformation that improves outcomes for people with LTCs, and staff, as well as supporting local areas to meet policy imperatives of realistic medicine, supported self-management and public service reform.

3. Ongoing expert support is required to spread the House of Care approach to new GP practices and areas as well as to sustain progress in current sites. This support needs to build on the learning from the previous six years of the programme, encapsulated within the recent House of Care Recommendations paper[3] and the collective learning from the Year of Care Partnerships.

4. Further evaluation of the programme would be beneficial, carried out with local sites to better understand the contribution of the House of Care to responding to COVID-19 as well as building a stronger picture of the extent to which the approach contributes to improved outcomes.

[3] Health and Social Care Alliance Scotland (2019) Key Recommendations for the Further Spread of Care and Support Planning and the House of Care framework across Scottish General Practice.

2. Background

The importance of focusing on what matters to the person has been recognised in primary care for many years. In 1995, Stewart et al[4] showed that clinical outcomes for patients improved when practice focused on:

- providing clear information to people
- mutually agreed upon goals
- an active role for the person
- positive affect, empathy and encouragement from the professional.

Despite clear evidence for the benefits of this kind of approach, realising these changes in practice has taken time, requiring shifts in culture, systems and practice. The House of Care approach was introduced to Scotland in 2013 with the explicit intention of supporting primary care to overcome the barriers to implementing person centred approaches.

2.1 The House of Care approach

The House of Care approach has been developed over 15 years by Year of Care Partnerships[5] to support primary care organisations to implement the holistic changes required to put people at the centre of care[6]. It is one of a family of approaches that encourage a shift in practice towards more person centred, personal outcome focused, asset based and preventative ways of working in line with the Scottish Approach to Public Service Reform as advocated by the Christie Commission[7].

The House of Care approach is underpinned by a robust evidence base and builds on the work of Ed Wagner and the Chronic Care Model[8]. It brings together five elements that make up the House of Care and enable meaningful conversations (at the centre of the house) to happen in the context of primary care.
These elements include; the care and support planning (CSP) conversation; engaged, informed and empowered individuals with long term conditions (LTCs) (left wall) working with health care professionals committed to working in partnership (right wall) and supported by robust organisational processes and arrangements (roof) with access to 'More than Medicine' (floor).

Figure 2 The House of Care framework

[4] Stewart, M., Brown, J.B., Weston, W.W., McWhinney, I.A., McWilliam, C.L, Freeman, T.R, (1995) Patient Centred Medicine: Transforming the Clinical Method.
[5] www.yearofcare.co.uk
[6] Roberts, S., Eaton, S., Finch, T. et al. (2019) The Year of Care approach: developing a model and delivery programme for care and support planning in long term conditions. https://doi.org/10.1186/s12875-019-1042-4
[7] Christie (2011) Christie Commission on the Future Delivery of Public Services. Edinburgh: Scottish Government. https://bit.ly/39f1pfb
[8] Wagner,E.H., Austin, B., Von Korff, M. (1996). Organizing Care for Patients with Chronic Illness. https://bit.ly/30tZakd

Critically, the model builds on an evidence-based understanding of the critical success factors required to change the relationship between patients and primary care. It does this by supporting general practices to implement CSP using the House of Care framework as the new clinical method for routine planned support for people with LTCs. CSP offers people active involvement in managing their LTC. The CSP process makes space for meaningful conversations, enabling the people with LTCs to have the same information about their health as the health professional, with the same time to prepare for the conversation: *"The conversation is considered to be a meeting between experts; those with lived experience (patients/people) and those with technical expertise (clinicians)."*[9]

Evaluation of the approach in England has shown that it brings a range of benefits including: improved patient outcomes, practitioner job satisfaction, changes in health behaviours, improved teamwork, improved practice organisation, between resource use and links with the wider community[10].

2.2 The House of Care in Scotland

The House of Care programme began in 2013 within Scottish Government's Self Management and Health Literacy programme. It has subsequently been sustained by a hugely important collaboration with, and funding from, Scottish Government's Primary Care Division. The first three sites to implement the House of Care approach were NHS Greater Glasgow and Clyde, NHS Lothian and NHS Tayside, in all cases championed by local leads who recognised that current practice needed to change and who saw the House of Care as providing a practical route map to achieving this change. As the Associate Medical Director for Tayside said in 2016:

"A simple message, a clear way of supporting person-centred planning with tools to help do it and an emphasis on recognising the importance of the multi-disciplinary team – what was not to like?!"[11]

This early work was funded by the Scottish Government and the British Heart Foundation (who provided funding to support the early sites to implement the approach with people with cardiovascular disease). The work was hosted by the Health and Social Care ALLIANCE and overseen by a core team of the ALLIANCE, the Scottish Government, and the Year of Care Partnerships.

Over the subsequent years the core team has continued to promote and support the approach within the context of a person-centred, supported self-management model in primary care. The House of Care approach is now being used across 11 health boards and 135 GP practices and supports implementation of key policies and strategies including Gaun Yersel[12], Realistic Medicine[13], Person Centred Care[14] , the NHS 24 Strategy[15] and the National Dementia Strategy[16].

[9] ICF Consulting Ltd, 2018. House of Care Evaluation: Final Report
[10] Roberts et al (2019) The Year of Care approach: developing a model and delivery programme for care and support planning in long term conditions within general practice. https://bit.ly/3hcJRml
[11] Scotland's House of Care Learning Report. 2016. https://bit.ly/3fO2YTP
[12] https://bit.ly/39drb3y
[13] https://www.realisticmedicine.scot/
[14] https://bit.ly/2BeIcOi
[15] https://bit.ly/30qm1gQ
[16] https://bit.ly/30qmK1v

It includes many characteristics of a whole systems approach[17] as advocated by Public Health Scotland. From the beginning, the House of Care has been used in Scotland as a 'framing narrative' to make the case for and to provide a tangible response to the ubiquitous challenge of implementing more joined up and holistic approaches to health and social care transformation.

The main focus of the implementation has been with GP practices, however, there has also been engagement with other parts of the health and social care system, including the third sector. For each of the early adopters there was a slightly different set of drivers for implementing the approach, which included:

- reducing health inequalities
- supporting self-management
- focus on personal outcomes
- chronic disease / LTCs management
- assets based and empowering approaches
- public health.

Despite the different drivers, the sites have experienced similar challenges and opportunities in taking forward the approach. In a workshop in early 2020 representatives from several of the sites reflected on the range of contextual factors that have shaped implementation in their local areas, including:

- the changing context for primary care, in particular, health and social care integration, the formation of GP clusters and changes in GP contract. All of these changes were seen in general to be very supportive, however, it was recognised that some practices were taking time to adapt, and the uncertainty made it harder to take on new ways of working.
- continued political austerity and the impacts of this on both the availability of other local services and supports as well as the health and wellbeing of people.
- the power imbalances within primary care that mean that some staff lack agency to push forward change, but also that others do have the autonomy to champion the approach.

2.3 House of Care in the context of COVID-19

The arrival of COVID-19 has brought new and urgent challenges for people living with LTCs as well as health and social care services supporting them. Not only have many thousands of people with LTCs been required to shield, staying in their houses and avoiding contact with others to reduce their risks of catching the virus, but they have been doing this in the context of significant disruptions to services, jobs and the economy. It is reasonable to assume that there will be many people living with LTCs who are substantially negatively affected by the current situation.

Alongside this, the work of many people working in primary care and across the health and social care system has transformed overnight and individual staff have faced significant disruptions to their working and family lives.

The evidence presented in this report was gathered before COVID-19 and we do not know how implementing the House of Care approach has contributed to effective CSP in this context.

[17] https://bit.ly/30xo42q

However, it is clear that the shift the House of Care advocates from fixer to facilitator is central in supporting people in these unprecedented times.

2.4 About this report

This report provides a high-level summary of the contribution of the House of Care approach to improving outcomes in Scotland. Over the past eight months, Matter of Focus have been working with the House of Care core team and local sites to reflect on the evidence that they have gathered over the course of the programme and to evaluate the contribution of the House of Care programme to improving outcomes for people with LTCs, as well as staff and the primary care system.

This report presents the findings from this work and makes recommendations for the future. First the approach to the evaluation is summarised.

3. Approach to the evaluation

The findings presented in this report have been generated using the Matter of Focus approach.

3.1 Evaluating complex people-based change

The Matter of Focus theory-based approach to evaluation is informed by contribution analysis, action research, participatory approaches and evidence to action. The approach is underpinned by cloud-based software OutNav[18] that provides a single platform for all evaluation planning, analysis and reporting.

At the heart of the approach is the recognition that when working in complex environments it is not possible to simply measure and attribute the difference that projects make to improving outcomes for people. However, it is possible to tell a robust story about how the project activities have *contributed* to making a change. Underpinning the evaluation approach is a simple framework that breaks the change process down into meaningful steps.

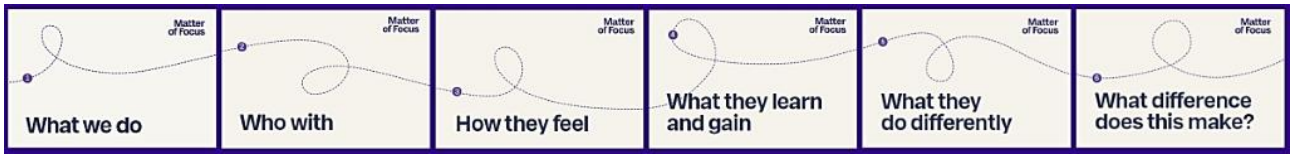


Figure 3 The Matter of Focus headings

The Matter of Focus headings are used to develop an outcome map that shows how planned activities are expected to contribute to intended outcomes. This outcome map provides a framework against which to track progress with the work. This includes developing an evaluation plan and analysing and reporting on findings.

[18] www.matter-of-focus.com/OutNav

The Matter of Focus approach and OutNav were initially used by Lothian House of Care Collaboration[19] to underpin the evaluation of their work from 2018 and have since been adopted by the core team to underpin the programme evaluation.

3.2 The evaluation process

At outset of the evaluation the intention was that each House of Care site would use OutNav to tell their own story of the contribution of the House of Care approach to improving outcomes locally. This evidence would then be synthesised by the Matter of Focus team into a final report. We started the process by holding a workshop with representatives from all the sites mapping outcomes and understanding the data that each site already held that could inform the evaluation. This workshop led to the development of the outcome map and risks and assumptions on pages 15 and 16 showing how the House of Care contributes to improved outcomes and what needs to be in place for this to happen.

In practice, the need to adapt services in response to the coronavirus pandemic meant that none of the sites have had the capacity required to use OutNav to evaluate their work themselves. Therefore, the Matter of Focus team have worked with the core team and representatives from the sites to access relevant reports, data and information and have analysed this information to generate this high-level report.

