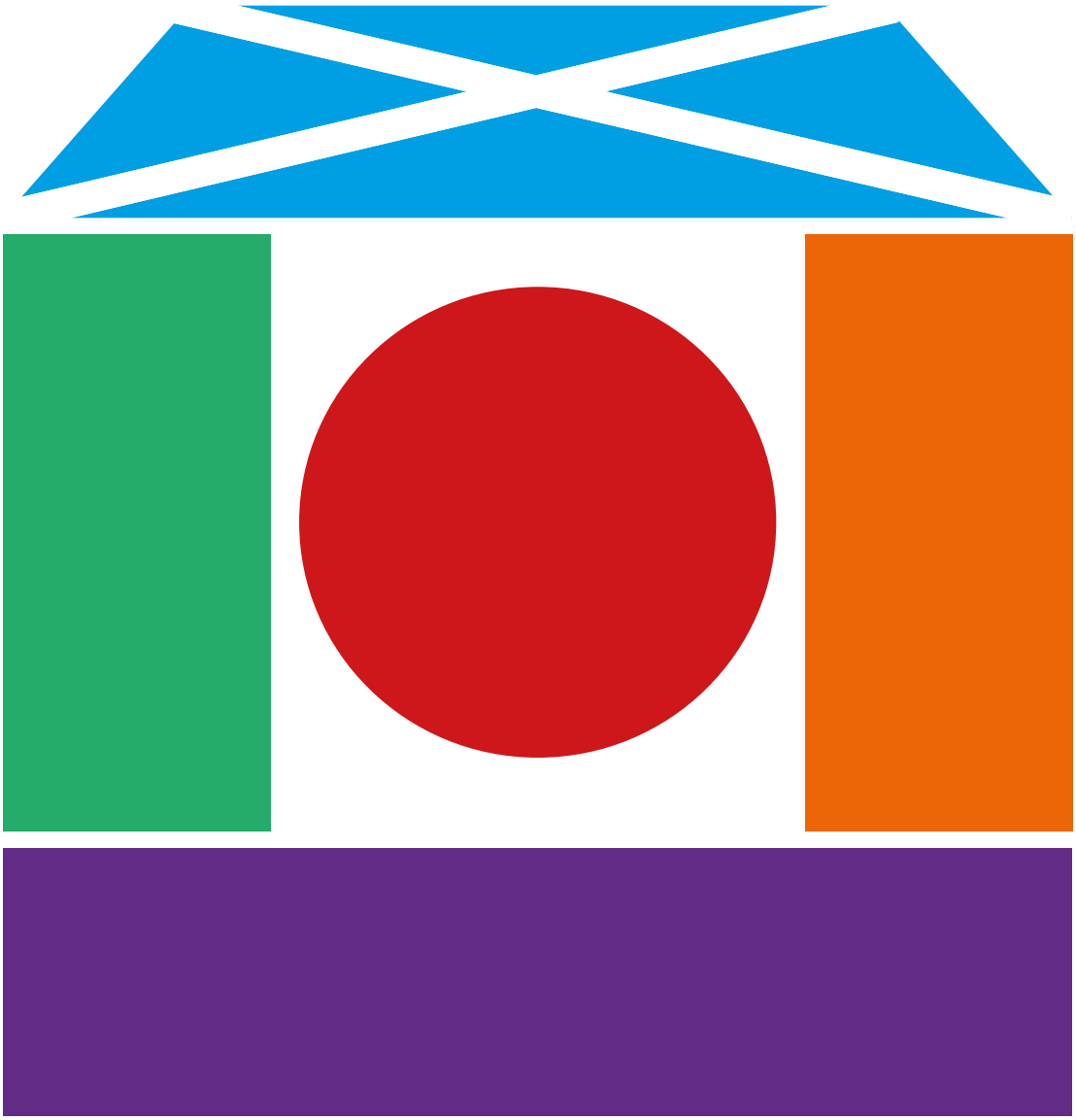
The House of Care in Scotland

Programme Plan Update October 2016



Scotland's House of Care

The Scottish Government

REALISTIC MEDICINE

ALLIANCE
HEALTH AND SOCIAL CARE
ALLIANCE SCOTLAND
people at the centre

Executive Summary

The House of Care model helps make sense of the key elements that enable people to live well in their communities

The Scottish Government in partnership with The ALLIANCE are promoting the adoption of Collaborative Care and Support Planning as an evidence-based approach in meeting the needs of people living with long term conditions in Scotland - the House of Care.

Scotland's House of Care programme aims to facilitate a fundamental shift in the relationship between person and professional, so that the person is in the driving seat of their health and social care, with self management at the heart of it.

The House of Care model

- Helps make sense of the key elements that enable people to live well in their communities. Each of the structures, the roof, foundation and the two walls of the house, represent the essential elements needed to enable people to shape their care
- Illustrates the components required to make sure that care and planning conversations link people to sources of support to keep them well. Mutual signposting and referrals, represent the criss-crossing pathways which connect the structures of the house.

Scotland's House of Care programme aims to support health and social care to flourish by:

- Building the Scottish capacity for person centred care through care and support planning conversations that include, and are informed by, the voices of people with lived experience
- Capturing and sharing the stories of this working in ways that can be understood by a wide audience
- Amplifying and connecting the streams of good practice including ALISS and National Links Worker programmes.

HoC Adopter sites in Ayrshire & Arran, Greater Glasgow & Clyde, Lanarkshire, Lothian, and Tayside are working in partnership to ensure people living with long term conditions:

- Are empowered by the model of care and the care planning process
- Are enabled to articulate their own needs, deciding on their own priorities, supported by health and social care professionals through a conversation involving information sharing, joint decision making, with goal setting and action planning
- Are supported to develop the knowledge, skills and confidence to manage their condition effectively in the context of their everyday life
- Have an improvement in their experience of care: better coordinated, with a measurably improved patient experience.

British Heart Foundation Involvement in Tayside, Lothian and Glasgow

Funding to each of the three early adopter sites from the British Heart Foundation is to support work to more directly consider cardiovascular care (as part of a multi-morbidity approach). This funding has come with a robust Evaluation Programme with early focus on understanding the programme's theory of change, logic model, and evaluation approach. See Appendix 2 HoC BHF Logic Model.

Early Adopters

Tayside have undertaken Year of Care Partnerships Care & Support Planning training, with GPs and practice nurses from the 10 practices involved, along with a number of diabetes consultants, completing the 1½ day course.

Glasgow have also undertaken the C&SP training with 14 Practices, following very positive initial engagement events with GP practices, involving their cardiac and diabetes Managed Clinical Networks and Diabetes UK, with over 30 practices engaging.

Lothian are working in close partnership with the Thistle Foundation to ensure a cross- sectoral approach with 7 Practices, and have included adoption of the House of Care model as part of their longer term strategic plan for service redesign and improvement.

Mid Adopters

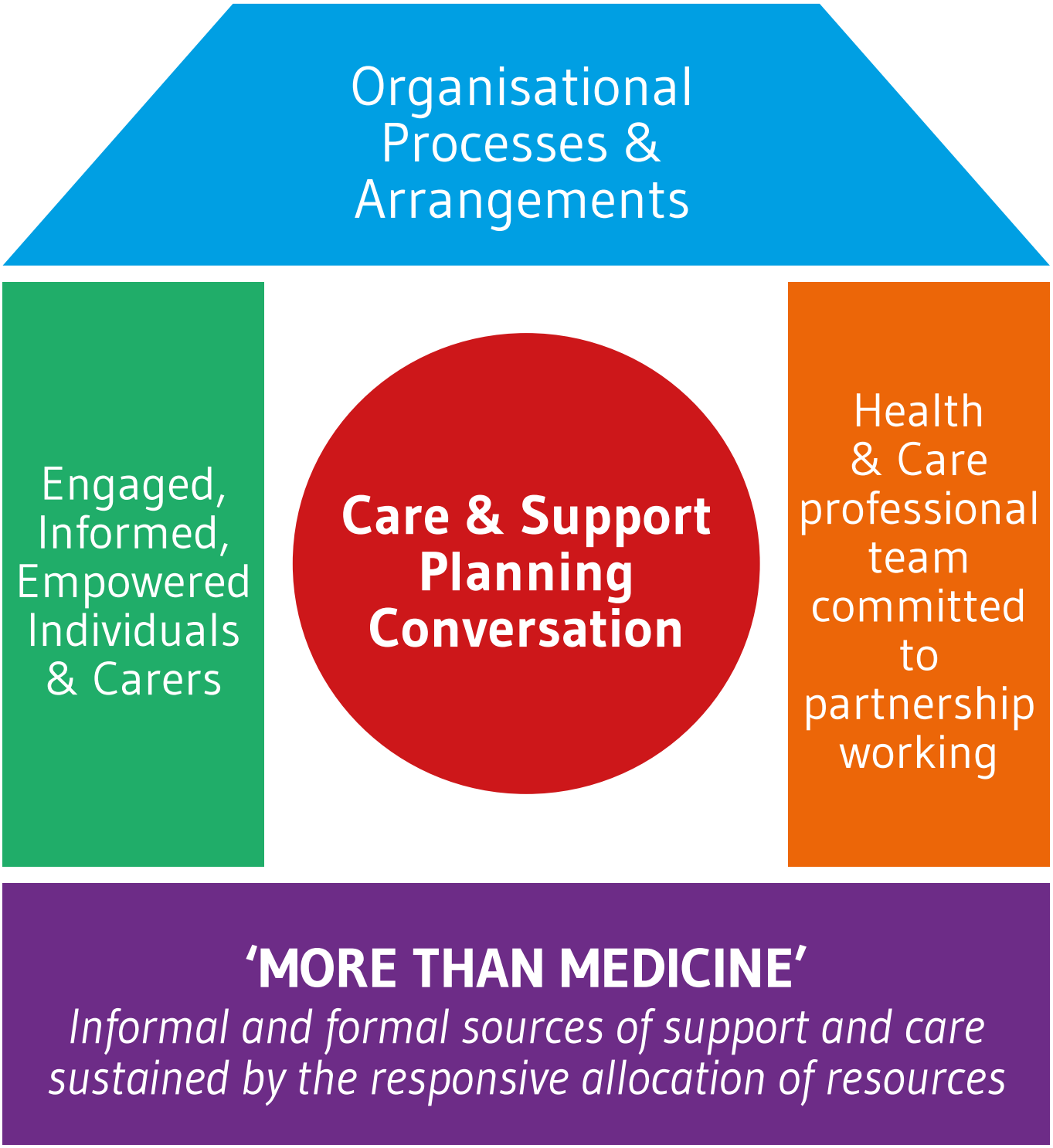
More recent additional resource from the Primary Care Development Fund has supported the spread and learning from the early adopter approach to two more areas in Lanarkshire and Ayrshire & Arran. Both sites bring considerable experience from previous projects and have considered how best the House of Care model can support their ambitions to support person centred care driven by a CC&SP approach.

Ayrshire are building on their Co-Creating Health person centred approach by delivering CC&SP training across each of the H&SCPs in Ayrshire.

Lanarkshire have embedded the HoC work within their organisational change programme and Primary Care Transformational workstreams and have begun by delivering training in practices in each of the H&SCPs.

1. Background

The House of Care represents a tangible and proven approach that allows healthcare to embrace *Collaborative Care and Support Planning* (CC&SP) and fulfil its responsibilities to support the self-management of people living with multiple long term conditions. This approach supports and enables people to articulate their own needs and decide on their own priorities, through a process of joint decision making, goal setting and action planning. See Appendix 3. CC&SP Outline.



The House of Care approach has emerged from a series of pilots in England that looked at improving Diabetes Care and work has developed in Scotland alongside the *Year of Care Partnerships* to build the capacity of the workforce in early adopter sites in Scotland.

2. What is the House of Care?

Enabling and sustaining productive CC&SP conversations requires changes to traditional processes, roles and systems. These fit into distinct categories that are presented in the visual and memorable *House of Care.*

The House represents both a visual check list but also a metaphor, in that if any of the elements of the House are missing it would leave the central CC&SP conversation unsupported. It is a modification of Wagner's Chronic Care Model (CCM), endorsed by Institute of Medicine (IOM). The CCM is based on a large systematic review of global interventions that have shown benefit in enhancing outcomes for people living with LTCs. Whilst the CCM relates to Health and Care systems, the House of Care is a more tangible adaption applicable at the level of practice/clinic settings. A wider discussion of this can be explored on

https://houseofcare.wordpress.com/2015/03/05/unlocking-the-house-of-care/

3. Strengthening the Voice of Lived Experience

Scotland's House of Care Programme, directed by The Health and Social Care Alliance Scotland (the ALLIANCE), was initiated in September 2014 working initially with three sites: Lothian, Greater Glasgow & Clyde and Tayside. Two further Mid Adopter sites were identified in early 2016 in Lanarkshire and Ayrshire & Arran.

The focus of the HoC programme is on ensuring people living with long term conditions:

- are empowered by the model of care and the care planning process;
- are enable to articulate their own needs, deciding on their own priorities, supported by health and social care professionals through a process (a conversation) of information sharing, joint decision making, with goal setting and action planning;
- are supported to develop the knowledge, skills and confidence to manage their condition(s) effectively in the context of their everyday life; and
- have an improvement in their experience of care, which should become more coordinated, with a measurably improved 'patient experience'.

The House is helpful for describing support and relationships at a regional, integrated Health and Social Care Partnership level, as well as nationally. These different levels can be described as a "Russian Doll" – the key feature is that the interaction between people and their professionals remains at the core (Fig 1).

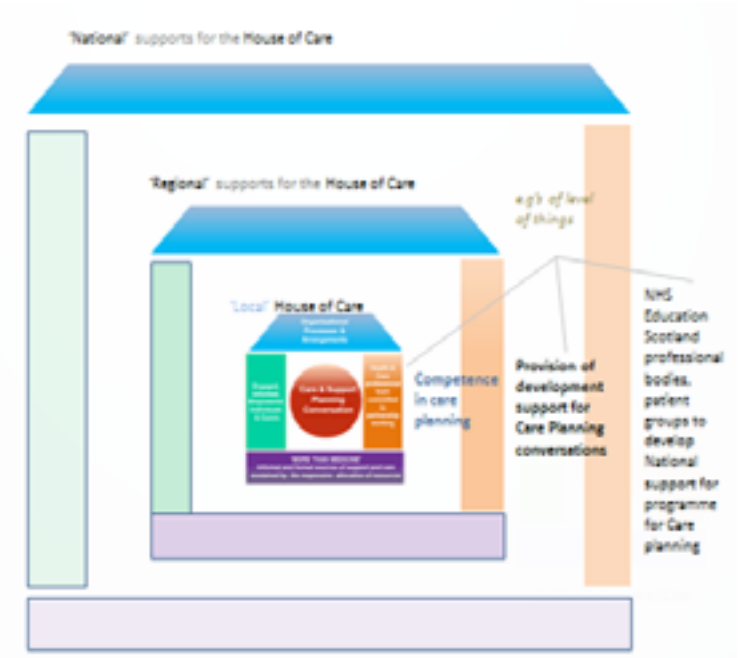


Fig 1 "Russian Dolls" House of Care showing the relationship of local organisations delivering CC&SP to regional and national support.

4. Governance

The work is governed by an Executive Group chaired by Graham Kramer, Clinical Lead for Self Management and Health Literacy (until July 2016). Short life sub- groups on Evaluation and Learning & Training report into the Executive Group. See Appendix 1 Terms of Reference.

5. Sponsorship within the Scottish Government

The House of Care work is homed within the person-centred and quality team, with Blythe Robertson leading from a policy perspective and Graham Kramer offering clinical leadership (until July 2016).

6. Policy Alignment

Collaborative Care & Support Planning has been developed chiefly in the context of people living with long term health conditions, however *collaborative conversations* between people and professionals (rather than traditional subordinate or structured consultations) are at the heart of many current policies and programmes within Health and Social Care in Scotland. These are summarised in the infographic below (Fig 2). Many of the principles of the CC&SP process can be applied to these various contexts.

Fig 2 Collaborative conversations at the heart of Health and Social Care

The Royal College of General Practitioners, both at a Scotland and UK level, are strongly committed to supporting developments in Collaborative Care and Support Planning, viewing it as fundamental to the change required to address the current crisis in GP services. Their Blueprint for Scottish General Practice and 2016 Manifesto makes explicit mentions of their support for the House of Care programme in Scotland. This buy-in from clinicians is key to the success of the programme, so represents very positive endorsement.

Positive discussions are on-going on how the approach can provide a coherent, integrative model supporting our wider aims around person centredness and health and social care integration, and how this links to ensuring the strategic role of the third sector. This has promoted connections across the Scottish Government with policy areas including primary care, integration, mental health, self-directed support, self management, health literacy and public health.

Realistic Medicine and the National Clinical Strategy

The Chief Medical Officer for Scotland (CMO), Dr Catherine Calderwood, used the publication her first annual report in January 2016 Realistic Medicine to engage with clinicians as collaborative leaders, to influence and be a driver for change. The report laid out many of the challenges facing healthcare and the profession today and aimed to start a conversation with doctors about how these could be addressed. She and her team have engaged with clinicians on how together, and with the Third Sector and people and their unpaid carers, we can address challenges to realise Realistic Medicine, by: changing the style of shared decision-making; building a personalised approach to care; reducing harm and waste; reducing unnecessary variation in practice and outcomes; managing risk better; and becoming improvers and innovators.

The ambition of Realistic Medicine has been incorporated as a key elements of Scotland's National Clinical Strategy.