A total of 31 evidence sources have been collected, reviewed and analysed. Of the 31 documents, three evidence sources are published, 21 sources are reports and the remaining 10 sources are a mix of qualitative and quantitative data. A total of 20 evidence sources were supplied by Scottish House of Care sites and the remaining evidence came from The ALLIANCE Scotland, Year of Care and the BHF funded project, which NHS Lothian, GGC and Tayside were part of. The balance of evidence between sites is shown below:

Health Board	No. of sources received	Evidence types
Greater Glasgow and Clyde	6	Training feedback, Practice reflections, BHF report, Patient experience report
Grampian	3	Interim evaluation report, video of patient experience, Link worker implementation report
Lanarkshire	5	Patient feedback, Healthcare professionals' surveys, patient biomedical measures
Lothian	5	Qualitative evaluation report, Local learning reports, BHF report
Tayside	1	BHF report

The Matter of Focus team analysed this evidence against the outcome map and risks and assumptions shown on pages 15 and 16. This was a collaborative process carried out in OutNav and included making an assessment for each stepping stone (box in the outcome map).

[19] Lothian's House of Care Collaboration. 2019. Embedding the House of Care Approach in Practice: Diabetes Cohort

The colours on the outcome map reflect this assessment, with green showing good progress and red showing no evidence of progress, whilst a strong colour shows high confidence in the evidence and a pale colour shows low confidence in the evidence. This quick visualisation of progress with the work is supported by a detailed narrative for each stepping stone.

3.3 Limitations

The timing of this work has limited the scope of the evaluation. As the list above shows, we have only been able to gather evidence directly from five of the 11 sites. We have not been able to access any of the primary data gathered by the sites or have the depth of engagement required with sites to gather evidence about the wider impacts of the approach or the support from the House of Care core team. Whilst it has been striking how consistent findings have been across the different sites and sources of data, we are aware that there are gaps in understanding that could be addressed through more in-depth engagement with people working in the local health board areas.

3.4 Embedding the House of Care approach, colour-coded pathway

3.5 Our risks and assumptions

RISKS

Health and Care professionals don't have the support, resources and permission required to embed and sustain this approach

Inflexible and commissioning and resource allocation processes get in the way of implementing More than Medicine

Longer term funding is required to sustain the approach and this is hard to access at local and national levels

Primary care teams think that this is something that they are doing already

People think they are doing this already

Implementing the preparation step in CSP can be a significant organisational challenge

ASSUMPTIONS

People with long term conditions are willing and able to play an active role in managing their long term conditions

Primary care teams are working to implement all five elements of the House of Care

There are appropriate formal and informal supports that primary care can partner with and support

House of Care is well aligned with broader policy and practice

There is strategic support for the approach

The person is seen as an equal partner

Staff need effective relationships to embed House of Care

4. Detailed findings

As the outcome map on page 15 shows, analysis of the evidence from the House of Care Programme shows substantial achievements over six years (2014 to 2020), including positive benefits for people with long term conditions (LTCs), and staff. The following sections outline these findings in more detail.

4.1 What we do

House of Care team raise awareness about the House of Care

From the start of the House of Care Programme, the core team has worked hard to raise awareness about the approach. They have done this through attending site board meetings; organising events and taster sessions; producing publications and resources; and through their social media accounts. Connecting with people face-to-face has been a key part of this work and has involved all of the core team members. They have done this through:

- attending and presenting at national policy events, and forums, for example, events around implementing person-centered care, quality strategy and realistic medicine. Some recent events are below.
    - CSP presentation at Microsystem Festival in Jönköping, Sweden 2019
    - Institute for Healthcare Improvement conference, Glasgow 2019
    - Care of Older persons conference, 2019
    - GP trainers events with NES
- attending and presenting at national events organized for clinicians and leaders in health boards
- organising events to introduce people to the approach
- organising taster sessions and events for people within local health board areas.

The core team has also produced a range of publications, for example a learning report published in 2016. They have an active Twitter presence and regularly update their website, YouTube, and blog.

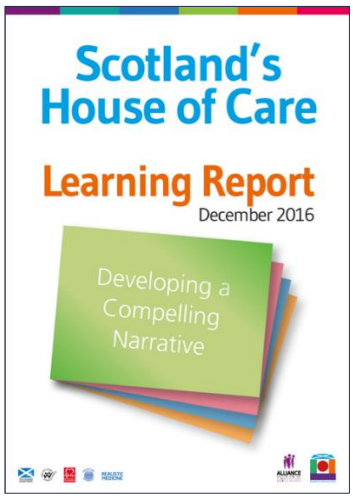


Figure 4 Scotland's House of Care Learning Report

Figure 5 House of Care are active on Twitter, with nearly 2000 followers

Over time, Year of Care Partnerships have developed a clear framework and structure for taster events that engages clinicians and the wider primary care team. The core package is designed to be adaptable depending on who the intended audience is, how big the audience is and what they want to cover. The Year of Care team make sure to understand the local contexts and adapt the structure to align with this.

Figure 6 Tweet of Lindsay Oliver (Year of Care) presenting the House of Care

"We would position the House of Care approach to the local need, e.g. in Glasgow, they wanted to focus on diabetes and improving outcomes in diabetes, in Lothian there was a focus on the 'more than medicine agenda'. Sites may look at the House of Care approach through a slightly different lens depending on local need."
Year of Care team

House of Care and Year of Care teams support organisations to embed the House of Care approach

Once organisations are committed to the approach, the Year of Care team use a tried and tested package of support, training and facilitation which the Year of Care Partnerships have developed over the past fifteen years in their work across the UK and beyond. A review of the package was carried out in August 2019 with Scottish trainers and key implementers who described the package as 'well-constructed and designed.' The package of training includes:

- core care planning training - one and a half days of training for clinical teams
- in practice facilitation sessions to engage wider team and support practical implementation
- train the trainer and quality assurance programmes
- training and mentoring for local facilitators
- healthcare assistant training - focusing on their role within CSP
- administrator and practice manager awareness sessions.

Figure 7 Training delivered in NHS Dumfries & Galloway

Local trainers in Tayside noted that "clinicians attending CSP training continue to find the consultation framework different and useful" . In Glasgow, the training was viewed positively with broad agreement that it was comprehensive. The interactive elements were considered to

be helpful. The consultation skills were an opportunity to refresh skills and the opportunity to learn with peers was valued by practitioners[20].

The ALLIANCE have held several 'More than Medicine' events linking GP practices and the local third sector. For example, one 'Lunch and Learn' event held in Paisley aimed to strengthen links between the third sector, community organisations and general practices. There have also been 'More than Medicine' events held in Renfrewshire, Moray and Grampian. Another event was scheduled to be held in Inverness earlier this year but has been postponed due to COVID-19 outbreak, however there is discussion around the option to deliver the event virtually.

Events are also held in partnership with NHS Education Scotland, presenting House of Care, with Link Workers and ALISS as an opportunity to create connections between primary care and third sector. This is delivered alongside coaching and mentoring support, and regular opportunities to connect in with other sites implementing the approach.

Figure 8 ALISS presenting during a 'More than Medicine' event

Local sites work in partnership to put in place the processes and arrangements to embed care and support planning

A key part of the Year of Care support was providing a range of templates and proformas for the local GP practices to use to put in place the processes and arrangements to embed CSP, including:

- sample letters, posters, and leaflets
- CSP results letters, care plans
- DVDs incorporating awareness raising and consultation skills
- IT Guidance for Key Systems (not all are applicable in Scotland)
- reflective tools for practitioners
- practice packs.

The roof of the House of Care model 'organisational processes and arrangements' highlights the administrative functions needed for the approach to run smoothly and coherently. Through a facilitated process, sites are supported to map out in detail what would need to change in their practices for the approach to be successfully implemented. The evidence from this review suggests that practices found these reviews helpful and that it was relatively straightforward to change processes to put new ones into place. There have been issues across the board in

[20] ICF Consulting Ltd, 2018. House of Care Evaluation: Final Report.

implementing the changes to IT systems to make the House of Care approach work and recent changes around community treatment and care services.

IT systems used by practices across Scotland have been continuously cited as a barrier for successful implementation of the CSP process. Practices often have to solve issues at a local level as there is no universal IT system. The current procurement of a new IT system for primary care in Scotland has also hampered developments in this area.

For example, in NHS GGC there have been significant IT issues; a new software system has been built over an older system and although additional IT support has resulted in practices being able to implement IT templates for their needs, this continues to cause issues for practices implementing the approach.

Similarly, in Lothian, considerable time and effort was involved in establishing IT systems to accommodate new administrative processes, recall systems and letter templates.

Some practices have been able to provide advice in setting up IT processes and arrangements for new practices coming on board. For example, a practice in the early stages of implementing the approach in Highland was put in touch with a practice in Lothian, St. Triduana's, to provide tips and guidance on adjusting their IT systems. An IT support professional from Glasgow was also put in touch with Dumfries and Galloway and Grampian practices to support them to embed IT changes.

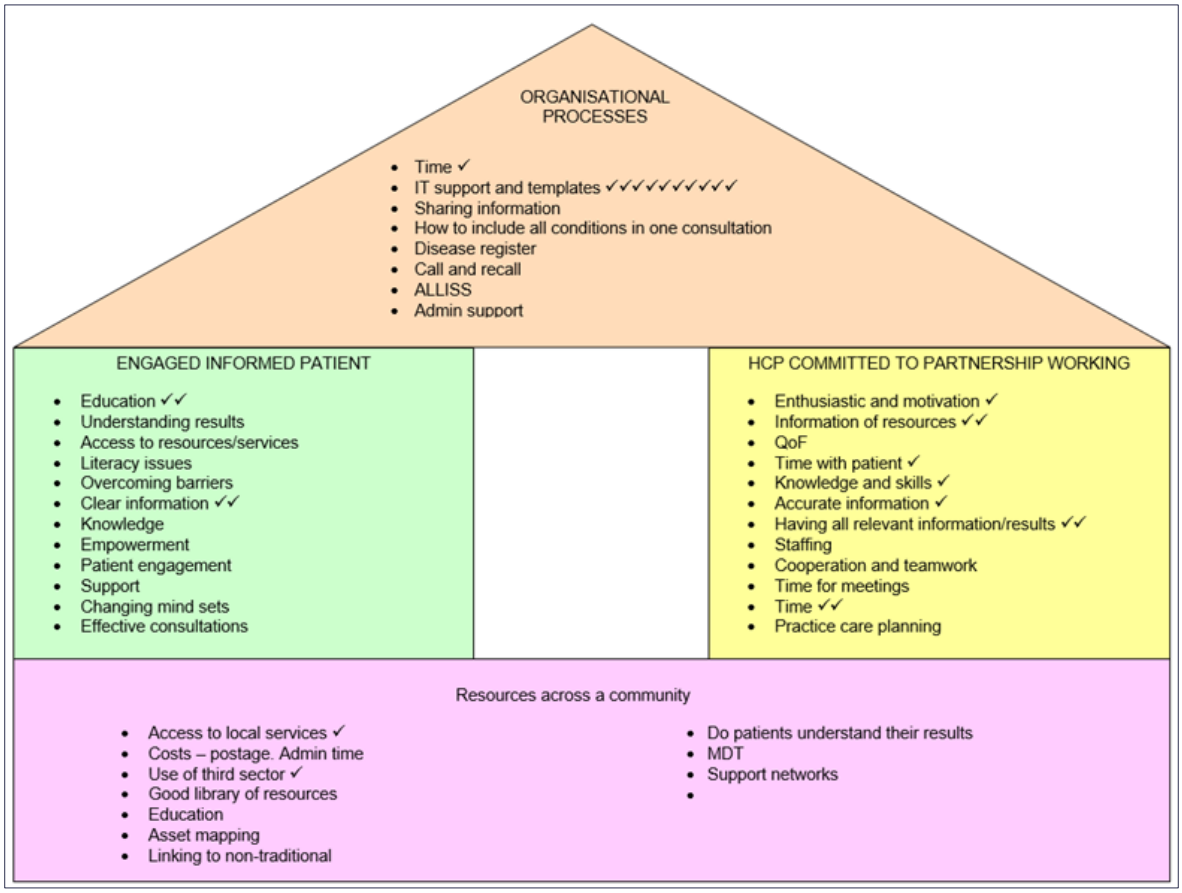


Figure 9 shows the importance of IT support and templates to practice staff in NHS GGC

Local sites prepare and support people to have good conversations about health and wellbeing

Preparing people to have good conversations about their health and wellbeing involves two steps. The first step for most people includes an 'information gathering appointment' or a home visit with a healthcare assistant, depending on the person's needs .This appointment will involve ensuring all the routine disease surveillance is completed at a single visit no matter how many conditions a person lives with. In addition, there is an opportunity to navigate people through the process and support them to consider what they wish to focus on.

Secondly, prior to the CSP conversation, a reflective agenda setting prompts, routine results with explanation and appointment details is sent to the person.

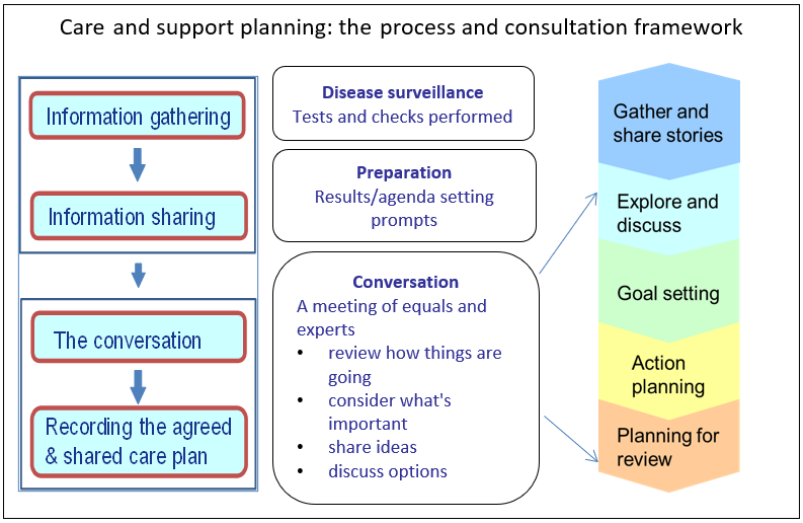


Figure 10 The Care and Support Planning (CSP) process

After the preparation step, people living with LTCs are then facilitated via a conversation with either a nurse or GP to identify what matters to them. This includes identifying any concerns the individual may have and discussing relevant clinical issues. The person then prioritises and identifies personal goals and an action plan is developed. The action plan, known as the care plan, provides a summary of the discussion and is made available for the person and the practice.

Scottish sites have tended to prepare and support people to have good conversations using resources provided by Year of Care without a great deal of local variation. A preparation leaflet, developed by a practice in Lanarkshire, given to patients before having a meaningful conversation is shown in Figure 11.

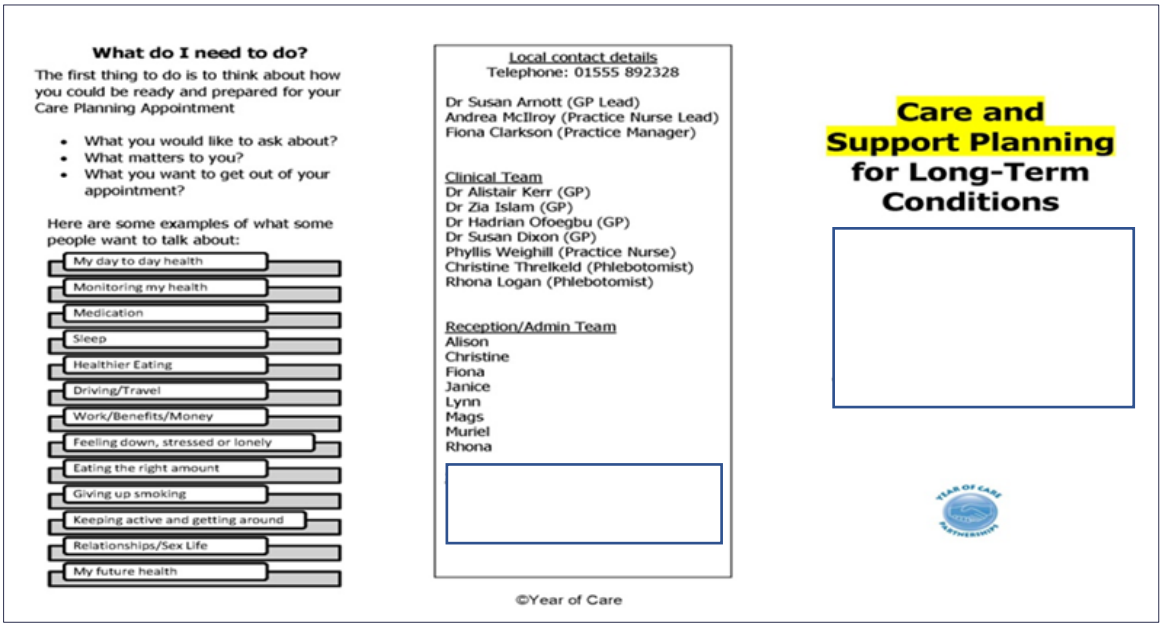


Figure 11 Preparation leaflet, developed by a practice in NHS Lanarkshire

It provides people with some prompt questions about what matters to them along with some examples of what the person may want to discuss during their appointment.

In Glasgow, a service-user group was set up to provide feedback on the preparation prompts and result letters sent out to people living with LTCs. They provided some feedback which was implemented such as translating the patient letter into seven languages used by the population. People living with LTCs in Glasgow noted that having a care plan provided a helpful structure for their discussions with a health practitioner at their CSP appointment. It also ensured that all issues were covered.

In NHS Lothian, a qualitative evaluation with patients found that most people were happy to receive their test results in the post prior to the appointment. In NHS Grampian it was reported that a fundamental change in this model compared to traditional care delivery was the mailing of results letters to people prior to follow-up appointments:

> *"the big difference being that they got stuff on paper that they can see before they come in … previously they would just come in and I was giving them their results verbally."*

Local sites develop an environment and culture where this approach can flourish

The floor of the House of Care model in Scotland represents enabling 'More than Medicine' by ensuring there is a responsive and appropriate allocation of resources, including community, voluntary and statutory resources. Commissioning of formal and informal resource is key to the success of enabling 'More than Medicine.'

What has this looked like in practice?

Lothian House of Care has been implemented in partnership with a third sector organisation- Thistle Foundation and has focused on 'More than Medicine' from the early stages of implementation. Lothian held events for practices implementing the approach to conduct peer learning between practices and share community resources. Link workers are also invited to come along to facilitated learning cycles.

NHS GGC initially recruited practices across a wide geographical area, subsequently moving to more targeted recruitment across specific clusters, which was beneficial for developing an environment where 'More than Medicine' could be embedded. This was because practices were able to learn about supports within their local area and share them with other teams.

One practice in NHS GGC developed their own community walking group for people with hypertension, diabetes and who were overweight, where there had been no community supports to refer people to previously. The practice stated that this development had been driven by the House of Care programme. The team also received the 'Chairman's Improving Health Category Gold Award' for this work.

> *It's something that we traditionally wouldn't have looked at because obviously the medical model is very different from the*

social model, I think you need to encompass both."
(Health professional)

Enabling 'More than Medicine' is the area of the House of Care that will take the most time to show evidence of progress. This is because sites will firstly take time embedding processes and arrangements to enable CSP to be embedded in practice prior to enabling 'More than Medicine', which can take longer to materialise. There are also factors outside of the House of Care teams' control such as the cultural changes required in moving to a social model of care, and improving the flexibility of the commissioning and resource allocation processes. The report funded by the British Heart Foundation similarly concluded that it will take time to develop an environment where this approach can flourish, with a recommendation that key partners continue to develop efforts around the 'More than Medicine' element of the approach[21].

4.2 Who with

People with long term conditions

The Year of Care partnership has worked with over 40 health communities with people with LTCs including COPD, cardiovascular disease, coronary diseases, musculoskeletal conditions, multimorbidity and frailty. It has been widely agreed that a multi-morbidity approach has the most potential for providing holistic and person-centred care for people living with LTCs.

To date, eleven health boards in Scotland are engaging people with varying LTCs in the House of Care approach. This includes persons living with diabetes, coronary heart disease and cardiovascular disease.

The implementation model of House of Care is flexible enough so that it allows practices to come on board at different starting points and with different target cohorts. For example, the data below shows the varying characteristics of people living with LTCs engaging in meaningful conversations in Scottish sites:

- **Grampian**: All practices focused on people with diabetes and multi-morbidity LTCs
- **Greater Glasgow and Clyde**: The initial focus has been on diabetes (some of whom also have coronary heart disease) with intentions to move to a multi-morbidity approach.
- **Lothian**: Multi-morbidity approach
- **Tayside**: Five practices are focused on people with at least one cardiovascular condition
- **Ayrshire and Arran**: Chronic disease management
- **Lanarkshire**: Multi-morbidity approach
- **Highland**: Multi-morbidity approach
- **Western Isles**: Multi-morbidity approach
- **Dumfries and Galloway**: Multi-morbidity approach

[21]Ibid

Health and care professional team

Health Board	Total no. trained/adopted HoC approach
NHS GGC	58
NHS LOTHIAN	18
NHS TAYSIDE	11
NHS LANARKSHIRE	12
NHS A&A	3
NHS GRAMPIAN	21
NHS FIFE	1
NHS FORTH VALLEY	1
NHS HIGHLAND	5
NHS WESTERN ISLES	2
NHS D&G	3
NHS BORDERS	0
NHS SHETLAND	0
NHS ORKNEY	0
Total	**135**

Table 1 Total no. of Health Boards in Scotland who have adopted the House of Care approach

From the data available, as of 2019 the number of practices that have been involved in embedding the House of Care approach is 135. The breakdown by health board is shown in Table 1. This represents about 12.5% of the total number of GP practices in Scotland (based on ISD data from 2018 showing 944 GP practices). This is a significant achievement for a programme of this size, operating at a time when there has been increasing pressure on primary care, as well as considerable structural changes.

House of Care core team members have emphasized that the quality of engagement by practices is as important as the quantity. Core team members particularly emphasised the need for a good project manager and champions within each local health board area, as well as engagement of practice managers and a steering group within the individual GP practices.

Our review of the evidence suggests that this has been achieved in some of the health board areas. For example, in NHS Lothian a minimum of three members of staff from each practice have received Year of Care training, with a total of nineteen health professionals having attended as of 2018. In Grampian, all practices were invited to two days of Year of Care training.