7. Funding and Evaluation

Funding for the programme has been identified from within the person centred and quality team and primary care teams: £210k from the person-centred team in 2014-15; £100k from the person-centred team in 2015- 16; and £150k from primary care 2015-16. This is in addition to funding from the British Heart Foundation: First Phase £200k across 2015-16 and 2016-17 to support early adopter activity; followed by the recently confirmed Second Phase of 195k across 2017-18 to support embedding of local implementation and evaluation activity.

Funding to each of *the three early adopter* sites from the British Heart Foundation is to support work to more directly consider Cardiovascular Disease. This funding has come with a robust Evaluation Programme with early focus on understanding the programme's theory of change, logic model, and evaluation approach. See Appendix 2 HoC BHF Logic Model.

8. Programme Leadership

An overall Scotland's HoC programme logic model has been developed that describes the expected outcomes, outputs, activity, resource input and programme and linked national evaluation measures. This outcomes model provides a coherent theory of change from which to:

- guide the direction of travel
- identify and build a sustainable learning model that is grounded within an understanding of the need to strengthen the voice of lived experience
- support the nested adopter sites to strengthen implementation and evaluation focus and capacity.

Implementing Care and Support Planning Using The House of Care Framework to Deliver Person Centred Care

Assumptions	Resources	Activities	Deliverables 2016-17	STOs 2016-17	MTOs 2017-18	LTOs 2018-19	Potential Measures
Collaborative Care and Support Planning (C&SP) is an evidence based approach for person centred care that meets the needs of people with LTCs and of staff Prevalence of long term conditions predicted to rise (already close to half the Scottish population) Current system of supporting people with LTCs not financially viable or broad enough in scope to meet all of their needs or respond to increased emphasis on person-centred support Need a shift – away from the 'medical model' of illness, towards model of care and support which works with expertise of those living with LTCs, utilising resources their communities provide in an holistic approach to their lives and to help best possible outcomes be achieved Staff morale and health under strain, recruitment issues in general practice and high numbers of retirement imminent Builds on the strong platform of activity, driven by the ALLIANCE, to embed self management as core plank of health and social care Crucial time of opportunity as integration demands far greater collaboration across sectors, new models of care and a deep shift in culture Reflects a direction of travel that has been reiterated in successive Scottish policy, most recently the National Clinical Strategy, Realistic Medicine, RCGP Blueprint and Gaun Yersel	National Executive Group and associated working groups Adopter Steering Groups and Project Managers ALLIANCE: Scotland HoC Programme Manager, ALISS, LWs, PPH&W, Third Sector Health & Social Care Support; Self Management; Dementia Carers Voices; and other ALLIANCE programmes and resources Year of Care Partnerships BHF National Clinical Lead SG Person Centred Lead at Scot Gov Realistic Medicine Team Nat Clinical Strategy Leads John Mitchell PMO HIS PCC Lead NES Lead Diabetes UK Macmillan Cancer Care *Committed Funding* SG PCC and primary care funding until March 2017; BHF funding until March 2017; BHF extension funds for 3 Early Adopter sites until March 2018 *Bids* RCGPS/ALLIANCE to Primary Care Transformation Fund, ALISS Phase 3, Links Worker Programme (+250) *Academic links* Aberdeen University- Vikki Entwhistle SSPC :Stewart Mercer and Frances Mair University of Oxford, Informed Medical Decisions Foundation Boston - Angela Coulter	**(i) Promote C&SP and HoC across Scotland so it becomes standard practice within primary care (ensuring better outcomes are achieved for patients, their families and carers, wider communities and staff)** **(ii) Build on successes in primary care and the early adopter sites, ensure that C&SP is available to all health and social care providers** **(iii) Ensure that C&SP in primary care, and the quality improvement required to build the HoC, are informed by and developed with people living with LTCs and their wider community** **(iv) Promote this model of person-centred care and support for self management and wellbeing across all health and social care disciplines for people with long term conditions** **(v) Support primary care teams to understand and adopt a framework that ensures Quality after QoF** **((vi) Agree recommendations around what needs to happen to support a high degree of fidelity to the process and better conversations and ensures links with more than medicine / self-management support**	**Health and social care supported to flourish by focussing on:** **a) Scottish capacity built for person centred care through collaborative care and support planning conversations that include, and are informed by, the voices of people with lived experience** **b) Stories of this working captured and shared in ways that can be understood by a wide audience** **c) Streams of good practice including ALISS, National Links Worker and PP&W programmes amplified and connected.**	*Practice Level* **Collaborative Care and Support Planning. (CC&SP) is adopted and spread in Scotland** *Cluster/locality Level* **Increased links with, and awareness of support for self management/ more than medicine** *IJB Level* **Mechanisms for C&SP to be able to influence resource allocation**	**People living with long-term conditions:** **• are empowered by the model of care and the care planning process** **• are enabled to articulate their own needs, deciding on their own priorities, supported by health and social care professionals through a collaborative conversation** **• are supported to develop the knowledge, skills and confidence to manage their condition(s) effectively in the context of their everyday life** **• have an improvement in their experience of care, which should become more coordinated, with a measurably improved 'patient experience'** **Staff are empowered by the model of collaborative care and support planning through improved skill mix and improved team working/job satisfaction, are supported to develop knowledge, skills and confidence in their person centred approach**	**A fundamental shift in the relationship between person and professional that supports that person to be in the driving seat of their health and social care, with self-management at the heart of it**	**National Health and Wellbeing Outcomes/ Indicators 1 3 4 5 6 8 9** **Personal Outcomes** **Primary care Transformation Evaluation** **BHF Measures** **In tune with guidance for the new GP Contract** *Indicators to be agreed that reflect all parts of the House:* -improvement in both health and personal outcomes for people (biomedical outcomes and care process measures) -improvement in level of support for self management, self efficacy - greater engagement with, and development of, community and peer support - people feel more involved and in control of decisions about their care -professionals have reported greater satisfaction in this way of working - whole systems change (described by the HoC) -catalyst for transformation, person-centred quality improvement and Health, Social and 3rd sector integration -service use (better use of primary care, more appropriate specialist referrals, better uptake of more than medicine

9. Building the Scottish Capacity and Evidence Base

Progress

Nested within the overall national programme aim, each site has developed an implementation plan, structure and approach that is responsive to local context, evaluation and models of implementation. Key, common activities have focussed on:

Staff development

Delivering Year of Care Training has helped to develop capacity for local clinical leadership, which is crucial for successful proliferation of the model. Participating staff to date have included GPs, Practice Nurses, Healthcare Assistants, Practice Administrative Staff, and Diabetes and Respiratory Consultants.

Buy-in

Attaining buy-in from professionals working to deliver health related services, and engagement of individuals living with long term conditions, has been the priority to create synergy with regional and national moves to further the implementation and use of the model.

Reaching the stage where all these necessary ingredients are in place for a range of relevant expressions of the House of Care approach to manifest has taken leadership and support. This has resulted in new symbiotic relationships, increased awareness of the HoC model, and staff development, as well as development of new communication channels and structures between all stakeholders that comprise the model. Being able to apply learning from HoC early adopter sites in England has been beneficial, specifically in confirming the importance of each setting being allowed time to identify the crucial ingredients to any component part of the model that exist, and any that may be missing. Support was then provided to instigate developments that would fill these gaps.

Summary of adopter activity (*from interim ICF HoC BHF evaluation)

• *NHS Greater Glasgow and Clyde is implementing the House with 14 of its 242 practices over two phases, all of which are due to be involved in the evaluation. Nine practices were involved in phase one of implementation, with a further seven starting training and implementation in 2016. GGC had considerable wider infrastructure already in place to help support implementation, and at the time of ICF's visit was predominantly focusing on the 'right wall' (clinicians) and 'roof' (supporting processes) of the House. Qualitative evaluation has been commissioned to better understand the experience of people of lived experience (left hand wall).

• *NHS Lothian/Thistle Foundation is implementing the House with seven practices. Of these practices, four are also participating in a Wellbeing workstream, a complementary initiative (also part of the overarching House of Care Collaboration) which embeds wellbeing practitioners in general practices to support self-management. All are participating in the evaluation. The first round of training sessions were held in November 2015 and the second in January 2016. Regular 'learning sets' are held every 6-8 weeks to support practices with implementation.

• *NHS Tayside is implementing the House of Care with 10 practices, all of which are due to be involved in the evaluation. The first six of these began implementation in early 2015, with BHF funding allowing Tayside to extend the model to a further four practices and two Keep Well sites (which are piloting model of anticipatory care with the aim of reducing cardiovascular disease). All but one of the practices was trained in late 2015, with the final practice attending training in early 2016. The rate of implementation and design of the House has varied between practices, partly reflecting their different starting points.

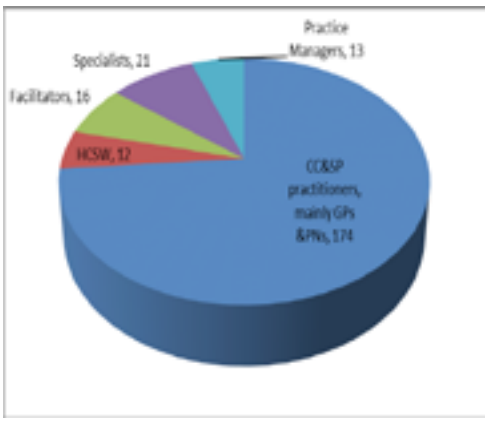
Both currently an earlier stage, NHS Lanarkshire and NHS Ayrshire and Arran have also been supported with funding from Primary Care Division to adopt CC&SP and are developing their own evaluation plans, nested within the national programme support and benefitting from learning and support shared from the BHF Early Adopter evaluation stream.

• The approach has become a key pillar within NHS Lanarkshire's Primary Care Transformation plan and evaluation will use

a Contribution Analysis method. 13 people have received Train the Trainer Training to spread teaching and training of practitioners regionally, they are currently undergoing quality assurance.

•Building on their Co-Creating Health person centred approach, NHS Ayrshire & Arran have begun a programme of CC&SP training across each of their three Health & Social Care Partnerships and will align with local Primary Care Transformation approaches.

The House of Care Scotland programme has been working closely with Year of Care Partnerships who have delivered training and advice to teams. To date 236 people have received training in the principles and practice of CC&SP mainly in primary care. See Fig. 4.below:



NHS

10. Moving Forward

A fundamental shift in the relationship between person and professional that supports that person to be in the driving seat of their health and social care, with self-management at the heart of it.

With this aim in mind, Scotland's House of Care programme has a clear focus on supporting Health and Social Care in Scotland to flourish by:

1) Building the Scottish capacity for person centred care through collaborative care and support planning conversations that include, and are informed by, the voices of people with lived experience

2) Capturing and sharing the stories of this working in ways that can be understood by a wide audience

3) Amplifying and connecting the streams of good practice including the National Links Worker, ALISS and PP&W programmes.

With the fundamental principle of ensuring that the voice of lived experience is involved in developments at all levels, the programme activities focus on key areas:

• Building on Adopter foundational work, a more coherent project management approach is coordinating emerging activity nationally, capturing a 'bigger picture' narrative that allows the variation in each regional setting to flourish

• Developing input from HIS/NES to think through a clearer plan for spread and knowledge transfer

• Establishing support structures to capture learning and facilitate shared learning pathways between localities, and to promote spread to other sites

• Workforce development and cross fertilisation between different organisational cultures: secondary care, general practice and the third sector are key to successful evolution of models of person centred care. Development of HoC in Scotland to date has helped further understanding of its utility as a framework around which tangible arrangements have begun to be put in place to advance challenging aspects of change

• Ensuring coordination and, where appropriate, alignment of evaluation activity across each of the sites,

ensuring maximum value is gained from the additional BHF funding for HoC development activity

• Developing reporting systems that allow for monitoring and recording of progress towards the milestones that have been identified, see below.

Planned processes and landmarks from localities

1. Identify and define participating neighbourhoods and groups of practices
2. Establish a local broad collaboration of stakeholders
3. Appoint local champions
4. Establish a local champions collaborative working group(s)
5. Identify an initial population target group (i.e. People with diabetes, cardiovascular disease, COPD, complex multi-morbidity, frail elderly etc.)
6. Provide collaborative care planning development training for practitioners and identify candidates for becoming trainers, in order to have local capacity.
7. Redesign pathways of care, to separate out information gathering, from information sharing and then Care and Support Planning
8. Develop IT that will assist in information sharing, recording personal goals and outcomes
9. Apply House of Care framework to checklist current service strengths and identify gaps for improvement
10. Prioritise improvement developments
11. Map and share local formal and informal resources and assets
12. Develop a "commissioning" process for non-traditional supports and service
13. Agree measures
14. Evaluate progress
15. Establish a quality control approach
16. Progress the alignment of guidance on the management of the main long term conditions across guidelines, MCNs etc.February 2016

References

1) Cochrane Review http://www.cochrane.org/CD010523/COMMUN_effects-of-personalised-care-planning-for-people-with-long-term-conditions

"Personalised care planning leads to improvements in certain indicators of physical and psychological health status, and people's capability to self-manage their condition when compared to usual care." And it goes on to confirm that the effects "appear greater when the intervention is more comprehensive, more intensive, and better integrated into routine care."

2) http://www.yearofcare.co.uk/key-documents

3) Care Plus study- related work looking at improving conversations with people living with multimorbidity from deprived communities in primary care settings https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-016-0634-2

4) Web resources via Scotland's House of Care Wordpress https://houseofcare.wordpress.com/2015/09/17/resources/

5) Scotland's House of Care https://houseofcare.wordpress.com/

Appendix 1 - Terms of Reference

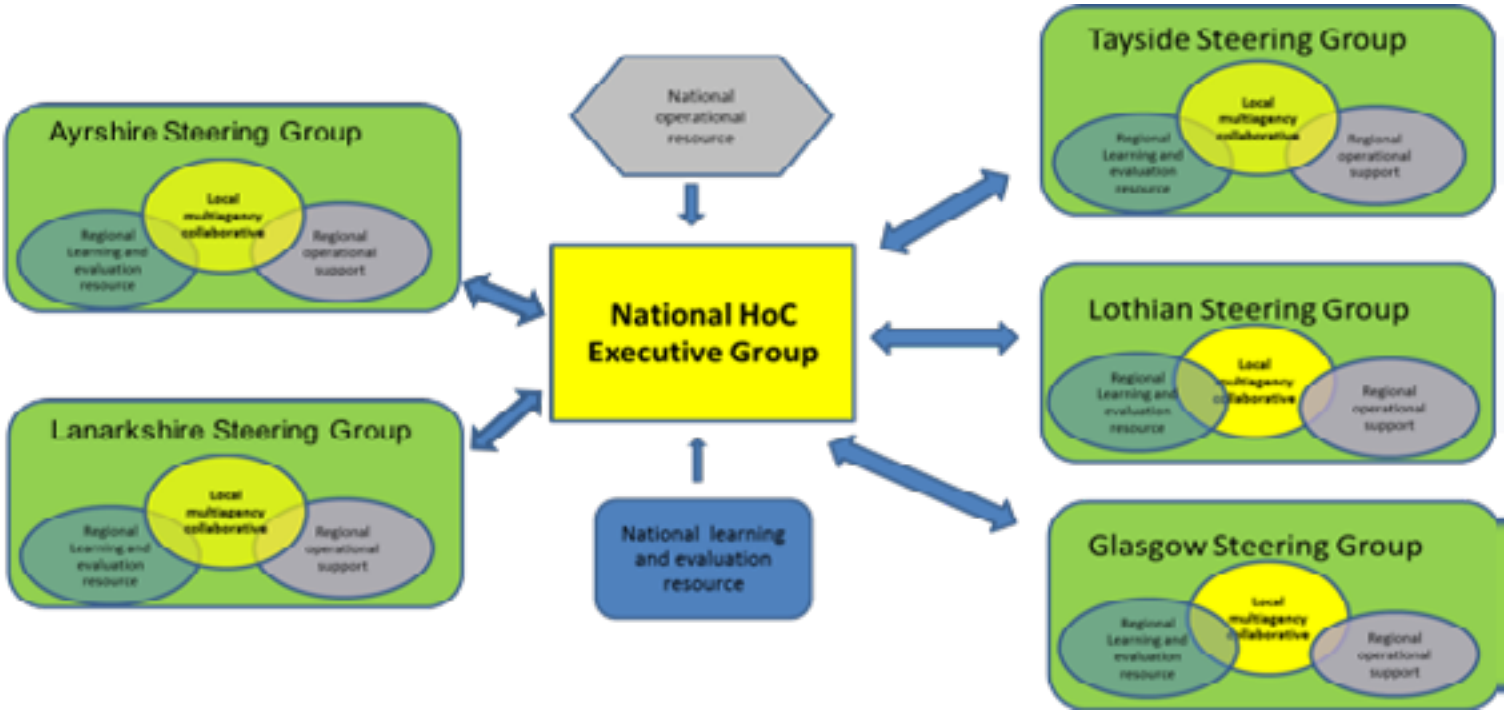
Background

The House of Care represents a tangible and proven approach that allows healthcare to embrace Collaborative Care and Support Planning and fulfil its responsibilities to support the self-management of people living with multiple long term conditions.

This approach supports and enables people to articulate their own needs and decide on their own priorities, through a process of joint decision making, goal setting and action planning.

Governance

Adopter projects in Lothian, Glasgow, Tayside, Lanarkshire and Ayrshire are working to make Care and Support Planning conversations routine for people living with one or more long term condition. Efforts are configured as a programme of work, with local project steering groups reporting into a programme executive group. Short life sub-groups focussing on evaluation and learning, will also be established as required in support of the broader BHF evaluation and local adopter site evaluation.



Remits

Programme Executive Group

- To provide overall programme governance for activities in the Adopter projects;
- To develop and deliver a workplan for programme-level activities;
- To review, monitor and evaluate progress in Adopter projects;
- To provide a mechanism for good communication across the programme;
- To provide a mechanism for gathering and sharing stories of change, impact and process learning across the programme, and with wider communities of interest.

Learning Short Life Sub-Group

- To provide overall programme governance for learning, training and development activities across partnerships;
- To develop an approved set of learning tools and approaches to create a "Scottish capacity" to support House of Care training.

Evaluation Short Life Sub-Group

- To provide overall programme governance for evaluation activities in the Adopter projects;
- To develop linkage with approved set of evaluation measures to effectively capture and assure progress throughout the lifecycle of the projects.

Expected Outputs

Programme Executive Group

- Assured, successful delivery of the overall programme of work;
- A quality assured set of outputs from the projects;
- A set of evaluation and learning products.

Learning Sub-Group

- An agreed, assured and responsive "Scottish capacity" to support House of Care training and learning across partnerships in Scotland.

Evaluation and Learning Sub-Group

An agreed evaluation methodology (or set of approaches) to effectively capture and assure progress throughout the lifecycle of the projects.

Membership

Membership of the groups will comprise the following:

Core Membership

- Graham Kramer (chair) – GP
- Blythe Robertson (vice chair) – Scottish Government
- Cath Cooney (national programme manager) – ALLIANCE

Representation from

- *Scottish Government*: Mairi MacPherson; Sinead Power; Joanna Swanson
- *Healthcare Improvement Scotland*: Brian Robson; Chris Bruce;
- *Adopter Sites*: Rachel Hardie – NHS Lothian; Diana Noel-Paton – Thistle Foundation; Michelle Watts and Shona Hyman – NHS Tayside; Heather Jarvie – NHS Greater Glasgow & Clyde; Kate Bell and Maureen Carrol – NHS Lanarkshire; Carol Nixon and Hans Hartung NHS Ayrshire & Arran
- *Diabetes UK* - Jane-Claire Judson and Rupert Pigot
- *BHF* -Iain Armstrong
- *Year of Care Partnerships* – Lindsay Oliver; Dawn Temple Scott
- *RCGP* - Jean Hannah
- *NES* – tbc

Learning and Evaluation Sub-Groups

Short life project groups, identified by the Executive Group, will cover items as part of the National themes and will in turn report to the Executive Group.

Frequency of meetings

Programme Executive Group

The group will meet quarterly, then frequency will follow need.

Learning Sub-Group

Attendance may be one off, with an initial meeting to set the direction of travel, then frequency will follow need.

Evaluation Sub-Group

Attendance may be one off, with an initial meeting to set the direction of travel, then frequency will follow need.

Minutes

A full and accurate set of minutes will be produced for all meetings, with copies circulated promptly to all members.

Appendix 2 - BHF Logic Model

Context: Ageing populations and improved healthcare mean more people are living with LTCs, including multiple co-morbidities. These individuals have a wide range of medical and social needs. The local and national policy context is supportive of working in a more integrated, person-centred way, to build on individual and community assets and to address these needs

Rationale: People with LTCs use a disproportionate amount of healthcare, but are particularly poorly served by current models. They frequently experience care which ignores their priorities and capacities, is organised around single conditions and is un-coordinated, failing to address all of their needs or build on their assets. Radical service transformation is required, centred around a conversation with each person, which respects the expertise patients and clinicians bring, and the importance of the context of services and the wider supportive processes in initiating and driving change.

Objectives: To implement Care and Support Planning as routine in Primary Care, to redesign CVD services, driven by care and support planning, and to develop support for self-management within wider community in areas of: health inequalities; high deprivation; and high prevalence of CVD.

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES	IMPACTS
£200k funding to each site Cash contributions from project partners In-kind contributions from project partners Year of Care support BHF support Evaluation support Scottish Government support including cash Support from the Health and Social Care Alliance Scotland	*Patient-level* Identify the target number of people for the project from local pathways/ practice registers Interventions to prepare people for collaborative consultation Work to explore how to engage poorly served groups *Practice/Team level* All steps for Care Support Planning in place, including: **Right wall** – staff training for HCPs held Training disseminated throughout practice, skill mix and action learning (ALS) sets **Left wall** – wider patient engagement **Roof** – IT, linked appointments, co-ordination, practice team meetings **Floor** – links with community *System-level* Recruitment of project manager Set up of project board and steering group Champions identified; Key local stakeholders (inc. commissioners, wider health, social care, voluntary sector) engaged Co-design of local CVD model Train the trainers sessions held Locally available voluntary and community services and activities (VCS) mapped, engagement mechanisms set up Supportive infrastructure (IT, tools) set up Provision of support and facilitation to participating practices e.g. action planning, IT changes, skill mix review, call and recall systems	Established organisational processes and protocols which support: Results/reflective tool letters sent out before care and support planning consultations, appointments held in a collaborative style, care plan produced in patient centred style 'Map' of locally available services and assets created Tools and IT systems developed No. clinicians and trainers gone through training. No. attendees at ALSs No. consultations conducted with 'changed' practice No. of patients from poorly served groups engaged with the service No. referrals/people linked with local VCS services and supports	*Patient-level* Feel they have the knowledge, skills and confidence to be able to self-care effectively within daily life Have been able to use results/reflection provided before consultations to help them make decisions about their own care plan. To know when to seeks support Increased self-efficacy Engage in a more collaborative consultation Have an improved, more seamless, experience of care Have increased quality of life, more able to self-manage their condition and achieve their goals Access a wider range of VCS services and supports *HCP-level* Understanding and knowledge of collaborative care planning is improved Individual HCPs act in a more person-centred way, and conduct more collaborative care and support planning consultations HCPS have a more holistic understanding of their patients, are aware of, and able to refer onto VCS services and supports *System-level* More efficient use of resources and reduction in repeat appointments in primary care Services and supports which address patients' holistic needs are mapped, funded and findable. Improved partnership working	Care and support planning established as routine care Better valued and utilised community resources Increased coordination across the health, social care and third sector Increased job satisfaction for HCPs Reduction in health inequalities Patients have improved clinical outcomes, and reduced morbidity Patients experience more personalised, coordinated care Less paternalistic and medicalised healthcare Individuals are more connected to their communities Patients involved in design, implementation and improvement of CSP

Enabling factors: the four elements of the House represent the enabling factors for this programme, facilitating the fifth element being the care and support planning conversation. They are: changed organisational and clinical processes; engaged, informed individuals and carers; health and care professionals committed to partnership working; and commissioning (in England) and links to the voluntary sector assets and activities (in both).

Assumptions: Local lead organisations and PMs will be able to effectively engage their local health, social care and voluntary sector communities, HCPs, and patients. That care and support planning is acceptable and achievable for patients and HCPs with CVD, and that it has positive outcomes for patients. That supportive systems and policies are able to adapt to support new ways of working. That the health, social care and voluntary sectors are willing and able to work in an integrated way to support people, both HCPs and patients.

Appendix 3 - CC&SP Outline

What is Collaborative Care and Support Planning (CC&SP)?

Collaborative Care & Support Planning enables the individual to identify their own goals, action plans and any support they may need. This becomes a gateway to providing personalised support, which:

- Links traditional clinical care with support for self management ("More than Medicine")
- Signposts to community resources made available as part of wider local commissioning
- Coordinates health and social care where appropriate.

CC&SP with people with long term conditions (LTCs) is about better conversations - emphasising the importance of the care planning process itself in achieving outcomes, rather than the written care plan that may emerge at the end.

Clinicians often have a structured approach to the consultation 'hard wired' into their everyday practice. CC&SP builds on these skills but differs in that the information that the patient can contribute about living their life with their LTCs, what matters to them and their own goals is actively sought and given equal prominence to traditional information about tests and examinations.

Personalised care plans developed during care planning with people with LTCs are very different from traditional treatment plans developed by healthcare professionals on behalf of patients.

There are four steps of care and support planning in both health and social care. There is particular emphasis on the importance of preparation for both the Health Care professional and the person living with the long term condition.

This diagram shows how this is carried out in general practice using a two 'contact' "Year of Care" approach.

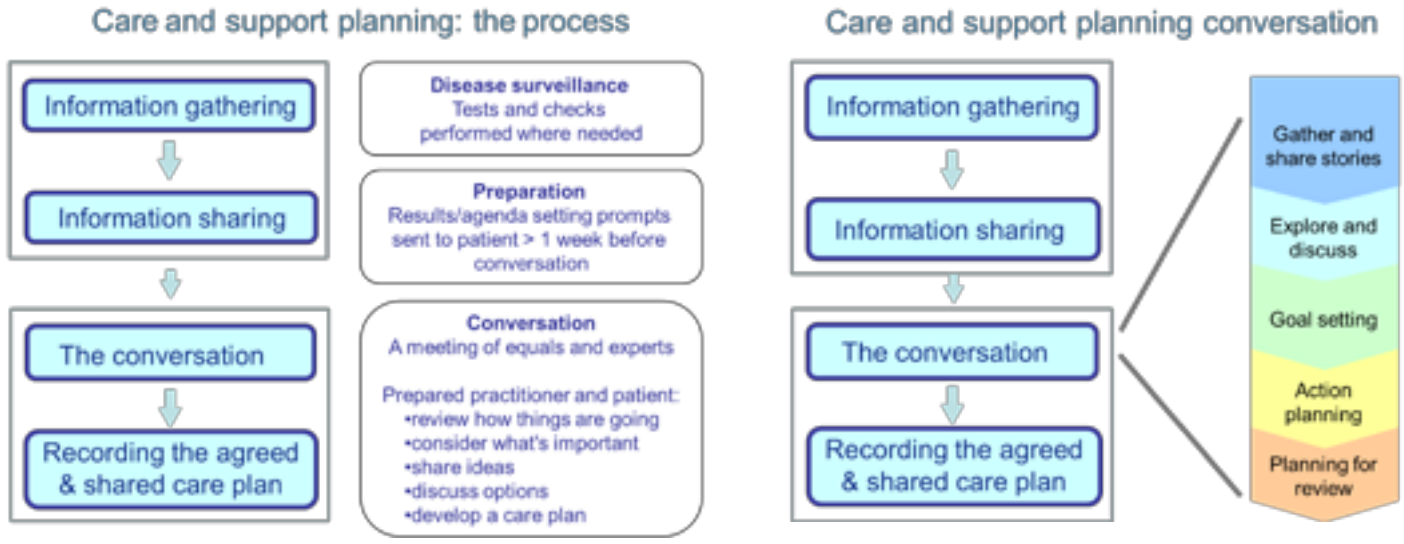


Fig 2 The two step Care and Support Planning Process

For people with some conditions, such as diabetes or chronic lung disease, there may be a need for tests or investigations as part of their routine monitoring. These would be done at the first contact and the results would be sent to the person in a meaningful format prior to their care planning consultation. This gives them the opportunity to consider their test results, and what these mean to them, along with family and friends as needed. They will also be provided with agenda setting prompts to help them reflect on life with their LTCs and what they would like to discuss in the consultation. For other conditions, there may be no need for specific monitoring tests and no results to share. However people should still be provided with tools to enable their preparation ahead of the care planning consultation (including agenda setting prompts, self-assessment or reflective tools)

This emphasises a core principle of care planning, which is that everyone should have the opportunity to prepare for the care planning discussions in advance to ensure they are in a much better position to contribute fully to the discussions and decisions made.

The second contact is the care planning consultation with a healthcare professional trained in partnership working, aiming to help the person identify their priorities, develop personal goals and action plans and identify services available to support these.

The agreed discussions and actions are summarised into a care plan, which is shared with the patient either immediately or subsequently by post or electronically. A review is also planned.

How was the CC&SP approach developed?

The approach was originally developed by a team of specialists working in diabetes in Northumbria, as part of a unique collaboration with local general practices, using principles of adult learning theory. They later formed into Year of Care Partnerships, an NHS based organisation that is dedicated to driving improvement in long term condition care using care planning to shape services which involve people in their own care and provide a more personalised approach which supports self management.

In 2007 the Department of Health sponsored Year of Care Partnerships (then hosted by Diabetes UK) to work with grassroots clinical teams to establish how to introduce care planning and support for self management as part of routine management for people with long term conditions (LTCs) using diabetes as an exemplar.

This "Year of Care Programme" recognised the challenge of LTC and the need firstly to enhance the routine biomedical surveillance and 'QOF review' with a collaborative consultation, based on supporting effective self management, via care planning and secondly to ensure that there is a choice of local services people need, to support the actions they want to take to improve their health, wellbeing and health outcomes, available through commissioning.

They successfully demonstrated how to use care planning as a systematic way to make routine contact between the person with the LTC and the healthcare professional more relevant and effective.

The Year of Care team has a wealth of experience, expertise and resources, and has developed a "gold standard" approach to support organisations who want to embed care planning and support for self management systematically, using the House of Care whole system approach. This is focused on culture change, care delivery and the development of care planning skills within the workforce which in turn support self management and coordinated care.

They have worked via local and national partnerships with clinical teams, commissioners, policy makers and others with similar aims and objectives.

Scottish House of Care Consortium

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RCGP

RC GP SCOTLAND
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Year of Care Partnerships

YEAR OF CARE PARTNERSHIPS

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British Heart Foundation

NHS Education for Scotland

NHS
Education for Scotland

Healthcare Improvement Scotland

Healthcare Improvement Scotland

The Scottish Government

The Scottish Government

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Scotland's House of Care

The Health and Social Care Alliance Scotland (the ALLIANCE)
Venlaw Building, 349 Bath Street, Glasgow G2 4AA

Contact: **Ian Welsh, Chief Executive** Email: **ian.welsh@alliance-scotland.org.uk**
Twitter: **@ALLIANCEScot @HoCScot**

www.**alliance-scotland**.org.uk

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Scotland's House of Care

Learning Report

December 2016

The Scottish Government

REALISTIC MEDICINE

ALLIANCE
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Contents

Foreword

When 'Gaun Yersel' was published it laid down a challenge for our healthcare system to level the playing field for people living with long term conditions and their professionals. This involves people and professionals having truly collaborative conversations, where each other's perspectives are shared, understood and appreciated so that people can make decisions and choose support that is right for them. When this happens outcomes, both personal and health outcomes, improve.

Enabling this requires shifts in traditional roles, values, processes and systems tangibly articulated by Care and Support Planning and the elements of the House of Care. This approach was pioneered in GP practices by the Year of Care Partnerships, originally with people living with diabetes, but extended to embrace people and all their long term conditions.

The ALLIANCE, working closely with Year of Care Partnerships, British Heart Foundation, Health Boards, partner organisations and Scottish Government have given huge support, leadership, energy and momentum to the local adoption and spread by primary care teams of the Year of Care approach as "Scotland's House of Care".

This think piece by the ALLIANCE of the early learning and experiences from people and professionals working together, supported by the "House of Care" is extremely welcome. It has been helpfully contextualised to national person centred programmes and policies.

Dr Graham Kramer
GP and Chair of House of Care Scotland Executive Group
RCGP Scotland Council member
Year of Care Trainer

I welcome this ALLIANCE Learning Report that shares stories of human connection about how the elements of good, person centred care are emerging and embedding across Scotland's House of Care Adopter network. Not only does it map out some of the ways that the House of Care approach is supporting a person centred direction of travel, it also invites us to ask us what else might we do, and stop doing, to not only make asking 'what matters to you' the norm across health and social care, but to ensure that something is done about the answer!

A national *Person-Centred Steering Group* was established in May 2014 to oversee delivery of the Person-Centred Health and Care Portfolio as a key priority in achieving the 2020 Vision for Health and Social Care. The Steering Group's membership includes Scottish Government directors and representatives of COSLA, the third sector, integrated joint boards and the NHS.

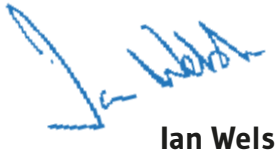
The *Person-Centred Stakeholder Group* was established alongside the Steering Group, to provide an informed and focussed source of advice and challenge. Its membership includes people with experience of using health and social care services and their family members and carers, healthcare professionals, policy makers, and representatives of statutory, third sector and independent organisations with expertise in co-production and the design and implementation of person-centred care.

Working together at joint meetings in 2016, the groups identified four leverage points for accelerating progress towards person-centred care:

In pulling together the stories in this Learning Report, we found it helpful to reflect on these **four themes** and to consider how the progress made and issues arising across all the parts of the House of Care can contribute to our learning on ensuring that **the voice of lived experience truly informs the transformation of health and social care services.**

Throughout this report you will see questions and prompts that are drawn from that work of the national Person-Centred Steering and Stakeholder Group did together, to look at the current health and care systems from all their various perspectives. They were therefore co-produced by professionals and people with lived experience of accessing, using and working within the system.

We see this as an invitation to test the prompts and queries co-produced by the groups, and to consider how the Collaborative Care and Support Planning work at the heart of Scotland's House of Care is helping to create the conditions across the roof, right hand and left hand walls and the more than medicine foundation of the House that truly puts the person living with long term conditions at the heart of the conversation and in the driving seat of their care and support.