However, there is some evidence that this breadth and depth of engagement has not always been there in NHS GGC and data is not available from other sites. Indeed, there are stark differences in the number of GP practices engaged across the different health board areas, which is a function of time and level of engagement with the approach. Both the House of Care core team and people from sites agree that engagement can be a challenge. There are some practices who are enthusiastic about the approach but who don't engage because it is not the right time. The main issues cited for not engaging are competing priorities, workload and workforce instability.

This highlights the importance of the continued work that the House of Care team and local sites do to raise awareness of and make the case for the approach.

Local and national community, health and policy partners

Central to the House of Care approach is ensuring the responsive and appropriate allocation of resources to enable 'More than Medicine'. This involves engaging with and referring to community supports, local authority and health partners. It is understood that this can be challenging due to the capacity required in sustaining continuous engagement with community supports.

Therefore, in Scotland, the role of the link worker is central to practice teams engaging with third sector organisations. The Scottish Government has funded a link worker programme in areas across Scotland. In Glasgow, this has been particularly beneficial for practices engaging with wider supports in their community as many practices are able to share a link worker within their cluster.

Sites have also reported engaging with third sector interfaces (TSIs) that act as the co-ordinating interface across third sector and Health and Social Care partnerships. Sites such as Grampian and Highland have been engaging with wider community supports via the TSI roles. They have been engaged in events aimed at raising the profile of third sector organisations locally.

With regard to creating and leading on higher profile for 'More than Medicine' activities, the ALLIANCE has also been involved in ongoing developments of strategic and operational links with national organisations and strategic links including; Scottish School of Primary Care Advisory Group, HIS, NES, Personal Outcomes Network, Active and Independent Living Programme, SSSC Carer Outcomes, National Links Worker programme, ALISS, Self-Management, Co-Production Hub; and the H&SC Academy Programme Board.

House of Care core group

The House of Care core team includes members of the ALLIANCE, Scottish Government, Year of Care and Dr Graham Kramer (Clinical Lead for House of Care Scotland).

The ALLIANCE holds the programme leadership and management role and has been actively engaged in creating an environment in Scotland where 'More than Medicine' within a supported self-management approach can flourish. Dr Graham Kramer has been able to provide clinical leadership where it has been lacking locally. The Year of Care Partnerships are engaged in set up support, training, facilitation and support of the Scottish sites and providing continuous guidance and resources to Scottish sites enabling CSP using the House of Care approach.

4.3 How they feel

Prepared, engaged and involved

For a meaningful conversation to take place between the person and healthcare professional, they both need to feel prepared, engaged and involved in managing the LTCs.

Qualitative feedback from across the Scottish sites shows that CSP has been received well by people living with LTCs. People have reflected feeling more prepared, because there is more time to reflect on and prepare to discuss their issues, and more involved, because there is clarity in what they need to do following their appointments.

What has this looked like in practice?

People living with LTCs involved with the House of Care approach in NHS GGC welcomed the direct receipt of written preparation materials (test results and agenda-setting prompts). Nearly all people interviewed welcomed and appreciated this change in the process. They frequently mentioned the benefit of receiving results prior to the appointment as it made them feel more informed and able to prepare questions for the health practitioner ahead of time.

> *"If they're not written down it's much more likely that the practitioner will say, 'oh yes, that's fine'. But 'fine' can be a huge range of results. If you actually have the results in front of you, it's*

much easier to do your research and see what does that mean? Because 'fine' sometimes means ok, sometimes it means good and sometimes it means well, not great."
(Person living with LTC, NHS Grampian)

Similarly, in NHS Grampian, 67% of 70 patients that responded who had been part of CSP conversations felt it was *very useful* to receive their test results letter to help prepare for the CSP conversation.

In NHS Tayside, patients reported feeling involved and that they and their healthcare professional worked well together and that goals were agreed on collaboratively,

> *"We are a team, a real partnership. I feel that I understand her, and she* understands *me"* (Person living with a LTC, NHS Tayside)

This is the right approach

For the House of Care to make a difference, we need the GP practices and staff, practitioners and people living with LTCs to all think it is the right approach.

Review of the evidence from sites and GP practices where the approach was up and running was very positive. Whilst people felt a bit daunted about making the change, they really believed in the approach and felt it was the right thing to do.

> *I think we just thought sod it, it was a really good idea and we were really busy, and we were passionate about it. When you are passionate about something you get going. When we went to the taster session and then the first day, they said this is what we want you to do, so that is what we did."*

In NHS Lothian and GGC, the approach to getting practitioners on board mirrored the approach taken with patients, where staff are encouraged to reflect on their hopes and benefits of the approach. In Lothian, they used the same 'Best Hopes' tool (pictured below). These reflections often illustrate that staff do see the House of Care model as the 'right approach'.

In NHS GGC, practices reflected during a learning event that this approach would allow the team to develop partnerships with the local community and third sector organisations, allowing a more holistic approach to person-centred care.

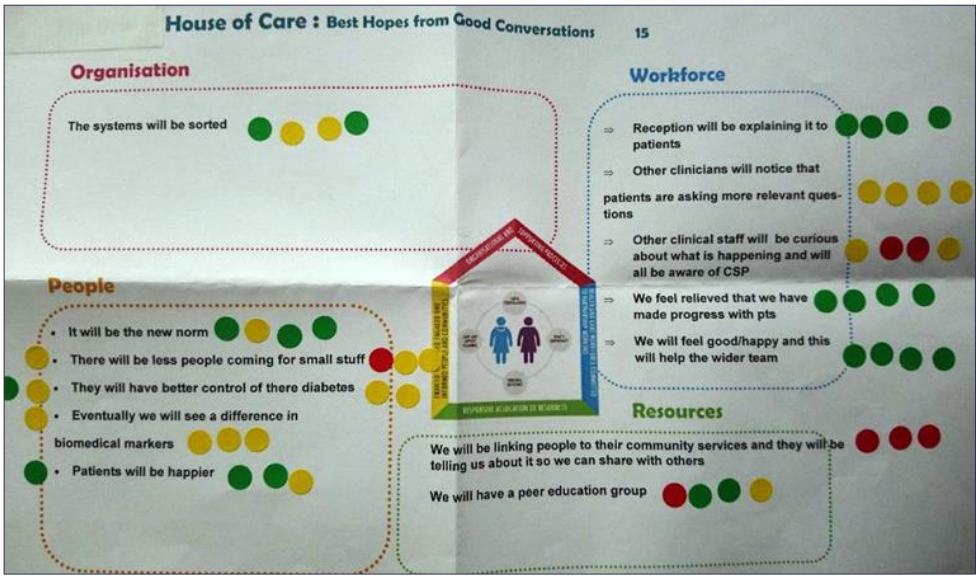


Figure 12 An example of the 'Best Hopes' tool, used by practice in NHS Lothian

In Grampian, it was noted that a key enabler to the successful delivery of the House of Care approach was also a positive and committed attitude among the practice team:

Another example of overcoming any resistance felt by staff in NHS Lothian was through, *"taking the time to communicate and discuss changes and their potential impact with the staff who would be implementing them"*.

The evidence collected strongly suggests that sites see a more holistic and person-centred approach to the management of LTCs as the 'right approach' and the House of Care work allows practices involved to put his way of working into practice.

This helps me develop in my role from fixer to facilitator

Year of Care state that it is important for healthcare professionals to be 'expert generalists' in handling a range of health, social and behavioural topics within the CSP conversations rather than attending to the 'condition' solely'[22]. For this to happen, the meaningful conversation between the person and health care professional moves from a question of *what is the matter with you?* to *what matters to you?* This change requires a shift in the way health professionals perceive their role from a 'fixer' to a 'facilitator'.

What has this looked like in practice?

In NHS Lothian, facilitated learning cycles were used as a tool to help staff reflect on the changes they were making in embedding the House of Care approach along with the challenges and potential solutions. Quotes taken from the learning cycles illustrate health professionals changing their perspective from 'fixer' to 'facilitator' and understanding the importance of this shift:

[22] Roberts et al (2019) The Year of Care approach: developing a model and delivery programme for care and support planning in long term conditions within general practice. https://bit.ly/39fkBcl

> *We are focusing on the person, we have 30 minutes which gives us more time to have the conversation. We are more relaxed, it is less intense which helps."*

> *More rewarding, patients are helping themselves. When you just give people advice, they do nothing, and it gets worse. It is draining of your emotional energy. Working in this way will get easier, it is no longer about a 'Fix' it approach, we are now changing, learning."*

> *I don't wrestle, I now dance with people, it feels better".*

In Grampian, one element of the House of Care model that was cited by staff as being particularly enjoyable was the move from talking 'to' the patient to having more of a partnership dialogue. One mechanism which helped this change in role was the provision of results to patients prior to their CSP conversation.

However, this shift can often take time to be realised by the entire practice team. Constructive feedback provided by a GP in Grampian noted the importance of staff viewing the House of Care approach as a shift to a more holistic way of working:

> *I explained to my admin team, that probably, although we have seen this mainly as an admin exercise to simplify the number of visits people with LTC are making, really this is much more a 'philosophy' of care and that is not a quick or easy thing to convey…"*

4.4 What they learn and gain

Practitioners gain knowledge, confidence and skills to engage, empower and support people to maximise their health and wellbeing

Four sites in Scotland have provided evidence of teams gaining increased knowledge, confidence and skills to engage and support people to maximise their health and wellbeing. Most of this evidence has been collected in the form of post-training feedback and surveys. The majority of staff who completed training feedback in Grampian reported having confidence in their knowledge and skills to support patients with 'goal setting' and developing 'action plans', as shown in Figure 13.

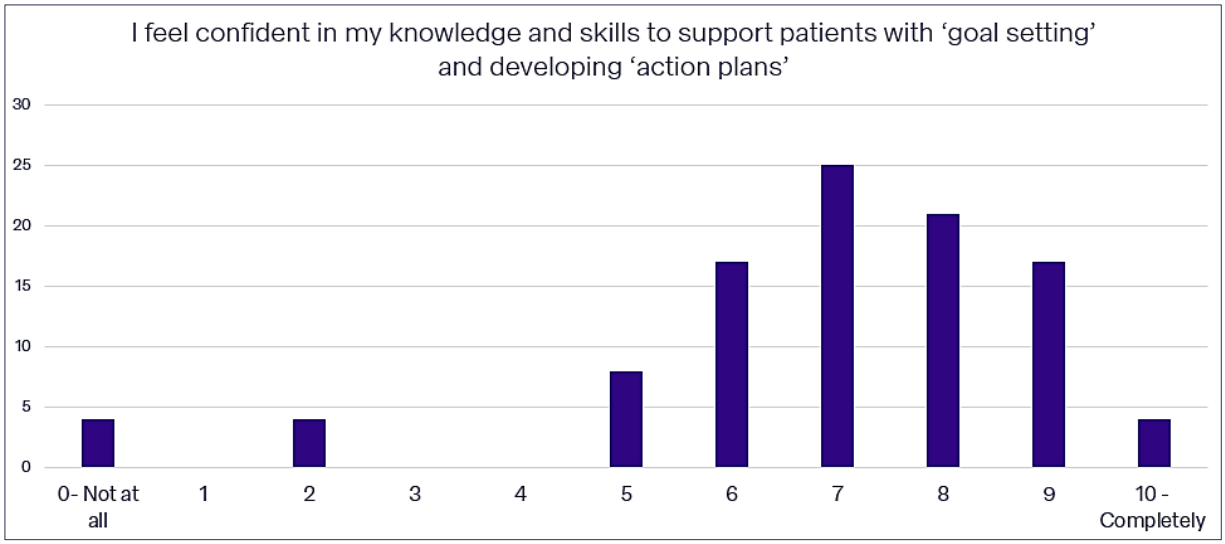


Figure 13 Feedback from health professionals in NHS Grampian

As shown in Figure 14 below, feedback from staff in NHS GGC, illustrated an increased understanding of the importance of preparing patients for their meaningful conversation after attending CSP training. Like Grampian, after the training the majority of staff agreed they understood the skills required in goal setting and action planning with patients.