Ian Welsh OBE
Chief Executive
The Health and Social Care Alliance Scotland

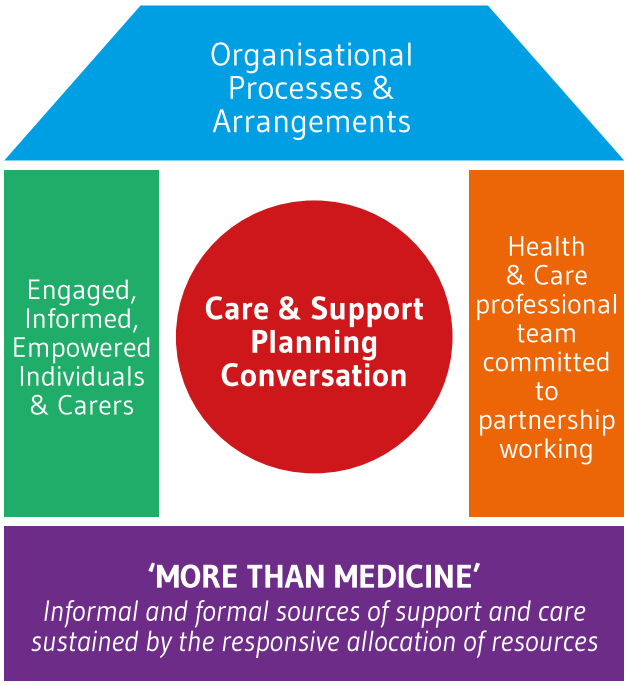
Introduction

Why Collaborative Care and Support Planning?

The current system of supporting people to live well on their own terms with whatever conditions they have is neither financially viable nor broad enough in scope.

We need a transformational change to move from the 'medical model' of treatment, towards a model of care and support which builds on people's expertise in living with their conditions and the resources available to support them in their own communities to provide a more holistic approach to achieving the best possible outcomes.

It comes at a crucial time of opportunity as integration demands far greater collaboration across sectors, greater emphasis on embedding self management as a core component of health and social care, the development of new models of care, and a deep shift in culture. All this reflects a direction of travel that has been reiterated in successive policy statements, most recently the National Clinical Strategy, to which the Royal College of General Practitioners (RCGP) Scotland and the Health and Social Care Alliance (the ALLIANCE) have contributed substantially.



The Scottish Government in partnership with the ALLIANCE are promoting the adoption of Collaborative Care and Support Planning (CC&SP) as an evidence-based approach to meeting the needs of people living with long term conditions in Scotland, with the House of Care a key concept.

The House of Care provides a simple visual model of a house built around collaborative care planning conversations between people and their health care professionals, which then organises care and support around what matters to people and their carers, rooted in the assets of local communities. Building the House of Care requires the kind of whole-system transformation needed to recognise the assets, rights and capabilities of people, and place them in the driving seat of their care and support.

The care and support planning conversation approach supported by the House of Care has been shown to:

- Support self management, putting people in the driving seat of their care;
- Improve the coordination of care around each person's needs;
- Improve both personal and health outcomes for individuals;
- Improve health service use;
- Improve the care experience of both people and their professionals.

The ALLIANCE has led the implementation programme for the House of Care in five adopter sites in Scotland, working in partnership with local partnerships in Lothian, Glasgow, Tayside, Ayrshire & Arran and Lanarkshire, the Year of Care Partnerships and The British Heart Foundation.

This Learning Report creates a space to reflect on progress made so far and going forward, sets out the elements required to deliver this change in practice, focussed on co-ordinated and capacity-building training, to promote the whole-

Introduction

system transformation needed to improve the interactions and conversations between people and their practitioners.

Local ingredients, lovingly prepared will produce a much tastier dish!

"I became interested in the Year of Care Model after attending a taster session in my Board area. I came away enthused after a noisy and very productive conversation which demonstrated that whether we work in primary or secondary care, putting the person at the heart of all that we do is a shared value. A simple message, a clear way of supporting person centred care planning with tools to help do it and an emphasis on recognising the importance of the multi-disciplinary team- what was not to like?!

I became a convert after attending the workshop- pragmatic learning, well delivered, and best of all attended by people from across the system. Supported by a wee but incredible team, we have steadily worked with our partners in Tayside and beyond to test, then spread our house. We have kept true to the ethos, but have also worked to co-produce local pathways and solutions which best meet our needs. There has been lots of healthy scepticism, but the feedback from patients, and the teams who are really embracing this has steadily produced a growing list of converts.

A number of our practices have now embedded this model across all long term condition management, and our colleagues in cancer and palliative care, pharmacy and mental health are keen to learn more. We believe this is about changing culture, and our approach has been slow and steady - (like the slow food movement, we believe local ingredients, lovingly prepared will produce a much tastier dish!)

Things we have learned so far...

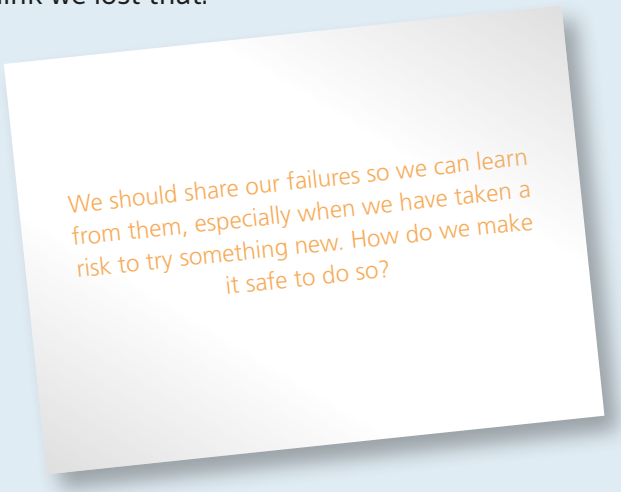
- Its great to have enthusiasts, but we also need whole team buy in.
- People need time to prepare, share and care.
- We need to have all the prepared process elements in place eg IT/templates to support enablement of the prepared patient.
- There must be ongoing opportunities for networking, learning and development to ensure we maintain the prepared professional.
- Each locality house will look different- recognising and embracing each local communities assets.
- The support we offer must make it "easy to do the right thing"
- Establishing good relationships with all agencies, sharing and collaboration makes things happen.

Our vision? We will work collaboratively to ensure every person in Tayside has the opportunity to have a person centred care planning approach to their care at every stage of their journey."

Dr. Michelle Watts,
Associate Medical Director
Primary Care, NHS Tayside

Quality After Quality Outcome Framework

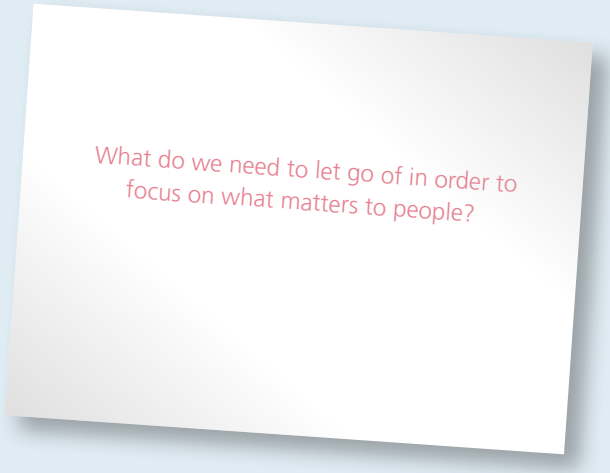
"I think for me it's just about getting back to basics; back to making a difference; back to building that relationship that we should have with people, with patients. I think over the last ten years with the Quality and Outcome Framework we've been so focussed on measuring things and ticking boxes and we've kind of lost the message as to why we're doing that. The Quality and Outcome Framework I think was very, very innovative to start with and brought a lot of benefits to general practice, but I think the continuity of care, the relationship we have with our patients kind of got lost along the way and that's really why I went into family medicine in the first place, it was to get to know my own patients, their family and their wider social background – and I think we lost that.



I think that collaborative care and support planning and the House of Care model is a way to allow patients to have the opportunity just to become involved again, because they were used to having tests and tasks done and things measured, but when you actually get down to it there was very, very little opportunity for them to tell their story and I really felt that this was a way for them to do that.

The IT infrastructure really matters

The IT is make or break as far as the House of Care is concerned. We had some discussions at the beginning; it was almost a deal-breaker. It can become quite intrusive and obstructive sometimes, the amount of information that you have to gather for certain things. So we wanted the IT in Lanarkshire that supported the House of Care to contribute really



to the process as opposed to becoming a barrier to the process. We worked quite closely with our local IT facilitators who we had a relationship with already around using the IT system that we had in place at the moment and the functionality that already existed. We didn't want to create something new or something to add-on, we wanted it to already exist to make it easy to use and we really created it as a front page, if you like, to give people who were involved with the House of Care model really some advice about what to test and tasks to gather, but also as a means of sharing information in a quick and easy way and in a way that was easy to understand; so that it doesn't interfere really with the conversation, but augments it.

I was invited down to the Year of Care Partnership to show them what IT we had developed, because alongside the IT developed in terms of gathering the information, we managed to develop an IT package to produce a summary of the tests and tasks that we could communicate or share with the patient or person before they came in for their conversation. That wasn't something that they'd ever seen before, so again it was creating a document that supported the House of Care model and the way of working that was easy to understand but gave people the information that they needed to help them understand what the tests and tasks were all about before we actually had the conversation. They were really quite interested in the work we had done and would like to disseminate it further."

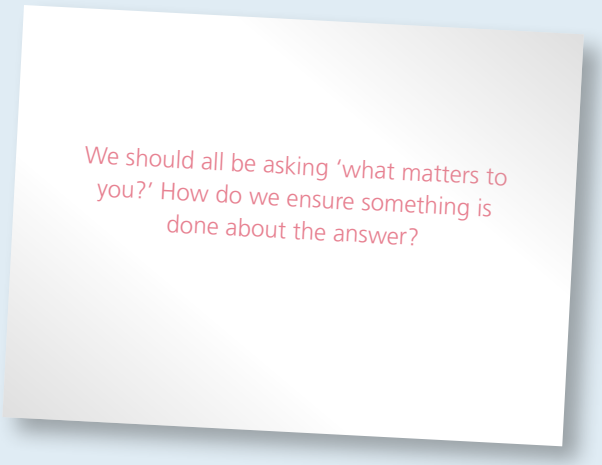
Dr Sue Arnott
GP and Clinical Lead HoC
in NHS Lanarkshire

The Hard Work of Managing Long Term Conditions

"If you live with a long term condition you will appreciate that navigating health and social care systems can be really challenging. The workload of managing a long term condition includes lots of things ranging from taking and enduring the side effects of medication, attending appointments and tests, chasing up results, negotiating with health and social care staff to get access to services and trying to gain an understanding of different illnesses and their implications. This might seem familiar and part of your everyday life. This work can be increased by the focus on "diseases" rather than "people" by health care services, clinical guidelines and professionals.

Today in Scotland and around the world more and more people are living with long term conditions such as diabetes, depression, multiple sclerosis, heart disease and stroke. It is increasingly likely that people live with a number of long term health conditions. There are a number of reasons for this ranging from changing demographics, namely we are all living longer, through to improvements in medical care, and changes in lifestyle. People know that it's not always easy living with long term conditions but what is less well understood or acknowledged is the effort and "work" people have to do to manage all their health problems. The term "Treatment Burden" has been coined as a way of describing this (http://www.bmj.com/content/349/bmj.g6680). That burden that treatment may bring, can be increased by the way health and social care services are delivered and configured.

General Practitioners are very aware of this because increasingly the people we see on a day to day basis have multiple health issues and to focus only on one of them does not seem helpful, especially as treatment can overlap and interact. There is also growing evidence that the workload of healthcare can make it difficult for people to do all the things recommended in clinical guidelines for all the conditions that they have, which can result in poorer outcomes. People will vary in the level of support they might need to live well and self manage their condition. It's important to ask what matters on an individual basis and to understand that people's ability or "capacity" to cope with any given level of treatment burden can change over time for a variety of reasons including a range of personal, psychological, social, and environmental factors. People may simply be "time poor" because



of competing demands of work, home life and other caring responsibilities that means their own health care needs seem less of a priority and do not get the time and attention needed.

Our research group is investigating the issue of treatment burden and have written a short briefing paper on this subject (http://www.sspc.ac.uk/media/media_484740_en.pdf) for the Scottish School of Primary Care. We believe that health care services can be configured to lessen this burden and are eager to investigate various ways this might be achieved. We have termed this new approach "Minimally Disruptive Medicine" and there's even a short video clip that someone in the United States has created that helps to clarify what we mean in a simple and fun way! (https://www.youtube.com/watch?v=b18EWaTevu4).

There is growing awareness of these issues in Scotland and in response the Joint Improvement Team have produced a new action plan to improve care and support for those living with multiple conditions in Scotland (http://www.jitscotland.org.uk/resource/many-conditions-one-life-living-well-multiple-conditions/).

However, there remains much still to do and improve. I believe it is important for us to engage with third sector organisations, like the ALLIANCE, about such issues and to engage with the people living with long term conditions and their unpaid carers in a meaningful conversation if we are to develop measures and interventions that are likely to be beneficial and really meet the needs of people living with long term conditions. Such partnership working is likely to help us find the "right solutions" rather than merely the professional view of what might work."

Frances Mair
Professor of Primary Care Research, University of Glasgow

Health Literacy and House of Care - what can I do?

Health literacy is about people having enough knowledge, understanding, skills and confidence to use health information, to be active partners in their care, and to navigate health and social care systems. **(Scottish Government, 2014)**

Promoting health literacy is an important activity for all staff working in health and social care. Health literacy links very closely to the principles and activities of Scotland's House of Care programme to support health and social care to flourish by focussing on:

a) Building the Scottish capacity for person centred care through collaborative care and support planning conversations that include, and are informed by, the voices of people with lived experience

b) Capturing and sharing the stories of this and working in ways that can be understood by a wide audience

c) Amplifying and connecting the streams of good practice including ALISS, National Links Worker and People Powered Health and Wellbeing programmes.

We would therefore ask that all staff working in House of Care consider finding out more about health literacy and how they can promote it with the people they work with. There are a range of resources available to support you in this, including:

- The Health Literacy Place website – the go to place for health literacy information in Scotland
- The Health Literacy Place Twitter account @healthlitplace
- Health literacy training and awareness raising

Think about your own practice and how you could promote health literacy with those you work with. Some ideas could be:

- Visiting the Health Literacy Place and finding out more about the tools and techniques you can use
- Attending health literacy training
- When speaking to people use 'teach back' to check that you have explained things properly... 'I want to make sure that I've explained things clearly today, would you mind telling me what it is we have discussed and what we have agreed is going to happen?'
- Promote good sources of information, for example, NHS 24 and NHS Inform
- Identify opportunities to use visuals and images to support communication and promote recall of the things discussed
- Always offer support with paperwork, you can't tell by looking at someone if they might have problems with reading and writing.

You can visit the Tools and Techniques section of the website to find out more about the things you can do to improve and promote health literacy

with others, and access resources to support you in this. To find out more about health literacy and how you can get involved please email knowledge@nes.scot.nhs.uk. Please follow us on Twitter @healthlitplace.

Lindsey Murphy
Senior Knowledge Manager
NHS Education Scotland

Blythe Robertson
Policy Lead Health Literacy and House of Care
Healthcare Quality and Improvement
Scottish Government

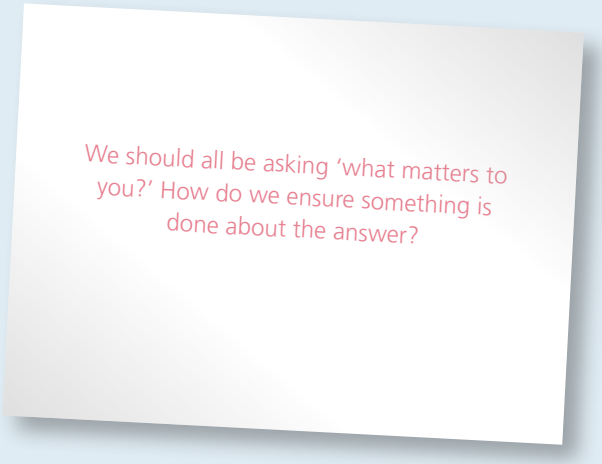
BHF House of Care Programme

The British Heart Foundation are the UK's largest funder of research into heart and circulatory disease, investing more than over £100 million each year across the UK. This research has led to improvements in treatments and improved survival rates. People are living longer with their cardiovascular condition. Over 650,000 people in Scotland are living with a cardiovascular disease as a long term condition and the majority of will have at least one other condition.

BHF recognises that people need to be better supported in the management of their cardiovascular condition, and enabling supported self management to make informed decisions about their own care. BHF is seeking to ensure that everyone in Scotland has access to high-quality, integrated health and social care services. People living with cardiovascular disease should be empowered to manage their condition through access to high-quality information, support and guidance. BHF sees collaborative care and support planning (CC&SP) and the House of Care as means to achieving these aims.

The British Heart Foundation are contributing to funding of three early adopter sites across Scotland to implement collaborative care and support planning using the House of Care approach to support people with cardiovascular conditions, and put them in the driving seat of their care. These adopter sites are either focusing on cardiovascular conditions or are implementing as part of a multi-morbidity approach. We have supported each site to implement collaborative care and support planning and the components of the House of Care including CC&SP training and support to sites from the Year of Care Partnerships.