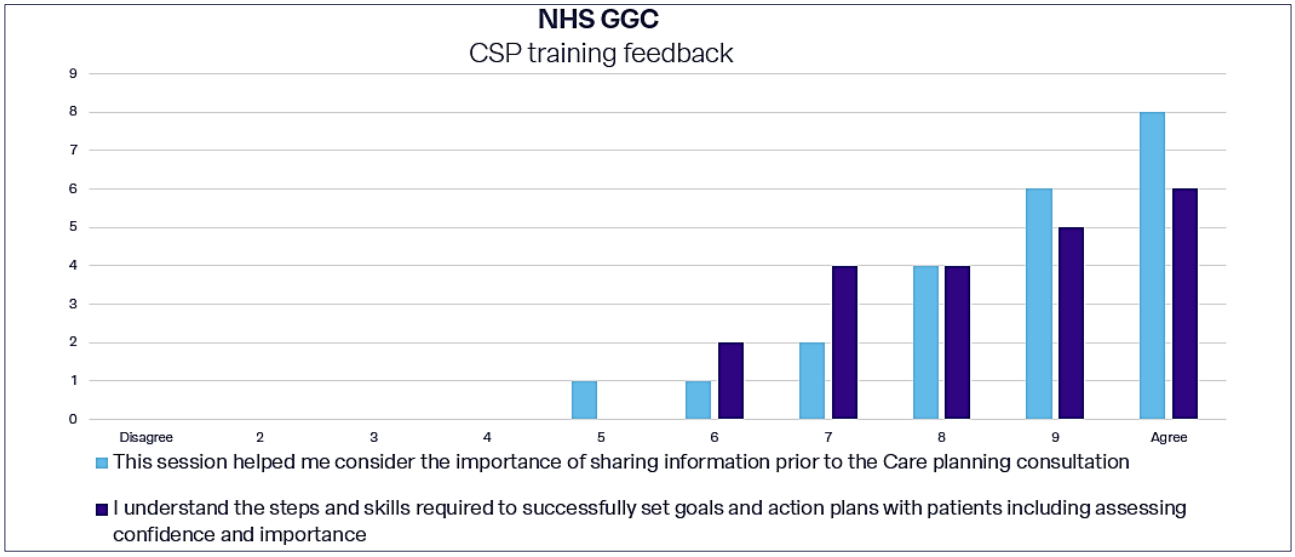


Figure 14 Feedback from CSP training with health professionals in NHS GGC

One risk to ensuring teams have the knowledge, confidence and skills to support patients, is staff turnover. This issue was reported by NHS Lothian with the potential to impact significantly on implementation and progression of CSP, as skills and knowledge may be lost, and time is needed to train up new staff. However, Lothian did provide many quotes from professionals evidencing that patients felt engaged and supported to maximise their health and wellbeing;

> *"We describe this work as the best thing ever, we are taking less and giving the person more control. We are using the tools and focusing on people's strengths, and we are noticing the changes people are making." (Practice nurse, Lothian)*

> *It really helped me to find ways to talk to patients in a way that encourages them to take more responsibility to self-manage, especially when working with patients for weight loss and with diabetes." (Practice nurse, NHS Lothian)*

There were also reports of staff, particularly nurses, upskilling and gaining some professional development in dealing with new diseases which could enable them to work with multi-morbidities:

> *The respiratory side is really new to me, I have only done that within basically the last year, so since we started talking about House of Care, developing a new skill at the same time was quite difficult but I am much more confident in that now."*
> *(Nurse, NHS Grampian)*

This learning is enabled by investments made in Scotland to enhance nurses' skills around supporting people with complex conditions as *"the role of nurse practitioners is key to ensuring the House of Care approach is embedded sustainably."* [23]

People gain knowledge confidence and skills to manage their health and wellbeing

Evidence from Scottish sites indicates that providing information and support to the patient about their health and wellbeing enables them to gain the knowledge, confidence and skills to actively manage their LTCs.

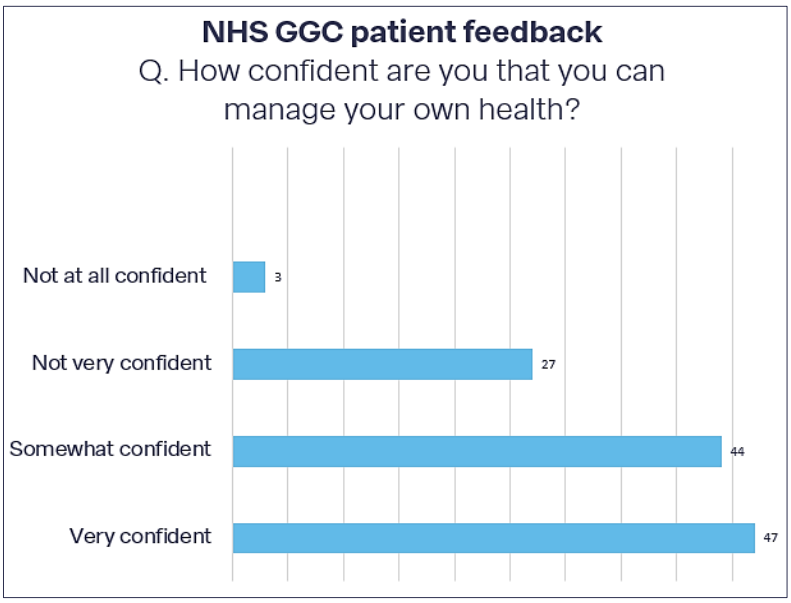


Figure 15 NHS GGC patient feedback

In NHS GGC, patients felt more motivation to make changes and address relevant issues about their health and wellbeing after receiving test results prior to their appointment. They described the importance of gaining information about their health and wellbeing in a format that would not be forgotten about or ignored.

[23] ICF Consulting Ltd, 2018. House of Care Evaluation: Final Report

> *Having the results in writing is definitely helpful, and definitely made me feel more pro-active about my diabetes as opposed to just finding out the results and then forgetting about it. I had it sitting there in front of me and I'm thinking I'll need to work on that". (Person living with LTC, NHS GGC)*

> *I think it's much better when the test results are committed to paper. I think as much as anything, you're going to take them more seriously because it reinforces them. It's easy to forget otherwise".*
> *(Person living with LTC, NHS GGC)*

The bar chart below provided by NHS Lanarkshire shows that most patients who provided feedback felt they were able to talk about what they were going to do to achieve their goals and discuss how confident they felt in achieving them.

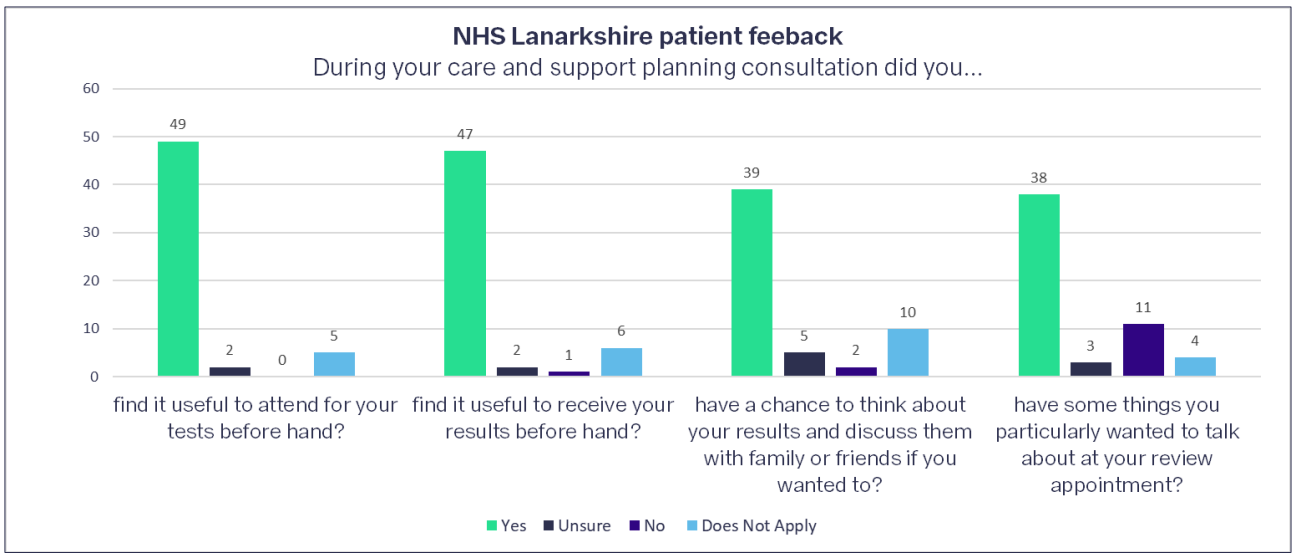


Figure 16 Patient feedback on the CSP conversation provided by NHS Lanarkshire

Similar findings were provided by NHS Grampian where 91% of patients who took part in an evaluation agreed that receiving the results letter prior to their appointment was beneficial. Additionally, evidence from patient feedback showed that 64% of patients rated the CSP conversations as excellent or very good in 'helping them to take control', with 70% rating they were now able 'to help themselves'. The figure below also shows positive feedback from patients in Lanarkshire.