The cardiovascular patient pathway in primary care is less well defined, and combined with the significant number of people with more than one condition, implementing CC&SP for these people has been a challenge. However across the BHF programme over 3,700 people have participated in collaborative care and support planning conversations with healthcare professionals **focussing on what matters to them in order to manage their cardiovascular condition.**



We are looking to support the spread and adoption of care and support planning for people living with cardiovascular conditions across Scotland and the rest of the UK by providing evidence, resources and best practice information to other adopter sites and commissioners. We have commissioned an external evaluator and recognising the challenges sites have faced in implementation have extended funding of all three sites in Scotland to 2018 in order to support adopter site to embed care and support planning as routine care and support the evaluation and evidence base.

www.bhf.org.uk

Prepared Staff

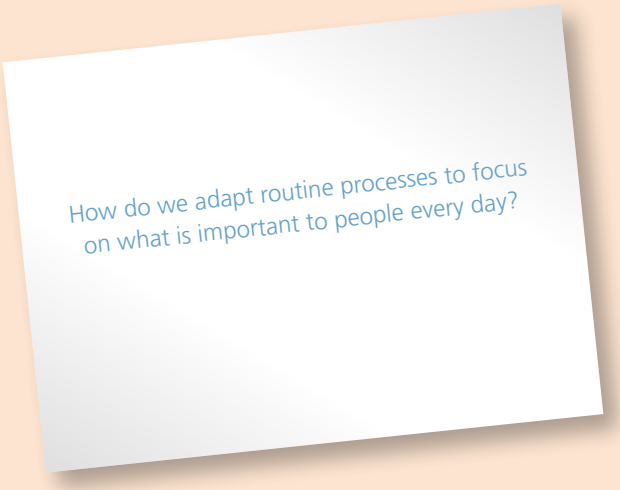
"It's the way that we should all be working it's the way that some of us think that as practice nurses that we are working, but House of Care is different…and it works!" **Practice Nurse**

"…I think the thing that's different about the House of Care model in terms of the Primary Care Transformation Fund is that it's from the bottom up if you like. I think it only works in practice if you have a committed individual who believes in the House of Care way of working, who's committed to it and is willing to do some things slightly differently. For me it's very, very rewarding. Being able to have that relationship with patients that I always wanted to have when I went into general practice and I think I've kind of rediscovered that. I think we lost it a bit along the way with other competing pressures, but we've found it again." **GP**

Practice Nurses

It gives the patient ownership of their results; they have a chance after having all their screening done at one time, which isn't always possible within general practice, so they have all the chronic disease areas that affect them. We then send the results out to the patients about two weeks later. They have a week to think about the results and come in and they set the agenda to us and they love it. We've had visible results in people's HbA1c for diabetics dropping down. People thinking more about what they can do for them self and a lot more referral onto third parties as well as is necessary.

The patients love it because they can set their return date and decide when they want to come back –'what I'll do is I'll come back and see you if there's any problems,' or 'I'll come back and see you in six



months' time.' So then again we're saving and that person feels as if they've taken ownership of their body because they're able to get the results shared with them.

We've been doing House of Care now since June and it's now the end of October and I've had one 'dna' from my House of Care appointments. That speaks for itself!

The second part of the interview process with the patients, or consultations as they are, is more about what the patient wants and they respond better to it. I think that you see that in the way that they interact with you and the way that they go and tell other people about it and even medication compliance it's 'Well now I know what that's for,' and we've seen some good results.

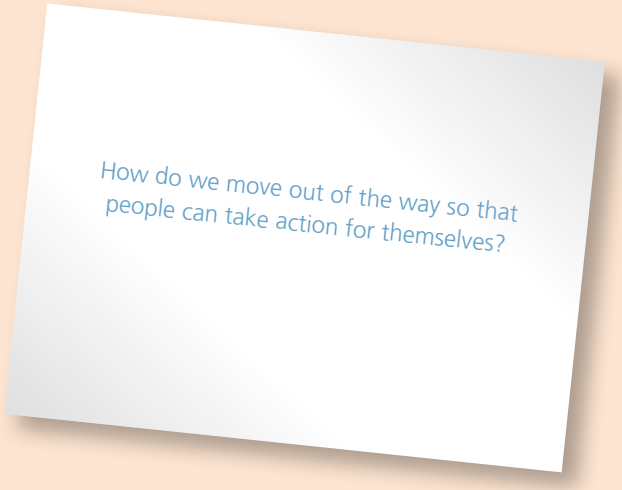
One of the ladies was a young COPD patient, diagnosed about two years ago, was really struggling - Optimum Inhaler Therapy Technique, still smoking, didn't want to give up smoking but knew that it was having an effect on her. By working through the House of Care and Care Planning she's given up smoking; her breathlessness score has dropped to practically zero; she has managed to stop one of her inhalers; she's enjoying life at the moment and is enjoying playing with her grandson again which she wasn't fit to before.

One gentleman was struggling with his weight, he was diabetic, was always telling me that he was going to the gym and working out and watching what he was eating. He lost five kilograms in four weeks, which is absolutely amazing.

From walking club to social work, we're actually looking to see if we can get some more clubs up and running in the area because of House of Care and social work are coming in to see what else they can suggest for us.

As a practice nurse previously I had thought that I was working that way and we were always working along

with the patients, but it's not until you start working along the guidelines for House of Care and Care Planning that you actually see it works and it works well.



As a practice nurse and as a hard-working nurse and for GPs as well, it's hard. Time constraints are horrendous in our neck of the woods at the moment. It (HoC) gives you better job satisfaction as well. It's working along the way that we are all trained to work but it's within a safe foundation and it's, what can I say? I love it! It saves the patient time, it saves the practice appointments and it's worthwhile. House of Care works and I can't say that strongly enough.

The future health and social care workforce pledging to make a difference

Dementia Carer Voices, managed by the the ALLIANCE, is a Scottish Government funded project to engage with Health and Social Care professionals and students to promote a fuller understanding of the carer journey; provide a platform where carers can express their views and experiences of caring for a loved one with dementia; and to harness the awareness raising activity undertaken by Tommy Whitelaw. dementiacarervoices@alliance-scotland.org.uk .

Dementia Carer Voices' Project Lead, Tommy Whitelaw regularly engages with Health and Social Care professionals and students to highlight the importance of a person centred approach to dementia care, with carers as equal partners. Tommy recently presented to 150 second year Nursing and Mental Health students at The University West of Scotland Hamilton Campus and then at Glasgow Caledonian University to 400 second year Nursing Students. Tommy was joined by Heather Edwards from the Care Inspectorate and Cath Cooney from the ALLIANCE's Scotland's House of Care programme, who both helped by sharing the work they do and emphasising the importance of turning good intentions into purposeful action in practice and how care and support planning can support that. At the end, the student nurses had a chance to write down a pledge describing the kind of nurse they wanted to be.

UWS Pledge to Make a Difference

https://dementiacarervoices.wordpress.com/2016/09/16/nursing-students-uws-hamilton-pledge-to-make-a-difference/

GCU Pledge to Make a Difference

https://dementiacarervoices.wordpress.com/2016/11/04/glasgow-caledonian-nursing-pledge-to-make-a-difference/

Hopes for the future

Are we starting by appreciating each other and by modelling the behaviour we want to see?

"I pledge to treat people with respect, love and compassion."

"I pledge to stay true to myself allowing me to wholeheartedly help others."

"I pledge to always be the best I can be as a caring, loving nurse. Take a break if ever I feel my ability for the job is going so I never become bad nurse."

"My pledge is to treat my patients as an individual ensuring they feel valued, respected and have confidence in my ability to make a difference to their lives. Also care for my patient the way I would want my loved ones to be cared for."

Are we asking ourselves 'would I find this acceptable for someone I cared about'?

"My pledge is to continue to see the person, not the illness, listen understand and support people in their journey, make them smile and respect them as an individual and always remember why I have chosen this career, the people!"

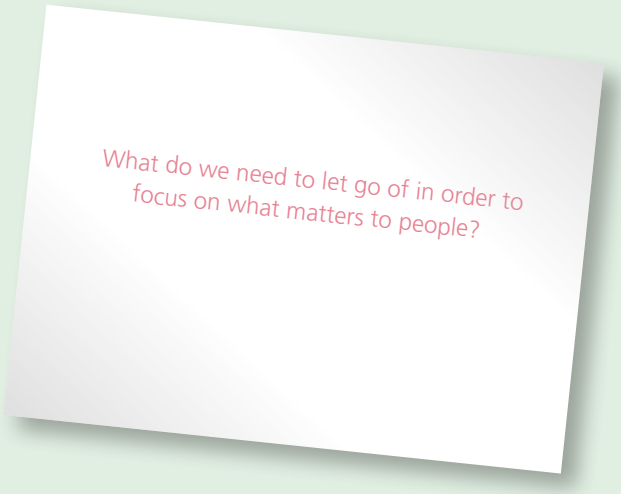
"My pledge is to commit myself 100% to caring for others today, tomorrow and the next day, and to spread the word to others about keeping love stories going."

How do we find, and protect, time for reflection on person-centred care?

"I applied to study nursing because I enjoying caring people, it is such a natural act, that is so easy get incredible rewarding, I want to make a difference."

What's been the experience of people taking part in care and support planning conversations?

"It was held in a nice relaxing atmosphere and you could talk about anything that was worrying you health wise or anything else. You weren't rushed, so it was beneficial and it made you think how you could help yourself, not just wait till you're ill and then come to the doctors - ways of preventing getting ill. I felt you'd more input…you actually had more say and control of what was happening. It was all what I really wanted, not what somebody else is telling me I wanted, so it was good from that aspect. It did make you think, you know. It made me realise that I had to act a bit sooner, not wait till something got really bad, act on the symptoms before they got there.



It really made you think more about your conditions and how to manage them to be quite honest. It definitely has helped to self manage more. It's made me more aware of things. I feel there's just been so many things that you didn't really think about before. Now I do get myself wrapped up going out in the morning, I watch my breathing, how to breathe better.

You feel that you are in control of your health and your goals, what you're wanting to aim for, you know, health wise.

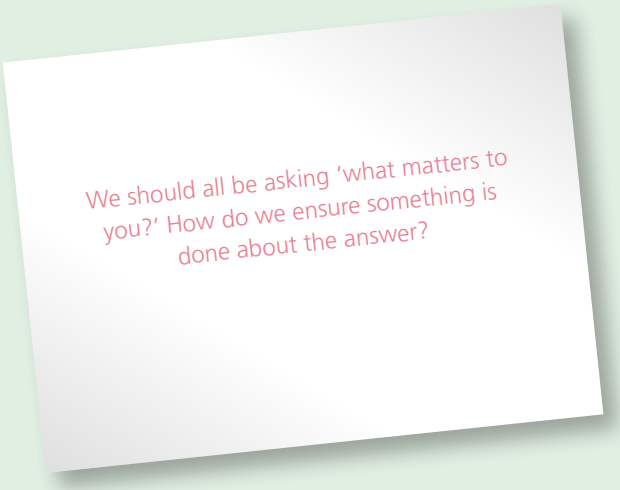
You feel that you've got the support there. You've got the backup and as I say you know that somebody's there and you make your own goals when you want to come back for the next time. It makes me feel

Taken from the PPHW Open Space event, where people were asked - What does co-production look like to you?

that that, well, I've decided, not somebody else has decided - from that aspect you feel as if you've got the whole control of your life and your health and your wellbeing." **June**

"You feel now that the professional carers are really investing in you and looking after you better. The biggest thing for me is a sense of security, you know, at my age, it's good to get a complete check and just make sure everything is okay and then if there is anything wrong, they can tell you there and then and they can take steps to get it under control. For me it's a sense of security more than anything because I think this is a really good initiative this and you're building a relationship with your professional carers, which is what I like, I like to know who I'm dealing with.

Well before you got a wee letter, once a year, just to come down and have a wee talk and they basically asked you how you were and that was that but now they take blood, they take your blood pressure, they



do a lot more health checks and it makes you feel as if they are looking at your whole wellbeing now, not just your condition.

Some of the questions that's in that paperwork, gets you thinking about things and it makes you look at your life a wee bit more deeply and when you are coming to see the nurse you are much more prepared and you can actually guide the way the interview is going. It's not all about the nurse asking you questions, you can actually ask the nurse questions now, you are participating now, you don't feel as if you are just coming in and getting a pat on the back and then you're out the door again.

For my condition, I've taken steps to control it better and with the help of the nurse advising me, it makes sure I am always going in the right direction. I mean I've spoken to my relatives, especially my elderly mother about it, encouraged her to participate because she was also invited to do this but she is a wee bit shy so I kind of helped her through the questionnaire and tried to encourage her to be more, participate more.

I think it's the way forward!"

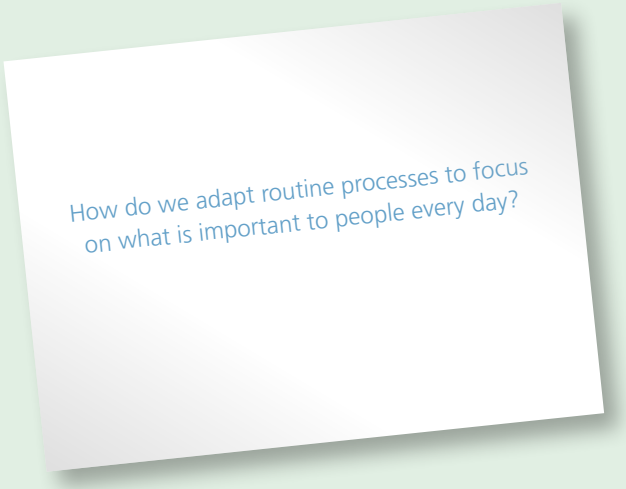
Sam

"It was nice to have a good long session…I was weighed, blood was taken because I have other issues besides the diabetes, it has been most helpful and as I say, the staff have explained things to me.

I didn't know that the odd pie would be a nightmare so, I have stopped eating pies now and I am much more happier eating liver and things like that. I now know that if I've got a 7.3 on the Richter scale of bloods then I have to watch my sugar intake.

Altogether they have been so professional and so helpful on it. We're given a pamphlet which we have various items to discuss - mine is medication, is what I am more interested in and I do find that it's so helpful to be able to discuss if I have a particular ache and pain.

Let me give you an example, for example, I have been taking statins regularly but I have experienced an awful lot of pain over the shoulders and down the arms and I want, I know that statins are connected with cholesterol but my cholesterol is quite low but these pains are stopping me from doing my most favourite hobby which is Scottish country dancing and I've had to give up the statins - oh well I've given up the statins because of the pain but I didn't know what the limit of cholesterol should be, which was explained to me in full detail by the kind nurses here. The most important thing is it gives me exercise, that's lovely and also it exercises my brainpower… though it's hard work but most enjoyable, yes. I've made so many friends, it was thanks to Scottish country dancing that I found a wife.



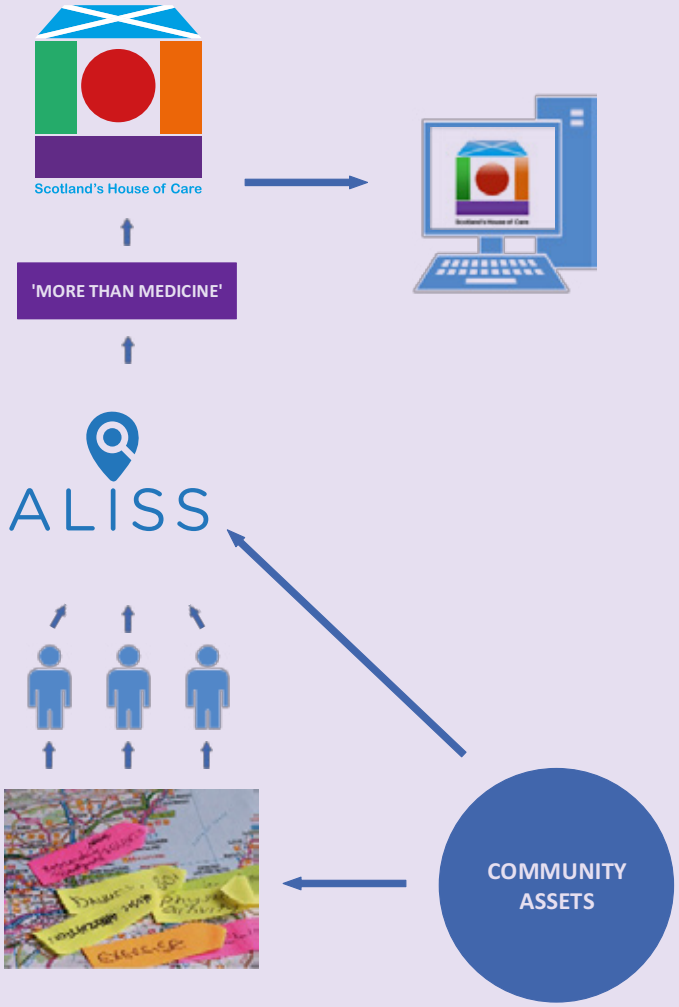
For me personally it's been wonderful. I've got a rapport with my nurses in this practice and they are so kind and they listen and they communicate to me which is so helpful.
Well I would recommend anyone to go for this pathway of care and if you've got as good professionals looking after you as I have, you'll not go wrong."

Stephen

More Than Medicine

There's a lot more to medicine than tests and measurements and bio-medical markers, which we've been so focussed on in the last ten years.