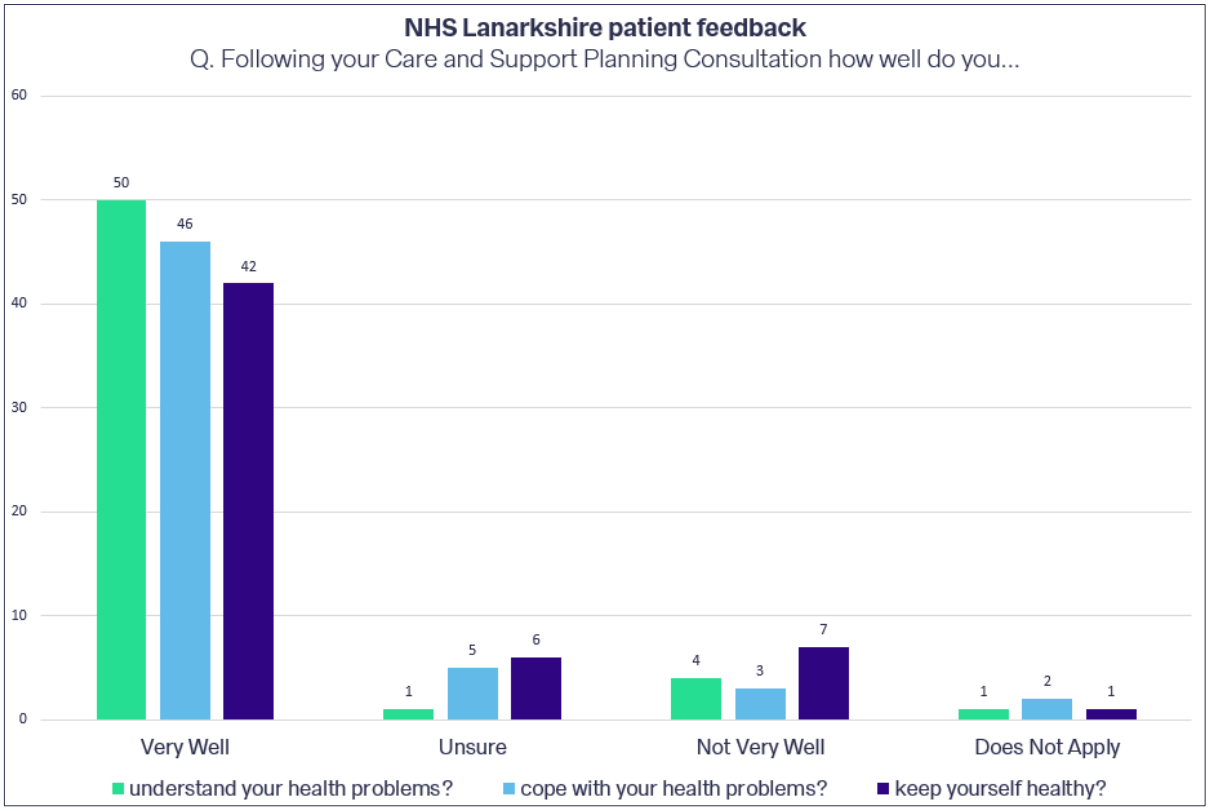


Figure 17 Feedback from patients in NHS Lanarkshire on understandings following the CSP conversation

In NHS Lothian, during their facilitated learning cycles, practices provided examples of patients gaining knowledge and skills to manage their health and wellbeing:

> *Man [with] diabetes way out of control, now very controlled, he commented about CSP 'this is about me taking control'."*

> *One person surprised me because I did not expect her to engage, she came prepared with ideas, I was able to narrow what she wanted down to finding an exercise class with other larger people."*

Understanding of the formal and informal support available and how to access it

Within the House of Care approach, the meaningful conversation shifts the focus from a clinical model to a social model of ongoing care. A patient's self-management may include non-traditional forms of formal and informal support from groups and peers. The conversation can also help identify and provide information about appropriate referrals or self-access for the patient to a range of community activities.

There is evidence among Scottish sites that patients and health professionals gained an increased understanding of the formal and informal supports available within their communities.

Below are some qualitative examples of people gaining an increased understanding of supports in their local community. For example, in NHS Grampian, one health professional commented on how they were:

> *"...getting up to speed with what facilities are out there, now we are referring to agencies which you maybe knew of them but were not used to referring to them, money issues, we are only used to dealing with health issues and I know a lot of other things come into it also but it is just getting your head round what is available locally and doing a lot of work to get that information".*

Additionally, patients who took part in an interim evaluation in Grampian were asked whether they had been signposted to relevant supports in their local community during their CSP conversation, with 70% answering yes, (55/78). This included support groups and patient organisations.

However, in NHS GGC it was reported that there was variation between whether patients were given referrals to appropriate services during the meaningful conversation. One patient felt that although he was offered a referral to a weight management programme and had refused, the health practitioner didn't take the time to explain why he should go, and therefore he regretted his decision after the conversation.

Lastly, the lunch and learn event held by the ALLIANCE provided evidence that attendees had gained awareness of available local supports and knowledge of and confidence in those local supports. This is shown in the graphs below. The ALLIANCE developed this event in the hope it could be implemented in other localities and this could be a potential approach to improving sites' understandings of local supports and how to access them.

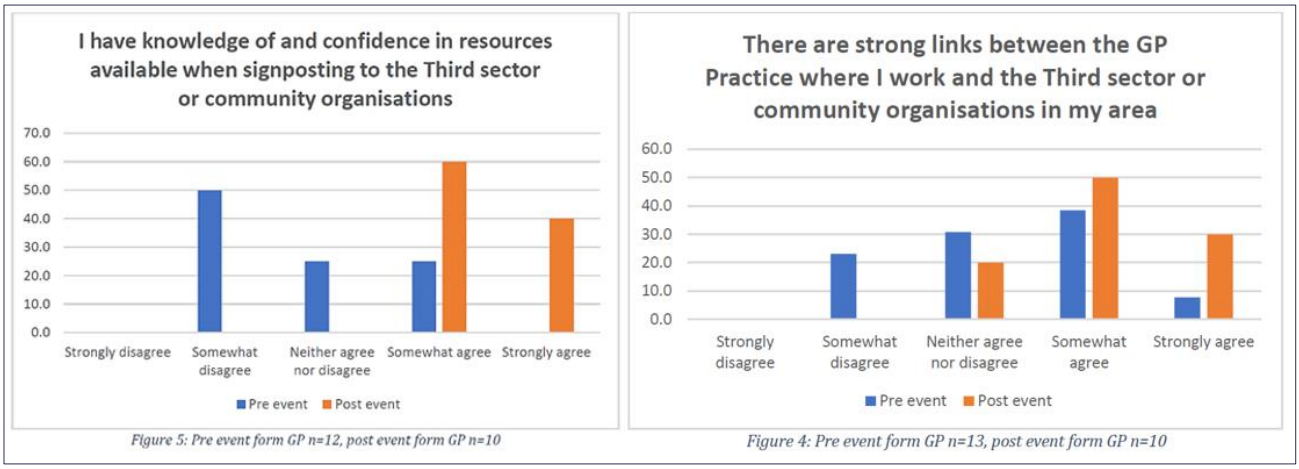


Figure 5: Pre event form GP n=12, post event form GP n=10

Figure 4: Pre event form GP n=13, post event form GP n=10

Figure 18 Pre and post event feedback from health professionals attending the 'Lunch and Learn' event in Paisley

4.5 What they do differently

Practitioners facilitate good care and support planning conversations

Through embedding the House of Care approach, staff across Scottish sites have gained the skills to have a meaningful conversation and the permission to have person-centred conversations and recognise the value of a good conversation. Feedback from health professionals and patients suggest that across all sites, meaningful conversations are taking place. Health professionals in NHS Lothian, GGC and Grampian have provided positive feedback about their CSP conversations. Examples are given below:

In Grampian, professionals delivering the CSP conversation were rated consistently highly by their patient in terms of 'showing care and compassion (88% 'very good' or 'excellent') and 'letting you tell your story' (85% either 'very good' or 'excellent').

In NHS Lothian, during their facilitated learning cycles health professionals reflected on the good conversations:

> *We are now getting their ideas rather than telling them what to do. Using more Open questions. Giving more information because more time asking [about] impact."*

> *People are happy and enjoying the new approach and achieving goals...They open up, they feel more control."*

Findings from a patient experience report in NHS GGC were largely positive regarding the experiences of the CSP appointment.

> *They take care of you. They don't just pap you out and say this is a five-minute or ten-minute appointment. They have plenty of time".* (Patient)

The report stated that nearly all patients were happy with their appointments and felt at ease and listened to:

> *The appointments are fine. There is no rush. You don't feel as if you're being rushed out of the door.. They're there to listen. They do seem to have time for you".* (Carer)

People identify what they can do to manage their health and wellbeing as well as what the team can do to support them

It is assumed that through a meaningful conversation, which involves a collaborative approach to goal setting and decision making, patients are able to identify what matters to them and contribute to actively managing their health and wellbeing with health professionals supporting them to do this.

There is strong evidence of this in England, where NHS Gateshead and NHS North Essex have recorded sustained improvements in biomedical measures among patients involved in the House of Care. Data from a local evaluation in Newcastle and Gateshead showed that blood pressure had improved, with an 11% increase in patients who had BP recorded in the previous 12 months and an increase of 10.9% of patients with CHD who recorded BP of 150/190 or less[24].

To date, there is limited evidence of practice and behaviour change among patients across the Scottish sites, but there are some examples of patients' intentions to actively manage their health and wellbeing. For example, in Grampian, colour coding was used in patient letters to highlight areas where the patient's health could be improved. This was found to be a motivator to promote positive behaviour change, as one practitioner stated:

> *I have had quite a number of people saying this is great, this is really good, and they are really engaging with it. It has motivated them. I had one bloke I had been seeing for two years who has been obese for all that time, he gets his form back it is in the red and he sees that he is obese, he thought oh well I better do something about that then".*

72% of people living with LTCs involved in the NHS Grampian interim evaluation felt the care and support planning conversation had enabled them to keep themselves healthy compared to traditional consultation methods

A patient evaluation from NHS GGC stated that people living with LTCs had experienced a more collaborative review as part of being involved in the House of Care approach. Some people mentioned that although they gained knowledge in how to manage their condition successfully, they still struggled to make the right lifestyle decisions, for example in diet and exercise due to lack of willpower.

One person stated that knowing he would be monitored again in 12 months gave him an incentive to stay on track with managing his health and wellbeing in the form of his blood sugars and weight (diabetes).

Most people living with LTCs interviewed in GGC felt they had the knowledge and skills they needed to successfully manage their condition. They felt more able to make informed decisions, although they acknowledged that they did not always follow advice.

> *"I'm just trying to do the best I can. I know exactly what I'm supposed to do and what I'm not supposed to do. But If I stuck too closely to what they told me to do I wouldn't enjoy my life".*

> *"The results made me very aware of what was going on. I knew that I was slipping away a wee bit, but the results were a wee wake-up call".*

[24]https://bit.ly/32z9cTR

Allocate resources responsively to sustain formal and informal sources of support

In the current healthcare climate, there is wide recognition about the importance of providing integrated care in the community and supporting people to manage their own condition.[25]

Managing increasing demand in primary care will mean focusing on prevention and working across local supports more effectively. However, there is currently limited evidence of practice change in the responsive allocation of resources, as this will take time to progress and requires wider system change.

Nevertheless, there is evidence of the awareness of health professionals to utilise wider supports within the community:

> *Improve the health outcomes of the patients, leading to less need for involvement by the practice as the patients utilise more of the wider support network'" (Practice, NHS Lothian)*

> *Whilst we are aware of numerous third sector or non-traditional care support in the community, we know we do not fully utilise them." (Practice, NHS Lothian)*

One example of responsive allocation of resources can be found in NHS Lanarkshire where, as part of the House of Care Programme in partnership with the Thistle Foundation, a Lifestyle Management Course was set up for people living with LTCs. The course aimed to improve attendees' ability to self-manage their health. The course received good attendance at the weekly sessions and was reported to have been well received by the participants:

> *[Course facilitator] asked us what we wanted out of the course, like you could do up to ten things. I said I'd be quite happy if I got two out of the ten and I ended up I think at the end of the course putting down that I'd got six or seven different things out of the course"*

> *every single week it was something different…it was always exciting, it was always interesting".*

Figure 19 shows an example of how the partnerships between practices and the third sector are being publicised within a practice in NHS Lothian: House of Care language is being used by practices to introduce third sector supports to people living with LTCs. This shows a strategic commitment to More than Medicine within the House of Care approach.

[25]ICF Consulting Ltd, 2018. House of Care Evaluation: Final Report

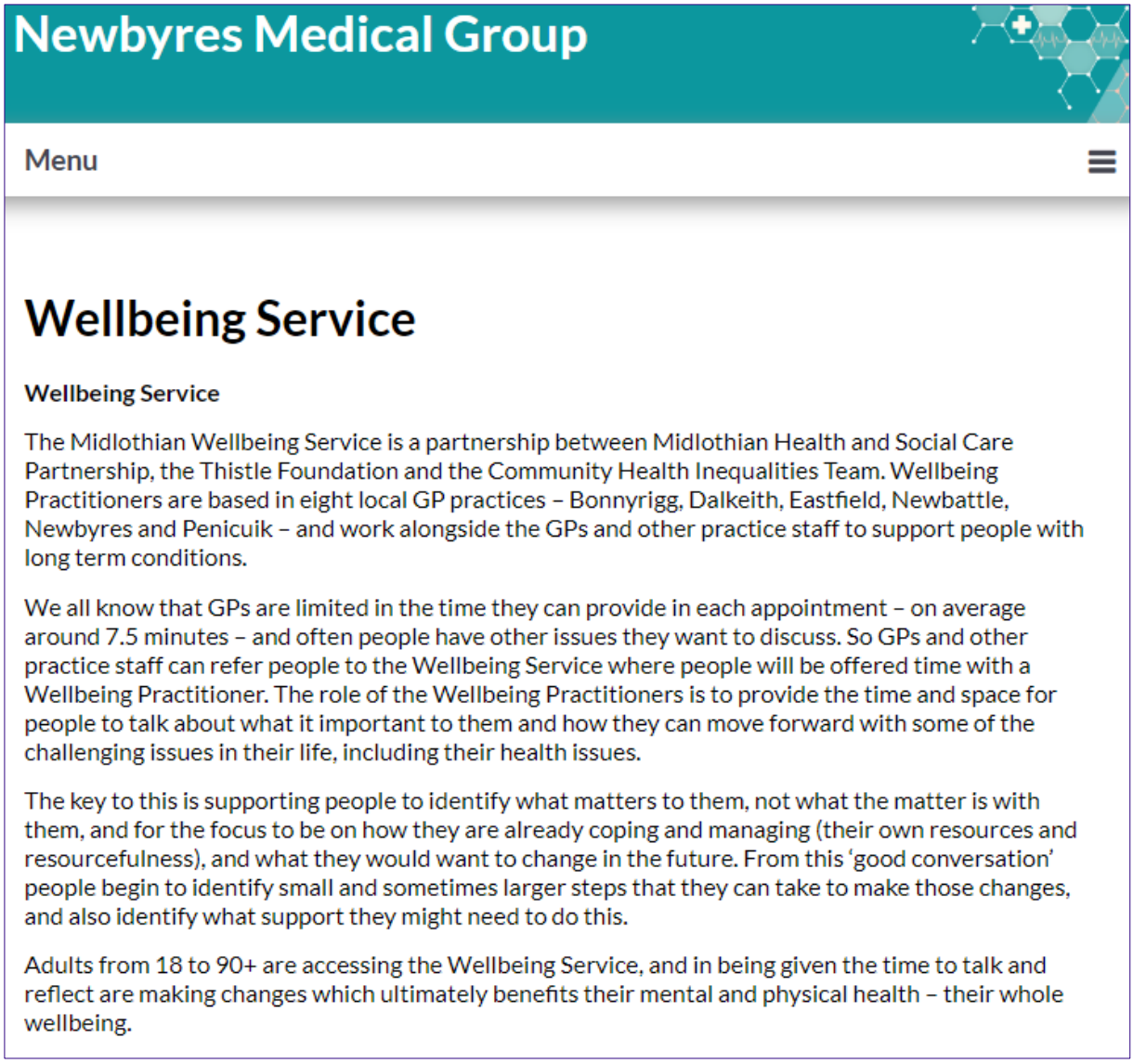


Figure 19 Screenshot of a practice website in NHS Lothian

People access appropriate services and supports

Health boards have been investing in more formal and informal sources of support, which House of Care teams are linking to closely. For example, in Grampian link workers are being invited to House of Care training to support relationships developing between the teams. The link workers provide valuable input to the group discussions during CSP training and often provide reassurance to the nursing teams around signposting.

There are also examples of practices enabling 'More than Medicine' and supporting people to access appropriate services and supports. For example, in NHS GGC a new walking group was set up to fill a gap in community provision and has shown impact on improved clinical outcomes. In NHS Lothian, qualitative evidence of people accessing relevant supports has been collected during facilitated learning cycles:

> *People like to use groups in the community e.g. for walking."*

> *GP referring people to link worker for financial, low mood, isolation, great feedback"*

> *Less DNA, less stress because people are not having their blood taken multiple times. more time for them to get on living their lives rather than focusing on the next appointment."*

> *People are attending less general appointments because they are keeping well, this is reducing our costs"*

Across NHS Lothian and NHS GGC, it was acknowledged that key to developing 'More than Medicine' further was the need to expand knowledge of support services in the community. The House of Care and ALISS programmes are now collaborating to build an information platform that will ensure that everyone working within the House of Care framework can access the 'More than Medicine' information relevant to their localities.

Take action to embed and sustain the House of Care approach

Year of Care has reflected that it is important to balance fidelity and adaption to support the sustainability of the approach. Across the sites, there have been several adaptions to organisational processes to ensure that House of Care is fit for purpose within local contexts, as well as examples of the framework being adapted in national and international contexts.

Local context

Two sites have described flexes in their approach (while remaining faithful to the underlying principles) that helped with the practical implementation of the House of Care approach. For example, in Grampian appointment times were extended for people with several LTCs, reducing the subsequent pressure on staff:

"There were a few times because we are seeing a respiratory patient and diabetic patients at the same time, not enough time was allocated for both, so we realised that we needed more time to do the data gathering and the goal setting, we realised that we needed longer for that appointment that try to cover both big areas was just too much, we were running really late and getting stressed by it. Once the templates were changed so you were getting double, it just changed things completely."

NHS GGC and NHS Grampian also made necessary changes to face-to-face delivery of conversations when the person living with a LTC was housebound or unable to travel to the practice;

> *What we did, we printed out her care plan [results letter] and the district nursing team took it out to her. It was done over the phone,*

so you can do it remotely and that lady is so much happier, even when you speak to her on the phone her whole voice is different." (Practitioner)

Additionally, NHS GGC noted a key lesson in implementation was the importance of tailoring the approach to fit with practice and patient needs, and promoting a focus on culture not process. In NHS Lothian, practices were asked to provide feedback on their progress in implementing the House of Care approach (2019). As shown in Figure 20 below, three out of five practices felt they had great progress with the overall House of Care work, as evidenced by the square surrounding the colour- coded houses.

Figure 20 Practices in NHS Lothian colour-coded houses based on their progress implementing the House of Care approach

> *"We would give it a green – we have made great progress – it is the new norm and it is working well".*
> *(Practice 3, NHS Lothian)*

The House of Care core team have reflected that activities aimed at gaining strategic buy-in at all levels of the health system are crucial to gain depth across a locality before moving on to spread the approach.

National and international context

Although this programme has focused on supporting people with LTCs in a primary care setting, there is strong evidence of the adaptability of the House of Care approach due to its implementation across different contexts.

For example, House of Care is referred to in Scotland's Dementia Strategy – commitment 5: We will test and evaluate Alzheimer Scotland's Advanced Care Dementia Palliative and End of Life Care Model, as a model which focuses on having conversations about what matters to people, "which many are finding helpful in supporting such approaches"[26]

In the Isle of Man, a five-year plan for Integrated Palliative and End of Life Care on the Island has been developed, which used an adapted version of the House of Care framework to describe a whole system approach to the work.

Epilepsy Scotland have also shown interest in the House of Care framework, after a presentation by the ALLIANCE carried out during an Epilepsy Consortium meeting in 2017.

[26] https://bit.ly/30qmK1v

The framework has been adapted for use in Brazil, for the first pilot of integrated care in the state of São Paulo. Figure 21 shows the adapted House of Care model for the work carried out during this pilot projects.[27]

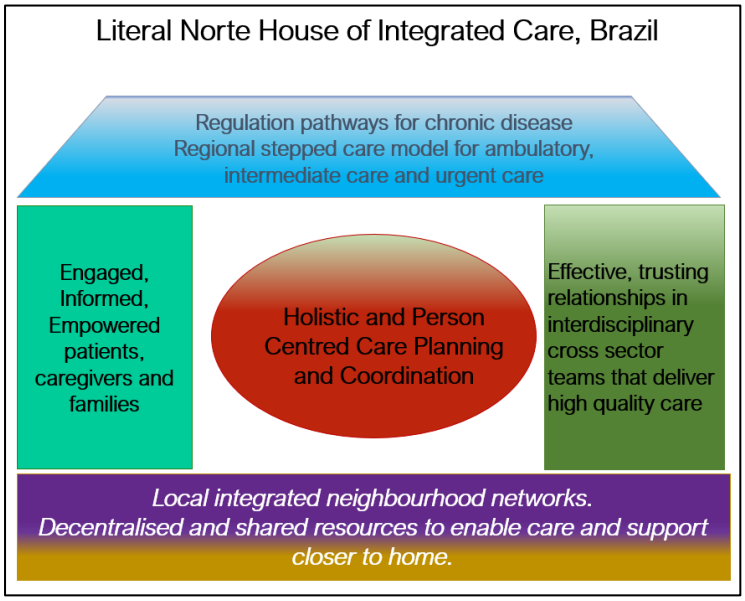


Figure 21 Example of the adaptions made to the House of Care in Brazil

4.6 What difference does this make?

People with long term conditions are living as well as they can

As shown throughout this pathway, Scottish sites have provided evidence of positive impacts on people living with LTCs which contribute to them living as well as they can. Examples include people feeling they had enough support from health professionals to manage their own health; people feeling more able to cope with life and their condition, and people feeling their care and support is more joined up:

> *Just being able to see where I was last year to where I am now, it just makes such a difference. I think if they'd just sent me my results for this review, it wouldn't have been that helpful to me. But because they're showing me where I was and where I am, it's a great help. When you sit and read it, you think 'well, at least it's going the right way".*
> (Person living with LTC, NHS GGC)

> *People are happy and enjoying the new approach and achieving goals. They are impressed with the practice and our commitment to improving services. There are less complaints about getting a GP appointment. They open up, they feel more control."* (Practitioner, NHS Lothian)

[27] https://bit.ly/2OFAKyP

> *I used to talk negatively, now I'll look at the positive rather than the negative"* (Person living with LTC, NHS Lanarkshire)

> *People like it and are happier. We are seeing early evidence of change in biomedical markers"* (Practitioner, NHS Lothian)

This video provided by NHS Grampian[28], gives evidence of a person living with a LTC accessing a smoking cessation service through his CSP conversation with a nurse.

A second video published by the ALLIANCE[29] which uses extracts from videos produced in NHS Lanarkshire, shares two people's stories and experiences of CSP. They both reflect on the positive difference the House of Care approach has made to managing their LTC and living as well as they can.