"The impact that mental health and social circumstances has on the ability for someone to live well with a long-term condition is something that I don't think you can quantify and it's something that we shouldn't be ignoring either. I think this just gives the opportunity to bring that into the conversation **and I think More than Medicine is crucial** - I think third-party and voluntary organisations have a huge part to play in supporting people with long term conditions just to live a better life. I think we're so focussed, or we were so focussed, on a pill for every ill and wanting to fix everything, where it's not always about fixing something, it's just about making life maybe a wee bit more bearable or a wee bit more enjoyable sometimes and just accepting things for what they are and appreciating that's there more out there for people than just what I can do really." **GP**



Involving someone who has experienced the same problem themselves could make for better communication. How do we develop this approach?

ALISS

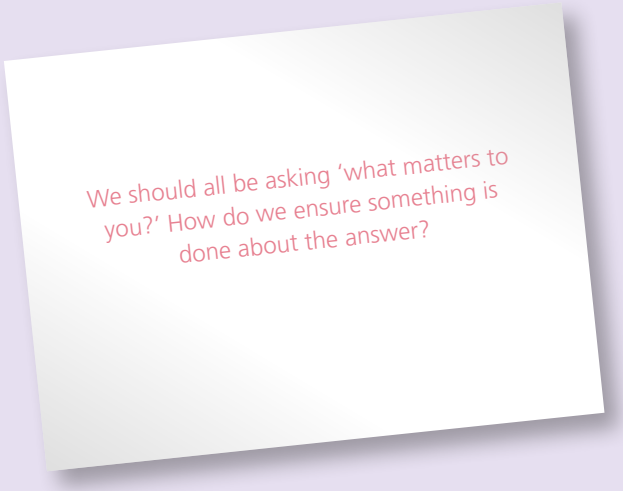
ALISS and Scotland's House of Care

The 'More Than Medicine' foundation of Scotland's House of Care recognises that positive health outcomes are intrinsically linked to social connectedness and being able to live as well as possible within a community setting. But how do people, including our health and social care professionals, know what type and range of support is available in local communities? ALISS (A Local Information System for Scotland) has the answer.

Funded by the Scottish Government and delivered by the Health and Social Care Alliance Scotland, ALISS helps people find and share information about local assets and services (including those delivered by volunteers and the third sector) that support health and wellbeing. ALISS does so by offering a unique digital service that allows information from lots of different sources to be brought together on www.aliss.org and which can be made searchable on virtually any other website or digital platform. This means that people can find resources that support them to live well from whichever place is most familiar and accessible for them.

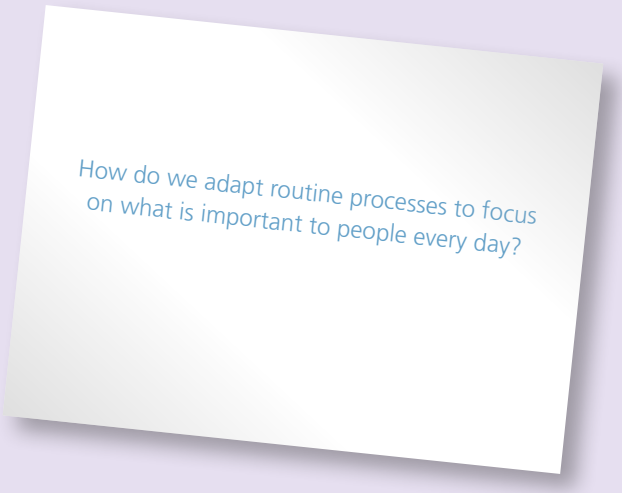
ALISS allows information to be collaboratively managed – so enabling people, communities and professionals to work together to keep the information up to date and accurate.

More Than Medicine



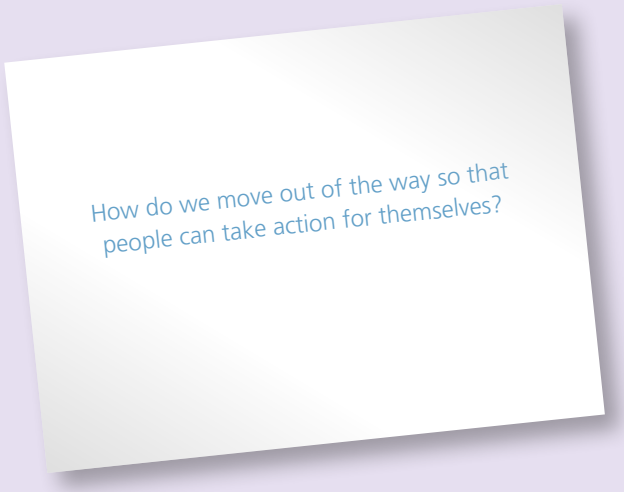
Alongside the digital service, ALISS can also support activities like asset mapping and community engagement. Like House of Care, ALISS is grounded in the principle of co-production having been co-designed with people living with disabilities, people living with long term conditions, unpaid carers, health and social care professionals and IT / data experts.

ALISS is now widely used across the Scottish health and social care landscape. The ALISS programme is working with a diverse range of partners including NHS 24, Community Pharmacy Scotland, Living It Up, the National



Link Worker Programme, Health and Social Care Partnerships and third sector interfaces. This partnership activity was commended in the 2015 NHS Scotland Chief Executive Annual Report. The impact and value of ALISS is also recognised by the Chief Medical Officer, Dr Catherine Calderwood who has stated that;

"ALISS is a fantastic aid to joining people to supports that fit their situation based on the needs they have identified....as professionals, it encourages us to be equally curious about our patients, not just trying to help address their illness, but also in drawing upon what keeps them well. Asking people to think about what matters to them is in itself a hugely powerful therapeutic intervention."



What does the future hold?

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. The ALISS team have also began a programme of engagement with House of Care practitioners to help them turn the information they gather as part of their interactions with people and communities into a tangible resource that can benefit others. They are also exploring exciting opportunities to generate and share analytic and other data that can be used to support future service planning and strategic outcomes focused decision making.

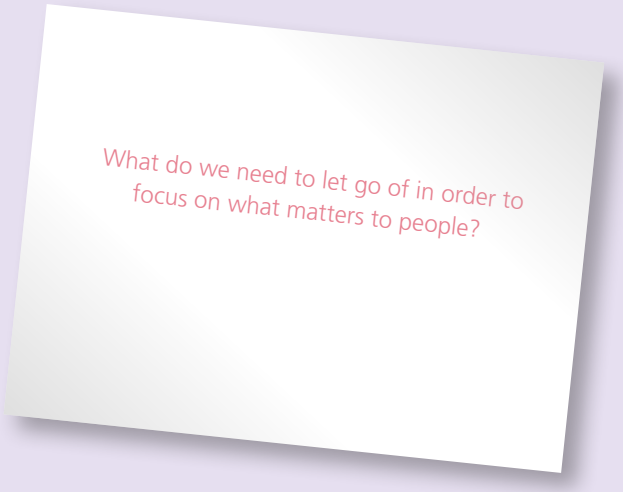
www.aliss.org/about

hello@aliss.org

@alissprogramme

More Than Medicine

It's all about making the connections – More than Medicine in action.

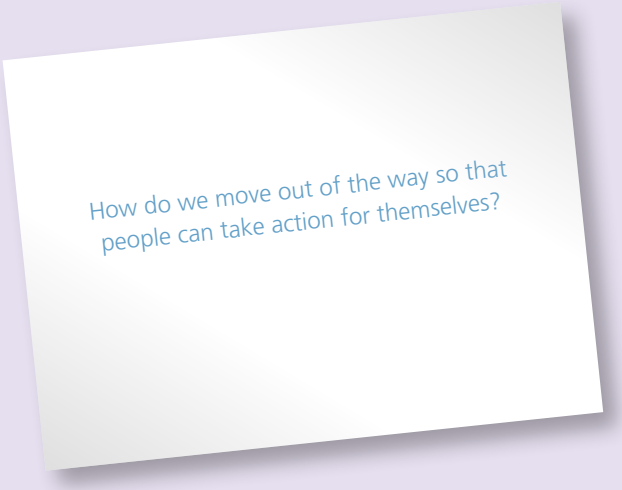


"One of my first tasks as a Community Links Practitioner was to become familiar with the local area and to map out community assets based within Easterhouse. Based within a House of Care GP Practice in a Health Centre, getting out and about on foot was a practical and useful way of exploring the local area to gauge the resources which might be useful in working with individuals referred by the GPs.

I decided to look at what was initially on the doorstep across the road and I started at The Bridge, a local arts centre situated in the heart of Easterhouse, which also contains Platform, Glasgow Club Easterhouse Pool, and The Library at The Bridge which also has entrances to Glasgow Kelvin College and an Adult Learning Centre.

At that point, I'd been supporting a person who was recently recovering from breast cancer but was struggling emotionally following treatment. I saw that Macmillan Cancer had a drop-in service based at the local library and discovered that they provided information, emotional support, complementary therapies, counselling and benefits advice to anyone who was affected by cancer. The advisors were very helpful and we arranged an initial appointment to meet the following week. On leaving the library I almost stumbled across The Phoenix Centre. According to locals, it was the original library, which had lain unused for years, and like the Phoenix that obtained new life by arising from the ashes this former library had been refurbished to become a hub of sports, music, art and learning for people of all ages.

I met with the manager Richard McShane, whose ambition it was to open the centre, after a 6 year plan of refurbishment. He was keen to involve local people and he invited me along to celebrate the official opening of the centre. Over the past 4 months I've regularly dropped in to look at the activities on offer and to see how the centre is developing. Recently, Richard had mentioned that they have an 80 year old ex-table tennis coach who had been coming in to the centre. That got me thinking. I facilitate a walking group on Thursdays made up of people who attend from the practice. I currently have 3-4 people who turn up each week and we usually head out for an hour and explore one of the five woodland trails spread across the Greater Easterhouse area. The trails are managed by the Forestry Commission and we enjoy the fresh air, woodlands and wildlife.



Most of the walkers are in their 70s and I had thought about other activities that my walking group could tap into over the winter months if the weather got bad and the paths are too icy. Thinking about table tennis would seem a great way of keeping my group active and it is a great sport to support physical and mental health with the advantage perhaps of introducing the group to some other activities on offer at the Phoenix centre.

It's all about making the connections – More than Medicine in action."

www.alliance-scotland.org.uk/what-we-do/our-work/primary-care/national-links-worker-programme/

Gayle Weir
Community Links Practitioner in Easterhouse

The Conversation

Scotland's House of Care programme aims to facilitate a fundamental shift in the relationship between person and professional, so that the person is in the driving seat of their health and social care, with self management at the heart of it.

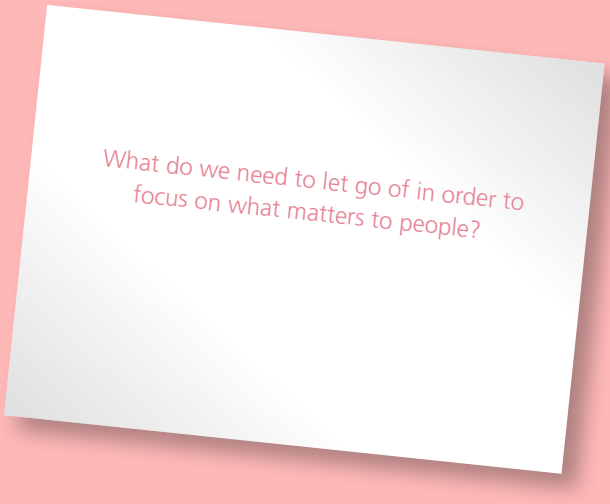
Being in the driving seat is not always easy

"The concept of putting people in 'the driving seat' of their lives, their care and their support has been at the fore since the ALLIANCE wrote the Scottish Governments Self Management Strategy, Gaun Yersel, in 2008. The work of the ALLIANCE in discussing, developing and promoting self management has supported understanding of the idea as well as supporting people themselves to become true partners in their health and care. Hundreds of innovative projects have been funded through the Self Management Fund demonstrating their impact in working towards the transformation of self management in Scotland. The My Condition My Terms My Life awareness raising campaign has encouraged more people to ask 'how can I self manage, and support others to?' rather than 'what is it?' Our Employability work and campaign has encouraged employers and workers alike to understand that people living with long term conditions are already and can even more contribute strongly to the workforce and economy. The Self Management Network Scotland is spreading all these messages to health and social care partners across the country, leading changes in the way 'services' are considered, designed and delivered.

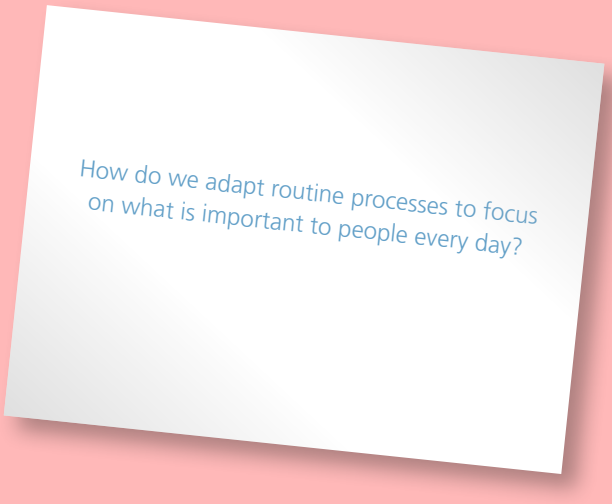
Being in the driving seat is not always easy – taking control of your condition suggests a shift in power, a shift in thinking and, often, a shift in direction. Being in the driving seat can mean taking more responsibility for yourself and those around you. Being in the driving seat can mean feeling and maintaining a momentum to be more motivated. Being in the driving seat does not mean 'going it alone' – partnerships and support can become more crucial. It may be that those partners are not ready to 'allow' people to take control. They may not be willing to change their own practice to support the changes that are required. They may not have the skills and knowledge to do so. They may not have had the chance to learn, or re-learn how to be helpful and supportive. There may not be the necessary additional resources available or visible to enable a different way or working, a different way of managing and a different way of living.

Self Management in Scotland is transforming. Individuals are changing the way they think about and manage their conditions. Communities are changing the way they are supporting and caring for those living with long term conditions. Service providers are changing too, but more change is needed to keep up with the transformations that are developing around them. Services often think in terms of 'improvements' that are needed, making small changes to the way things are already working. Self management is making significant changes to health and social care in Scotland, and for this 'innovation' to flourish, we need to be working together to plan in a different way, for different 'drivers' in different settings, to match these transformations with significant transformations in services and support."

Kevin Geddes
Director of Development
and Improvement,
the ALLIANCE



The Conversation



What is care and support planning using the House of Care approach?

The Year of Care programme was initially set up to look at how routine care for people with long term conditions could be reorganised to ensure people got more out of the time they spent in health and social care appointments. The aim is to offer individuals much more meaningful involvement, through a process of **care and support planning** which can link to support, tapping into both community based support (such as volunteering, walking groups and peer support) as well as existing traditional services (specialist care, rehab programmes and education). The House of Care describes all the activities that needs to be undertaken and change together, to make care and support planning (at the centre of the house) work well for the people who will experience it.

Care and support planning

Care and support planning recognises that both health care professional and the individual living with a long term condition bring different expertise and experience to a health care discussion. Although healthcare professionals have knowledge and expertise about the clinical care of a particular condition, it's really only the person with the condition who knows how it impacts on their life. In many cases care and support planning replaces the annual MOT or review, which is sometimes just a 'tick box activity', with a useful discussion based on what is most important to the person. There is a real opportunity for people to share information with their healthcare team and openly discuss issues and concerns, as well as get help with accessing the services and support that they require to live well with their long term condition.

This means that how care is organised changes using the House of Care framework:

- In general practice - a move away from separate disease reviews to a process which combines care, no matter how many conditions a person has
- An initial appointment with a trained health care assistant to complete all the tests and assessments needed to "monitor" health and a chance to explain the care and support planning appointment
- An opportunity for individuals to be "**Prepared"** - sending out test results with a short explanation and agenda setting prompts in easily understood language ahead of the care and support planning appointment
- A collaborative conversation in which both the person's agenda and the professional issues are shared and discussed and people are supported to develop their own ideas and plans
- Opportunities to link people to the kind of support they need and would value, where possible based locally within their communities. See link to the video about the process www.yearofcare.co.uk/process

This is been achieved by putting in place

- A systematic process of care and support planning including "preparation" within general practice
- Training for health care professionals in collaborative care and support planning
- Local work to link to support in communities -including traditional health and social services and community based services that support self-management and wellbeing.

The core concept is to develop services which work together around the needs of the person and acknowledge the individual's central role in managing their own health.

What have people said about care and support planning?

How it works?
"Much better organised and saves time"
"Helped me raise issues I was worried about"
"A place to write down what I really want to talk about"

Being "prepared"
"Helped me see what was happening and so I knew what to ask"
"I had some time to think about things"
"Its 100% better than being told "no action necessary"

Collaborative conversations
"Interested in what I had to say"
"Talking with me rather than looking at the computer"
"I could ask the questions instead of being asked the questions"

What has been achieved so far in Scotland?
The House of Care is now being adopted in Scotland. It is an integral part of Realistic Medicine (Scotland's Chief Medical Officer's Report). Supported by Scottish Government, the ALLIANCE and the British Heart Foundation, Year of Care has already worked with five sites across Scotland.

What are the challenges for Scotland?

Maintaining integrity to the underlying philosophy

of the programme – ensuring it doesn't get diluted or distorted over time.
Ensuring the centre of the House is delivered – people feel like they are experiencing a better kind of conversation.
Keeping the "whole house" approach. Many localities may believe they are "doing" House of Care, without considering all necessary elements.