They mention receiving the right amount of information and receiving the right support to manage their condition and make informed choices:

> *It has certainly made me live more healthily" (Person living with a LTC)*

> *All of these things, the little things add up to changing your lifestyle" (Person living with a LTC)*

Figure 22 Screenshot taken from the ALLIANCE video

[28] https://www.wevideo.com/view/1725393007
[29] https://www.youtube.com/watch?v=vOidO_vTq9c

Heath and care professionals enjoy their roles and feel they are making an effective contribution

The impact of embedding the House of Care approach on health professionals has been very positive. Staff have reported feeling more overall job satisfaction, feeling they now have permission to work in a more holistic way and feel they are really making a difference to the people they support.

In Grampian, participants involved in the interim evaluation described an overall improvement in their job satisfaction through delivering CSP conversations using the House of Care approach:

> *"It has been very fulfilling and I think in years to come, this is just six months it, it is very much person-centred and you are dealing with issues that might not have nothing to do with chronic disease but we have a directory we use now that [Staff name] updates it and we are using it"* (Health professional, NHS Grampian)

In NHS Lothian, health professionals reported feeling they were making a noticeable difference to their patients' health and wellbeing:

> *I feel proud on an individual level but also as a team we are having a massive impact on people because we are trying to prevent future problems."* (Health professional, NHS Lothian)

> *You do it because it makes a difference. It's why I do the job. Gives you a lift, inspires you."* (Lothian GP)

For some staff, embedding the House of Care in practice has led to a larger role for them within their practice and this has been rewarding:

> *It's much more enjoyable to do [reviews] now compared to what it was like previously."* (NHS GGC)

Staff have also reported feeling they are able to work together as a team more successfully:

> *We're better at managing it, I feel we work much more as a team because of House of Care, everyone has their own roles that work together but everyone knows what those roles are so there's not the stepping on each other's toes which is quite important."* (NHS GGC)

Health inequalities are mitigated

Evidence from the Year of Care has shown that the House of Care programme is suitable for disadvantaged groups, including those with poor health and language literacy (Year of Care, 2011). As discussed throughout this report, the House of Care approach to CSP focuses on tailoring and coordinating care around the person rather than specific diseases. This helps to accommodate the complexity of people's needs and is especially beneficial in disadvantaged communities: "*Enabling practices in deprived areas to provide longer and more patient-centred care for multimorbid patients may protect quality of life in a cost-effective way.*"[30]

A key element of CSP - preparation and information sharing - enables more productive conversations between the person and the healthcare professional as it clarifies people's understanding and usually indicates any hidden health literacy needs or compelling psychosocial problems, which are then more likely to be addressed.

Supporting evidence in Scotland was reported by NHS GGC, where an Equity and Reach analysis, conducted in 2017, found that there was, *"no significant difference in the percentage of patients being invited to or engaging with House of Care programme across deprivation groups"*[31]

In NHS Lothian, analysis of patient-level data from five sites found that although over a quarter (28%) of patients that were invited to participate in CSP, were from the most deprived quintile in Lothian (SIMD Q1), a significantly lower proportion of invited patients from SIMD Q1 attended the information gathering and CSP appointments compared to invited patients from the least deprived quintile (SIMD Q5).

However, as shown in Figure 23, once patients had attended the first appointment, there was a smaller difference in those attending subsequent appointments from the quintile least deprived compared to the most deprived. This shows that people living in more deprived areas find CSP valuable, once they attend.

[30] Mercer, S.W., Fitzpatrick, B., Guthrie, B. et al. (2016) The CARE Plus study – a whole-system intervention to improve quality of life of primary care patients with multimorbidity in areas of high socioeconomic deprivation: exploratory cluster randomised controlled trial and cost-utility analysis..
[31] Jarvie, H., Allardice, G. on behalf of NHSGGC House of Care Programme (2017) House of Care Equity and Reach Report.

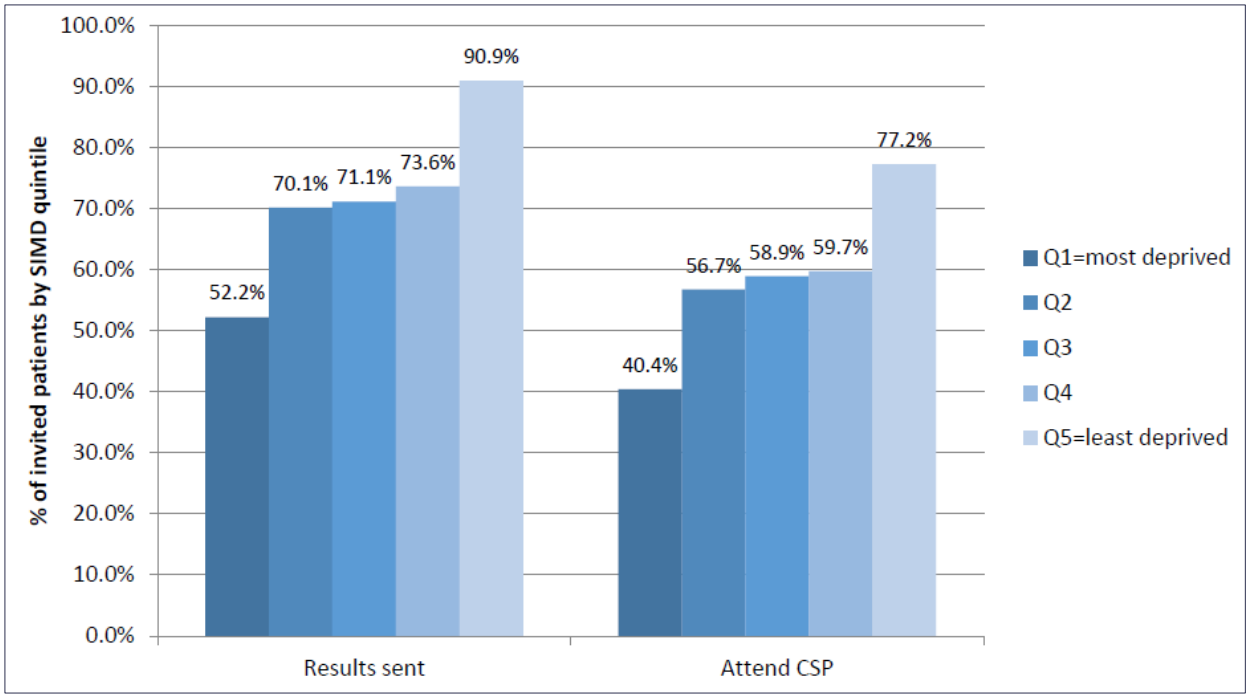


Figure 23 Taken from the NHS Lothian report, Embedding the House of Care Approach in Practice: Diabetes Cohort

Qualitative data from a handful of sites provide evidence for mitigating health inequalities among people living with LTCs. For example, where people were unable to attend CSP appointments, at times home visits were provided. It is however less sustainable than telephone calls in the longer term due to the resource required.

In Lothian, evidence that delivering the House of Care approach mitigates health inequalities was provided through qualitative data from healthcare professionals:

> *"We tackle health inequalities by being proactive, telephone call, reminder and letter, remind care plan."*

> *"They are very positive, like to know their result makes a difference as they come in ready to have a discussion. We tackle health inequalities by phoning them as we have a relationship and they are more likely to come"*

> *We know our poorer socio-economic patients but also others who have difficulties engaging and Practice Nurse will call'.*

> *The two appointments are better for people who are working... We are offering appointments later in the day'.*

As shown in the quotes above, efforts were made by health care professionals to adapt the CSP process so that it was suitable to individuals affected by health inequalities.

5. Conclusions and recommendations

This review of evidence gathered over the last six years of Scotland's House of Care programme shows it to be an effective approach that does make a meaningful contribution to improving outcomes for people living with long term conditions (LTCs), and staff. There is also some evidence that this approach can mitigate health inequalities. People living with LTCs and staff across multiple local sites were clear that care and support planning (CSP) works. Taking the time required to prepare the person and have a good conversation does open up new opportunities for people to manage their condition and have a good life. Furthermore, staff enjoy this way of working.

Central to success of the House of Care approach to realising these benefits is the holistic approach taken to addressing the system and process issues that can get in the way of more relational and person centred ways of working and to building a wider support infrastructure through 'More than Medicine'. As such, the House of Care provides a useful framework to underpin transformation in other contexts as evidenced by the wider influence of the programme across health and social care in Scotland, as well as internationally.

A key success of the programme is the spread of the approach that has been achieved, with more than 12% of GP practices in Scotland engaging in the programme to some extent. This is a considerable achievement given that the programme has been implemented in the context of many challenges, including political austerity, the change in GP contract and structural reorganisation. The change in evaluation plans due to COVID-19 meant that we did not get specific data on the contribution of the core team to successful implementation or how their support helped overcome these challenges. However, the positive engagement with all aspects of their work, raising awareness of the House of Care approach, making the case for the approach at local and national levels, linking with wider policy developments as well as providing expert, joined up training and support and facilitating peer support suggests that this has been an important component of success. This is something that could be usefully explored in more detail in future evaluation.

As the health and social care system moves into the COVID-19 recovery phase, there are important lessons that can be learnt from this programme. Whilst we do not know how CSP has been implemented with people who are shielding, we do know that taking time and preparing people with LTCs to engage in CSP does enable people living with LTCs to manage difficult situations better. It will be important to explore over time how practices using the approach have done so through the pandemic and how it has helped (or otherwise) their approaches to supporting people.

5.1 Next steps for evaluation

Using this complexity-informed, theory-based approach to evaluation and synthesis, we have been able to draw some clear conclusions about whether the approach can make a difference and how it does this. There was a remarkable consistency of findings across sites enabling us to be confident about the conclusions presented here. As already highlighted, there are gaps in the evaluation as we were not able to engage in the co-produced approach to evaluation and collective analysis planned with the local sites. Further evaluation would be beneficial, working closely with the local sites to address the gaps in understanding, in particular:

- how CSP is being implemented in the context of COVID-19 and with people who have been required to shield
- how implementation is influenced by local contextual factors
- the contribution of the core team and which elements of support have been most valuable
- the extent to which the approach contributes to improved outcomes and mitigating health inequalities.

5.2 Recommendations

Based on the findings from this work we recommend:

1. Relational, enabling and preventative approaches such as CSP are central to local and national policy responses to improving outcomes for people living with LTCs. These need to be supported by a continued shift towards community support.

2. The House of Care approach should continue to be promoted as an effective approach to primary care transformation that improves outcomes for people with LTCs, and staff, as well as supporting local areas to meet policy imperatives of realistic medicine, supported self-management and public service reform.

3. Ongoing expert support is required to spread the House of Care approach to new GP practices and areas as well as to sustain progress in current sites. This support needs to build on the learning from the previous six years of the programme, encapsulated within the recent House of Care Recommendations paper[32] and the collective learning from the Year of Care Partnerships.

4. Further evaluation of the programme would be beneficial, carried out with local sites to better understand the contribution of the House of Care to responding to COVID-19 as well as building a stronger picture of the extent to which the approach contributes to improved outcomes.

[32] Health and Social Care Alliance Scotland (2019) Key Recommendations for the Further Spread of Care and Support Planning and the House of Care framework across Scottish General Practice.