The care and support planning conversation comes to life: we're on an even footing and that is so powerful – a GP's perspective

"Beforehand, the care that we provided was based on Quality Outcome Framework indicators that were out of date, so it was very opportunistic. What we do now is we invite people in in the month of their birth for an 'MOT' - for a general health review. It's not fragmented the way it was before, where we concentrated on each individual long term condition that they had. This is more a holistic approach to whatever long term condition they might have. We invite them in - they can opt into the review. It's a planned episode of care, so it's not reactive in any way. We do all the business, the tests and tasks and information gathering beforehand and then share that with the person about a week before they come in to have a conversation with either myself or one of the practice nurses. I think that gives them a chance to have a think about things, to discuss

it with friends, family and the person always has the same information that I've got, so we're on an even footing and that is so powerful when I'm **prepared** for what they're going to talk about and they're also **prepared** for what they want to discuss. I think it just gives them the opportunity to be able to feel safe and have permission just to talk about things they maybe wouldn't talk about before.

For example, there was one gentleman that I got to know very well over the course of working with him. It was always very much focussed on his diabetes and the complications, particularly peripheral neuropathy, and on his insulin management, medication and what his legs looked like. When I invited him for this House of Care review, because he's got other long term conditions and we thought we'll take the opportunity to have a discussion together about how he was feeling about things. During that conversation, he brought up things to do with the relationship with his wife and the impact that his diabetes was having on the relationship. He'd never really had the opportunity to discuss with anyone else. That allowed us to focus more on his wellbeing and suggest things that might help him improve the relationship and his quality of life. I don't think he would ever have had that discussion with me unless he was given the opportunity to do so and he felt it was okay.

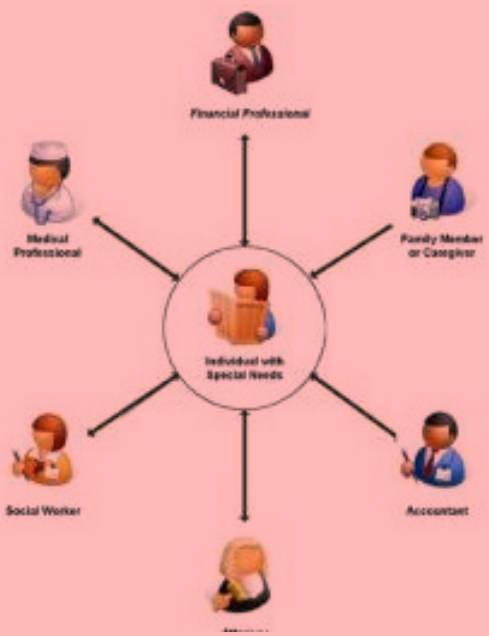
There was another elderly lady who again I had known for several months. She would always come into the practice and was always upbeat and happy and talked about her family and how they were all relying on her. It wasn't really until I got to know her a wee bit better and she came in for her House of Care review that she opened up about problems that she'd had since her husband had died and how she felt really quite lonely and isolated, even though she lives in a retirement village and there were lots of other like-minded people close by, she still felt that she was really quite alone. That was an opportunity to discuss other things that are available maybe in the community that she could get involved in, and certainly out with her medical care that might be of benefit to her. That was really useful, and again, I don't think she would ever have brought that up if she didn't feel able or have the permission to do so.

The Conversation is at the Core: A personal perspective on the House of Care

"I was first introduced to the House of Care some years ago as a fairly recently-in-post policy lead for Health Inequalities and Health Improvement in the Scottish Government. I was initially somewhat cool (who needs *another* model) but soon came to realise that it was a wonderfully **simple** way of making sense of a bewilderingly **complex** policy landscape. This realisation has been reinforced as the years have passed by. So what, in my opinion makes it so attractive?

By giving one side of the House over to the person, they are highlighted as an active partner, and not a passive recipient of services, with nothing to bring to the party, as often seems to be the case ('We will take account of what you want before deciding what we are going to do to you'). This dynamic focus is sometimes respected by focusing on the verb of 'planning' rather than the noun of the 'plan' – but this too easily becomes 'coordinated care' – and so the retention of the word 'conversation'.

The House also seems to remind health and social care workers of the commitment and values – the calling - that brought them into the job, and it gives visual representation to the idea of there being two experts in the room, each with greater knowledge than the other about their domains.



The **Foundation of the House is given over to the rich set of community assets,** an emphasis which is often missing in initiatives which only focus on health and social care services, missing out on the very things – friends, family, the local cafe, the community: that make life worth living and keep us well - in line with the Christie Report.

It continues to be useful in h**ighlighting the focus on good conversations, and the commonality and connections between disparate policies and their implementation.**

The House of Care plays nicely with the other children in the playground. Others can adapt and adopt it without doing violence to their own work. Just this morning while visiting Roxburghe House in Tayside, the team providing Supportive and End of Life Care told me that at a recent event on the health of the elderly, the House of Care had been used and they had found it really useful.

The Conversation

In Scottish Government it has appeared in **Realistic Medicine**, as a clear expression of the conditions required to support shared decision making, in the **Diabetes Improvement Plan** and in the **Cancer Strategy,** as a way of expressing the 'whole person' support required to sustain people after treatment.

Colleagues in **Self Directed Support** have adapted it too, but kept faith with the conversation focus, and with the basic simplicity of the model, which makes it 'sticky' and most importantly memorable.

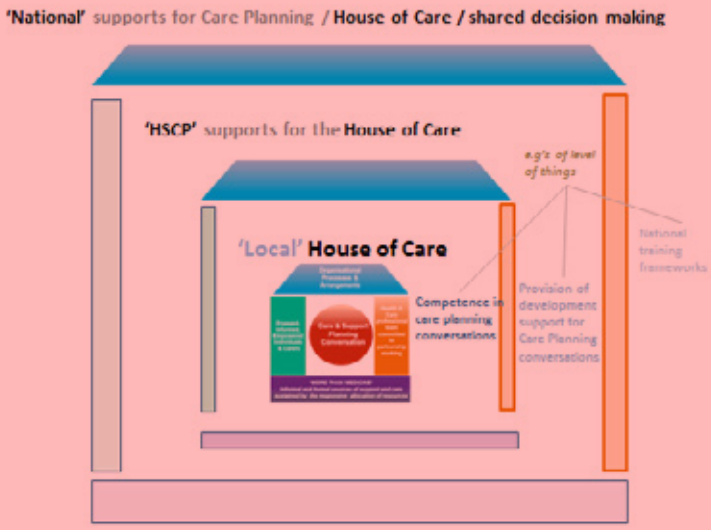
Having been in a succession of policy jobs, and having had the great experience of working at the ALLIANCE to support the spread and adoption of the House of Care, I'm now back at Scottish Government as the policy lead for Palliative and End of Life Care, where the House Of Care is more than ever finding use for navigating an increasingly complex health and social care landscape– whilst keeping the conversation with the person at the centre of both care planning and of strategic planning.

My new boss in Scottish Government likes to quote George Box who said 'All models are wrong – but some are useful'. In the case of the House of Care it is proving remarkably useful.

The House of Care can be seen as **another top down model** – imposed from on high.

Except that it always needs to be built locally, on 'brown field' sites, brought to life and made meaningful by the existing resources and people where it is sited. In this context I have found it useful to reference the '**Russian Doll'** version of the House of Care, (©Graham Kramer) as it places value on addressing all parts of the House, at a number of levels – but essentially **maintains that conversation as its core.**

My bottom line has been well expressed by Vikki Entwistle and colleagues-
'the purpose of support is to ensure that people have what they need to be able to live (and die) well on their own terms with their long-term condition(s)'.



Plans and decisions must flow from the conversations with people about what matters to them and we need to stay loyal and true to those plans and decisions, at all these levels."

Tim Warren
Team Leader
Palliative and End of Life Care
Integration Division
Directorate for Health and Social Care Integration
The Scottish Government

NHS Ayrshire & Arran

Carol Nixon
House of Care Project Manager

Older people and those with long term conditions often experience fragmentation in the services they receive. They can receive care from a variety of teams including specialist clinics in hospitals, pharmacists, GPs, AHPs and nurses in primary care, and some may also receive social care. The individual experience can often appear disjointed and fragmented. Their voices can often be lost along the continuum of care.

Ayrshire & Arran recognised the House of Care framework as a tool which not only enables Health Care Staff to use a more person centred holistic approach but supports patients to be more involved in their care.

During a recent improvement project, an early test of change using the Our Voice framework, we used storytelling technique at a patient and carer event that helped us look differently at our approaches toward interactions with patients.

Storytelling Techniques

'Role on the Wall'

Participants create fictional characters they can each see themselves reflected in. This establishes a safe and positive space for participants to offer their ideas, thoughts and feelings.

'Hot Seating'

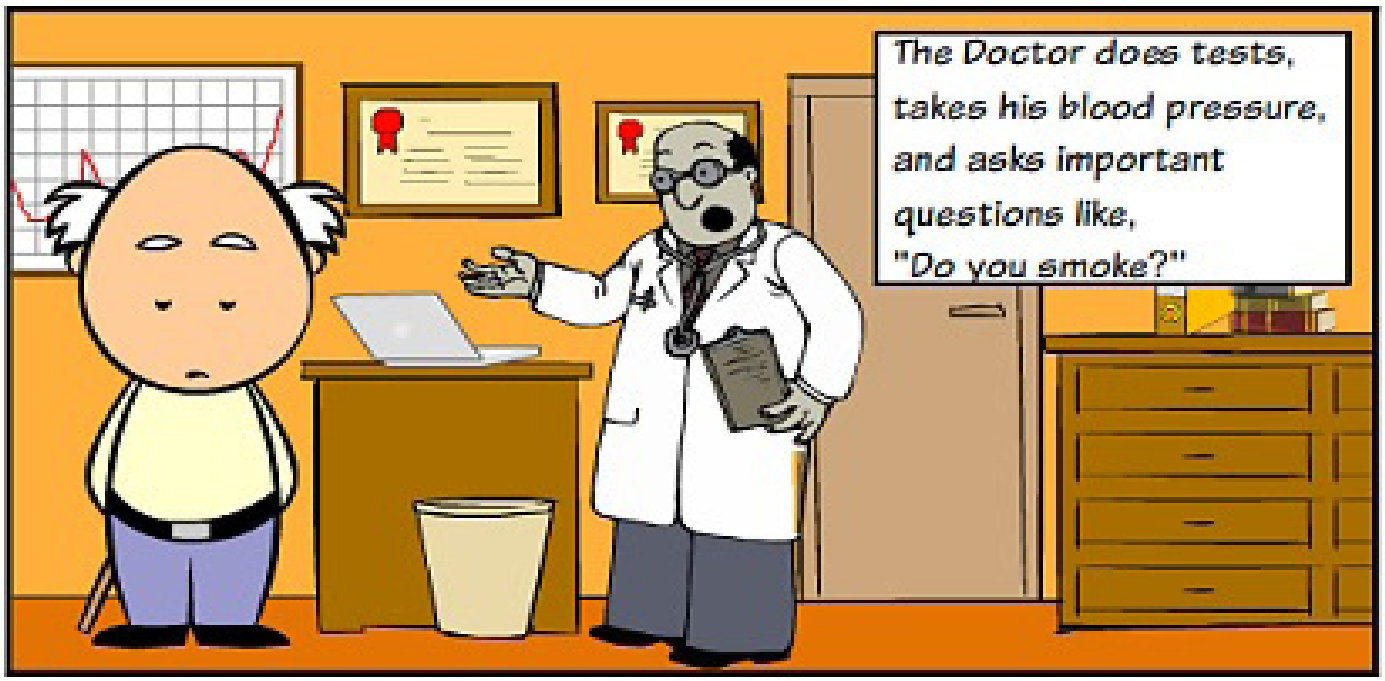
Participants take it in turn to sit in the 'hot seat' as the character the group have created. Others in the group ask questions about the character. This helps the group delve deeper into their character and gives them a voice.

It was apparent from the discussions that the House of Care model supports the type of conversations that our patients would like have with their health and care professionals to help them manage their condition. Typically, people said that they want to....

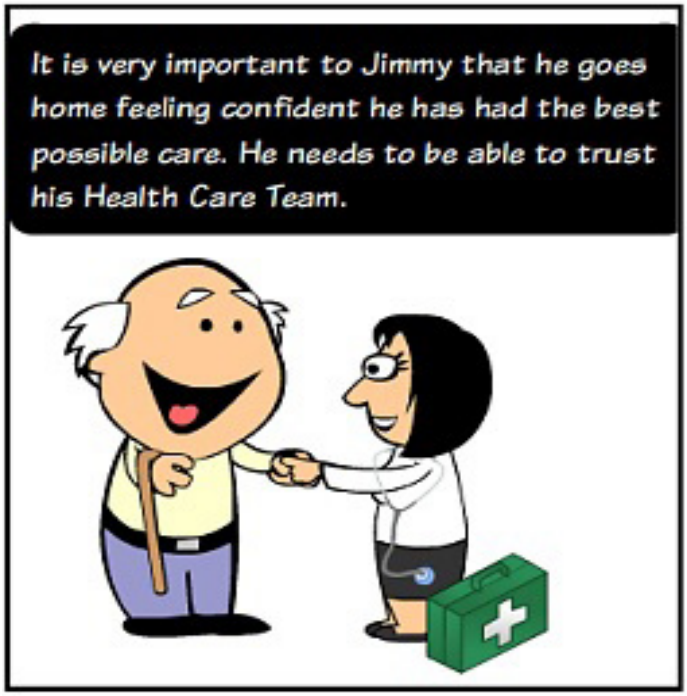
- feel confident and supported to manage their condition
- have better knowledge of condition, e.g. use of inhalers and medication
- know how to contact the right health and care professionals for prompt support
- have effective communication and conversations with their health and care professionals
- be asked questions that can help them get the correct treatment and support as early as possible, for example, about lifestyle, occupation (now and in the past), hobbies, how they are coping, do they understand, and importantly what matters to them.

NHS, Health & Social Care Partnerships and third sector strategic plans demonstrate an ongoing commitment to help people to achieve personal outcomes through collaborative conversations and access to all information and results. The House of Care approach is recognised as an effective way to achieve this. In Ayrshire & Arran we are implementing House of Care with a small number of Practices, with a view to further rollout following evaluation.


I wonder who I can ask about preventative care?
What meds?
Who will be following up with me?
Do I contact the Dr or will they contact me?


The Doctor does tests, takes his blood pressure, and asks important questions like, "Do you smoke?"


Jimmy feels it would be helpful if someone took time to explain about his condition, maybe in a group even


It is very important to Jimmy that he goes home feeling confident he has had the best possible care. He needs to be able to trust his Health Care Team.

NHS Greater Glasgow and Clyde

Learning and sharing - from a detached to a mid-terrace

Sandra McGuire
House of Care Project Manager
and local Year of Care Partnership trainer

So far, we have implemented House of Care in 14 of the 241 GP Practices within NHSGGC which are spread over a vast geographical area that is sub-divided into localities. The 14 HoC practices fall within four of these: East Dunbarton and Glasgow – which is further subdivided as the North East ; North West and South.

Each of the four localities/sub localities cover large, diverse demographic areas and this posed a challenge for the HoC Lead and facilitators supporting the implementation of the HoC Model within the practices because there were many differences between practices in close proximity and similarities between practices at opposite ends of the geographical spread. A Plan, Do, Study, Act (PDSA) model was undertaken to test out possible solutions.

HoC PDSA Cycle 1

- The Plan was to establish a network of support for the practices
- The Do was to bring the practices together for a one-off meeting to explore this further
- The Study was to collate the information about attendees and suggestions made
- The Act was the preparation for the roll out of the agreed quarterly locality network meetings.

The effort to take this forward was channelled through one particular locality that was keen to get started. This was undertaken as a second PDSA cycle with the hope that others would follow if they could hear of, and see, the benefits directly from their peers. The practices met and agreed a set of terms of reference outlining the purpose, frequency, membership and the agenda for each meeting. There are now four practices who take turns to host the meeting quarterly and HoC staff now attend in an advisory capacity rather than co-ordinating.

Through the locality meetings, staff have shared areas that were problematic, and offered advice and peer support. This included staff of one practice 'shadowing' another on more than one occasion as well as health care support workers and practise nurses exchanging contacts. Sharing best practice has encouraged others to follow suit. For example, one practice has a Links Worker who attends the meeting and through his knowledge of the locality, is able to share with the other practices the community assets available for the more than medicine aspect of the House and how to use ALISS. Two further localities have now started their own network meetings with similar benefits. In one locality, the practices are a 3 minute walk from each other and, until the first network meeting, hadn't met with their peers, other than two of the GPs knowing each other from another forum.

This model is working well within GGC with practices commenting that it has set them up well for the 'cluster' groups that they will soon be part of. The project lead and facilitators are able to share good examples and tips and hints across all four sites and put members of staff in touch with each other. One quote sums this up nicely:

I feel more of a mid-terraced house than a detached house with the support of the other practices in events of learning, sharing challenges etc.

Community Links Practitioner Approach Meets House of Care

As the practice Community Links Practitioner based within a GP Practice in Pollok, I've been exploring opportunities, along with the Practice Nurse, to develop a person centred care approach for people currently living with long term conditions and already engaged in the House of Care pathway. With the support of local resources, we will create a complimentary, bespoke

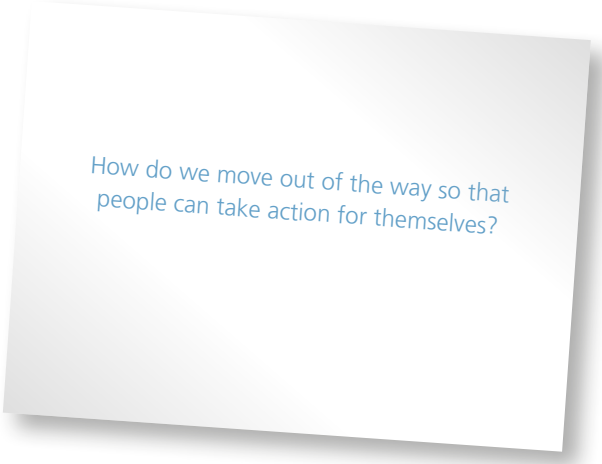
programme designed to improve health and wellbeing for people living with type 2 diabetes.

We really want to support people who would benefit from improved control of their diabetes and who currently see our Practice Nurse for this support. A new proposed programme, of partnership working between the GP Practice, Urban Roots and South West Community Cycles (SWCC), will be designed which will encompass the House of Care approach. Currently our practice HoC medical care involves support for patients through an 8 week clinic - a monitoring process involving patient contact with our Practice Nurse. In future, through the proposed programme, people will also be invited to access a series of bespoke sessions designed to help them improve their health and wellbeing. This will be offered in addition to the current format where our PN initially asks patients to complete a Chronic Disease Management Clinical Support Template, which is designed to support patients to set actions and goals around their condition.

This additional HoC inspired programme will be set up by the community links practioner and private nurse within the Practice, working in partnership with local resources (South West Community Cycles and Urban Roots), and referrals will be made to the new service during the existing HoC clinic appointments with the PN or during appointments with the CLP. A framework for the service will be designed before it launches and funding has already been obtained by both community projects to deliver this service.

Each participating local resource has been invited to take part because they are well established in the community and offer an existing service which has an emphasis on improving both diet and nutrition (Urban Roots), and activity levels (SWCC). Both have been shown to improve physical and mental health and wellbeing through the services they currently offer.

As a Practice team, we will continue to work together to provide a service which will support and involve the person in the journey. By using the existing HoC clinic appointments as an introduction to the new, additional programme, people will be encouraged to become involved in choices around their care and will be encouraged towards positive change. As the programme develops, it is envisaged that participants will be assisted to make decisions towards better self management of their condition and encouraged to create peer support groups with other programme participants. For example, it is expected that whilst participants may begin the programme by being offered close, one to one cycling support or nutritional advice/support, they will eventually progress to working with other programme participants in sustainable peer led groups.



Introducing a HoC modelled approach in partnership with two local resources offers the opportunity for those local resources to work in a cohesive and complimentary way with the primary care team. It will enable the resource to work with and better support local people. Each community project taking part will bring support and expertise which will be designed specifically for the people living with diabetes who are taking part. Our Practice Nurse will continue to monitor patient progress through the established HoC clinics. Any medication or medical needs will be managed by the Practice Nurse and GPs.

Access to other support services will be offered on a continuous basis throughout the programme, either by engaging with the PN, the CLP, or during programme information workshops where organisations will come to inform participants of services available to them including: other health and activity groups in area, gardening/food growing opportunities, smokefree services, welfare/housing support, counselling and mental health support, addiction support, training volunteering and employability support and other relevant services.

It's an exciting time as we work together on the practicalities of the course -the programme length, participant numbers, structure, and referral process – watch this space!

www.alliance-scotland.org.uk/what-we-do/our-work/primary-care/national-links-worker-programme/

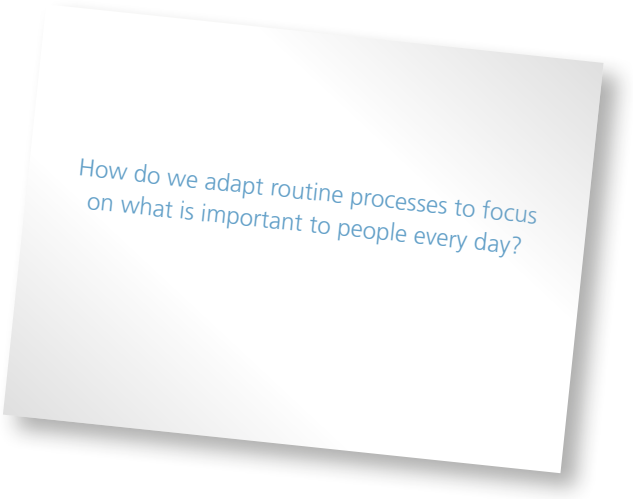
Gerry Mitchell
Community Links
Practitioner

NHS Lanarkshire

In recent years, more and more I can see the connections between the different conditions. It became obvious that certain groups of people maybe weren't getting access to the same level of services or support as others. So, for instance, we've got pulmonary rehabilitation, cardiac rehabilitation but we don't have diabetes rehabilitation. But there have been things that we've done in Lanarkshire like Active Health that takes it away from 'you are your disease' to 'you're a person who lives with' and I really do think in recent years my mind-set has been more and more if we're doing this for somebody with that condition, shouldn't we open it and be accessing all people that need that?

And I suppose also the increasing acknowledgement that wellbeing is so important for people that have long-term conditions and by only addressing the clinical side of the condition we're not addressing some of the things that might be preventing people from actually helping themselves. My perspective started to change when House of Care came around. It was automatically 'that's what I'm talking about!' so it was a natural progression for me to move into this area.

You can explain it to someone and they think they've got it and then the next time they maybe go to the training or maybe they get it explained again and it's always slightly different. And it's just about constantly reminding, yes, this might be difficult to start with, might take a lot of work to start with to get things moving to make the changes you



need to make, and to change the style of the conversation. But once you've managed that then the benefits all come through and you only have to do it once. Once you've done it then you're going to get more out of it, your patients are going to get more out of it and there's a whole host of benefits that can come to the practice.

It's all starting to connect. I did a talk recently to people within North Lanarkshire for the voluntary sector and it absolutely made sense to everybody and they thought it was a great thing and they wanted to know how they can get involved in it and it's going to take time to get it all to connect. And there are other things happening within Lanarkshire, such as the GP digital work that's going on, eConsult, all the rest of it.

There's lots of programmes going on: work-streams within the overall Primary Care and Mental Health Transformational Programme, but House of Care runs through everything and it's like a big jig-saw puzzle just now that's started to come together. And when I'm speaking to practices, they need to know we're working with you, and it is transformational in your practice, but it's actually going to be transformational across Lanarkshire, across Scotland. I do quite like the analogy of the Russian doll with the little one being your practice and then the bigger one being Lanarkshire and then you've got the NHS Scotland one.

One of the things that I think is very important is finding out what's out there. We've developed a 'more than medicines' prescription and on the front side it identifies what area that you would want to work on in terms of your goals and your actions as an individual and then on the flip-side of the prescription are some useful websites and telephone numbers. And that's services whether they be traditional health care services, whether it's with our partners within the leisure services or our further partners; or indeed, our voluntary sector partners as well. If you're interested in maybe doing something, maybe getting a bit more active: here are some options for you.

When you think about medical you don't think about an art class but it can be fabulous, the transformation in someone. If you're feeling good about yourself and good about your environment and you're getting out and about; well just getting out the door it's more activity, it's helping all the biomedical things that should be getting helped with.

We're wanting to put in a lifestyle management course and that could indeed be an outcome from your conversation with your health care practitioner so that if a joint decision was 'actually, I need to be a bit more confident in myself, I need to know more about my conditions. It can also help the person so the next time they come in for their conversation they are more empowered, they are more confident and they do have more skills and more resources within themselves to be able to then take that the next step; it's a very positive cycle.

Maureen Carrol
House of Care Project Manager
and local Year of Care Partnership trainer

Adopter Site Stories

NHS Lothian

In 2014, NHS Lothian was developing its new Strategic Plan. Work focused on Hannah, a reasonably active middle-aged woman with underlying health conditions with the aim of thinking about new ways of placing the person at the centre of health and social care. For a long time, care was planned separately in different parts of our system (primary and community care, acute care, mental health). Care has also been planned around buildings, individual services or even individual clinicians. It was recognised that there needed to be a shift towards an overarching approach that focused on the needs of people.

In this context, the House of Care was 'discovered' as a way to support whole systems change. It was an exciting idea that quickly attracted others; notably the Thistle Foundation whose depth of experience and understanding about person centred work provided genuine insight into what's important for people like Hannah.

Uniquely co-led by the NHS and third sector, we see the HoC as a powerful metaphor for change that offers an essential, unifying feature of ensuring care and support is based on the personal outcomes of people. It follows that the House will be different for people and places where resources and context vary. We've found that the concept crosses boundaries, resonating with health, social care and third sector professionals alike.

In an early awareness raising event, we asked professionals to locate themselves around the house. It looked something like this. We realised that there was little support for people and that a response was needed. We established a joint

team of NHS and Thistle Wellbeing practitioners to ensure self management support was readily available in eight practices in Edinburgh and Midlothian. The Wellbeing team used a HoC approach in their work with people. Equally, the service contributed to supporting people to be enabled, engaged and informed in their interactions with other professionals, a 'left hand wall' support to the practice.

Taking time to really listen, for someone to be heard is powerful. Whilst support is highly personalised as change might relate to family dynamics, money or health, the aim is to move from 'me thinking about my failure' to taking control. Support like this, that focuses on small practical changes, is crucial to both getting more out of life and being prepared to meet a professional as an equal: with expertise on their own life and what matters to them.

Soon after, the opportunity to work with the BHF arose with seven practices committing to adopt the House of Care approach to care and support planning. This opportunity was valuable because it gave practices a specific process to organise change around. Whilst the project focused on patients with or at risk of cardiovascular related diseases, each practice identified their own priority group of patients.

As momentum grew, we learned two lessons:

- Supporting partners to adapt the model to context helped to sustain engagement, and;
- Our work was enhanced and strengthened by embracing, acknowledging and working with existing projects and initiatives.

Flora Henderson
House of Care Project Manager and local Year of Care Partnership trainer

Supporting transformation across health and social care – being brave about change

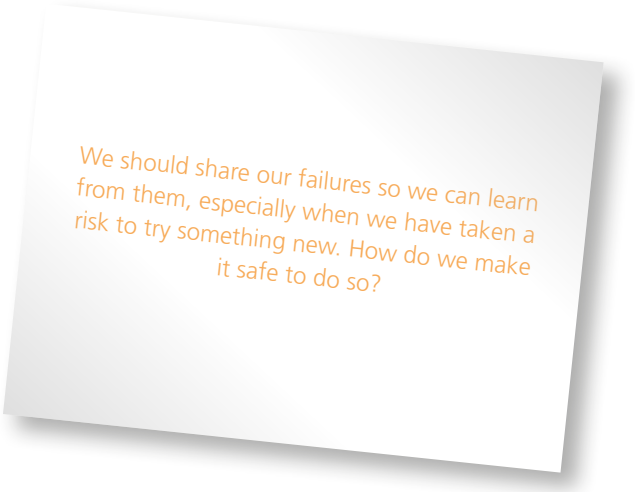
Midlothian Health and Social Care Partnership was an early adopter of the personal outcomes approach. They saw the new NHS strategy as an opportunity to 'get in front of the game' instead of managing failure demand. It was recognised that more could be done to address health inequalities and that services weren't joined up: this was true for people under 65 years who had more than one long term condition, and true for people with mental health needs. People were potentially very isolated.

Adopting the House of Care renewed focus on long term conditions and mental health. A Midlothian House of Care steering group was established to foster co-ordination and coherence across a wide range of services, not just the two early adopter partners. These services all have in common the objective to work with the whole person, taking the time through good conversations, to work out what matters to each individual. A 'Health and Wellbeing Practitioners' Forum' was established to provide regular space and time for practitioners to be in the same room, hearing the same conversations and trying to make decisions differently. Such an inclusive approach worked to break down territorial boundaries. One practitioner observed that while their posts might be funded from different places, there was a sense of working to a common goal.

"It's taken a lot of effort and work to create a culture that recognises particular areas of expertise alongside a common approach and set of values. Working this way entails being brave about change, being prepared to make mistakes and being prepared to learn. Sometimes it's unclear and communication could be better, however there's a real will and openness to keep trying to work in this way. While at times it can feel a bit clunky we believe that our approach is all the richer for embracing different services and avoiding the one standard approach."

Tom Welsh
Integration Manager
Midlothian Integration Joint Board

At the steering group, the aim is to identify relevant services and resources, enabling better coordination across these and identifying opportunities to

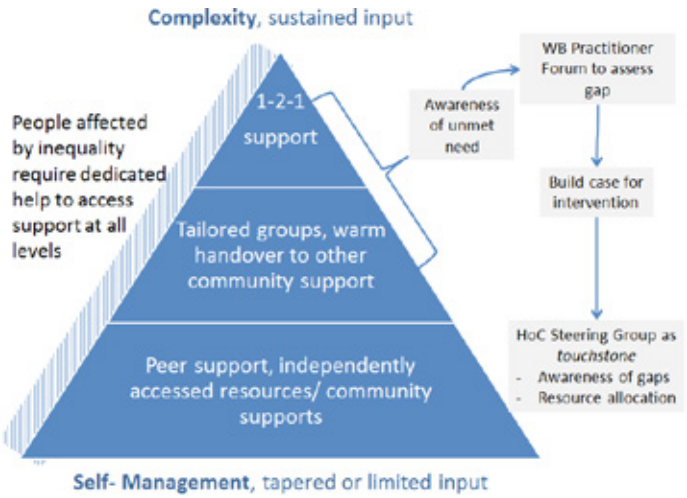


collaborate when people need extra help to access support. This strategic direction was facilitated by the timing of **House of Care**, an existing ethos of partnership working, and a shift in culture that has moved away from transactional relationships, including with the third sector. It's also fortunate that Midlothian is small so that the right people find each other more easily.

As the work gains momentum and a wider range of services are linked in, having capacity to respond to gaps alongside a mechanism that avoids duplication of effort is vital. Small scale examples are emerging: this might be a tailored intervention to bridge another resource or co-delivering an activity to respond quickly to the needs of small groups of people with similar challenges. It's early days but the practitioner forum and steering group offer places where services can check their awareness of unmet need against available people and resources.

Enablers:

- Focus on collaboration not competition
- Willingness of services to work together
- Good fit with integration
- Culture of conversations between staff groups
- Ethos of giving time and listening



NHS Tayside

Care and Support Planning – trying it out in NHS Tayside

Care and Support Planning training emphasises the importance of preparing people and sharing information prior to a care and support planning appointment. The training also introduces the Care and Support Planning Consultation Framework: gathering and sharing stories, exploring and discussing issues, goal setting and action planning, plus collaboratively discussing review options.

One practice was at the stage of planning their implementation approach for people with Diabetes and one of the Practice Nurses wanted to try out this more collaborative style of consultation before going 'live'. The Nurse framed this experience as an initial small test of change, part of a PDSA cycle (Plan, Do, Study, Act), as per The Improvement Model.

"Seeing it all here in front of me has given me the impetus to plan what I am going to do next (made 2 goals with specific and realistic actions). I felt able to express concerns about things I had not been able to discuss before."

Person after the consultation

"I came out of that appointment feeling very proud that I'd been able to put the training into practice, offer an alternate approach & received such positive feedback from the person! Evolving consultation skills really seems to make a difference. It's really boosted my confidence and made me want to keep going!

This approach helped capture what worked well and not so well and subsequently informed the next steps, plus strengthened the case for change amongst colleagues."

Practice Nurse

Support the heart of the House

Implementing Care and Support Planning, using

the House of Care does involve thinking about some system and process changes and we partner practices flexibly when they plan their specific approach, to ensure that the underpinning principles are not diluted. However, what's really important to me is that we support the heart of the house - the collaborative, truly person centred conversations that professionals can have in conjunction with people with long-term conditions.

Using the care and support planning consultation framework can really help evolve these conversations and support people to think about what's important to them, in terms of what they want to achieve and how they feel they can get there.

Nicola Stevens
House of Care Project Manager / Practice Facilitator and local Year of Care Partnership trainer

Going Forward

Collaborative Care and Support Planning using a House of Care approach introduces a new clinical approach to the management of long term conditions in primary care that has a much stronger emphasis on linking people to the community, both in terms of the formal and informal sources of support that exist.

This approach aligns well with cluster working – providing the conditions for them to set outcomes and develop their own quality improvements to help achieve these outcomes, the integration of health and social care, and the ethos shift towards shared decision making between people and practitioners as set out in Realistic Medicine.

Scotland's House of Care programme aims to facilitate a fundamental shift in the relationship between person and professional, so that the person is in the driving seat of their health and social care, with self management at the heart of it.

The aim of this Learning Report has been to create a space to reflect on progress made so far and going forward, sets out the elements required to deliver this change in practice, focussed on co-ordinated and capacity-building training, to promote the whole-system transformation needed to improve the interactions and conversations between people and their practitioners.

ALLIANCE
HEALTH AND SOCIAL CARE
ALLIANCE SCOTLAND
people at the centre

Scotland's House of Care

The Health and Social Care Alliance Scotland (the ALLIANCE)
Venlaw Building, 349 Bath Street, Glasgow G2 4AA

Email: **info@alliance-scotland.org.uk** Twitter: **@ALLIANCEScot** **@HoCScot**

www.**alliance-scotland**.org.uk

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