
House of Care Patient Experience Evaluation

Final Report

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Executive Summary

This report sets out findings of the House of Care Patient Experience Evaluation which was commissioned by NHS Greater Glasgow & Clyde (NHSGGC). This has been prepared by Traci Leven Research who conducted all the interviews and subsequent analysis for the evaluation.

Background

Care and Support Planning for People with Chronic Diseases includes patients having two appointments:

1. **Information Gathering** – during which all essential tests, tasks and assessments are completed and once available are shared with the patient, accompanied by explanations and prompts for reflection, prior to the second (consultation) appointment.
2. **Care and Support Planning Conversation** - during which there is an opportunity to explore issues, concerns and ideas and jointly agree a plan (care plan).

In the NHSGGC area, 15 practices have begun implementing Care and Support Planning using the House of Care model. The initial focus has been on diabetic patients (some of whom also have CHD), although there is an intention to move towards a multi-morbidity approach.

The Evaluation

The evaluation of the patient experience of the House of Care approach is one component of a larger overall evaluation of House of Care in NHSGGC and also the national programme evaluation. The overall stated aim of the patient experience evaluation was:

“to gain insight into whether the House of Care approach to CDM care planning is acceptable to patients, and whether patients have identified a change in the quality of the consultation”.

Method

Interviews were conducted with 29 patients who had recently been through a House of Care review – 27 face to face, and 2 by telephone.

Demographics

The 29 patients came from nine practices. Most (23) were aged 55 or over. Seventeen were men; 12 were women. Most (22) were in the most deprived or second most deprived SIMD quintile. Most (24) described their ethnicity as White Scottish, four were Asian, and one did not disclose their ethnicity.

Acceptability of the House of Care Appointment Process

The term ‘House of Care’ was not used or recognised among patients. However, most patients had been made aware that the review process had changed prior to attending, or during, their information gathering appointment. The key changes to the process observed by patients (in most cases) were:

- Receiving the test results in writing, and in advance of the consultation appointment;
- Experiencing a more collaborative review;
- Completing a care plan.

Information Letter/Test Results

The direct receipt of written test results was a key difference in the new review process which patients most frequently cited as a very obvious change in the review process and many enthused about this. The benefits of receiving written test results before the care and support planning conversation were:

- They helped patients prepare for their care and support planning conversation. They felt more informed and able to prepare questions for the nurse or GP.
- Having written, rather than verbal, feedback made the results much clearer.
- Written results were more likely to act as a motivator to change.
- Positive test results provided valuable feedback/reassurance that patients were managing well.
- Patients could easily share the results with others.

Most patients overall felt that the test results were set out in a clear way and were easy to understand, but some found some elements confusing. There was variation in the way test results were presented, including whether explanatory notes were included. Some patients received historic test results so they could see trends, while others received only their recent test results.

Care Plan

There was variety of approaches to the completion of a care plan, including:

- Issuing the care plan to the patient at the information gathering appointment for completion prior to the care and support planning conversation appointment;
- Issuing the care plan to the patient with the written test results for completion prior to the care and support planning conversation appointment (the most common approach);
- Providing the care plan at the care and support planning conversation appointment, and completed with the patient and practitioner together;
- Not providing a care plan at all.

Those who had completed (or partly completed) the care plan before their appointment said that the nurse went over the care plan with them during the appointment and discussed each of the issues. This often included assessing needs and providing advice about goals. During discussions, some of the entries in the care plan could be added to or revised. The care plan provided a very helpful structure for discussions with the nurse at the care and support planning conversation appointment, and ensured that all issues were covered.

Patients generally found it helpful to have their care plan in writing after their care and support planning conversation.

Barriers and Facilitators to Attending Appointments

No significant barriers to attending appointments were mentioned during interviews. Patients were generally motivated to attend their review appointment in order to obtain feedback about their condition and monitor their progress or areas which required to be addressed.

Experience of Appointments

Overall, nearly all patients were very happy with their appointments and felt at ease and listened to.

Accounts of information gathering appointments suggest that there was often not much detailed discussion, but this was not expected at this stage.

Most patients described the discussions at their care and support planning conversation appointment as focussing on the test results, with the practitioner often going over the test results in detail with the patient, ensuring that they understood what they meant and offering comment and advice on what the results indicated, often with reference to both previous tests and desirable levels. Most patients also described talking through the care plan with the practice nurse during the care and support planning conversation – either reviewing forms that had been completed in advance or completing it through consultation with the nurse during the appointment.

Patients' accounts of their care and support planning conversation suggest a variation in approach across practices with regard to multiple conditions. Some appeared to discuss and consider all patients' health conditions and concerns, whereas others seemed to focus only on diabetes. Not all patients expected, or saw the value in, a comprehensive review of all conditions/concerns. However, those who had a review which considered all conditions/concerns found this valuable.

There was, to some extent, discussion about mood/mental health in most care and support planning conversations because this was part of the care plan form. Many patients who were interviewed expressed some problems with low mood or depression. However, only one patient interviewed had been offered information about services which could help with depression (see Case Study 1).

Most patients felt that their care and support planning conversation was long enough to cover everything they wanted to cover, and that the nurse gave them plenty of time and showed a genuine interest in their condition and their goals. Most patients felt that the appointment was a very collaborative exercise. Two of the patients had attended the care and support planning conversation appointment with their spouse/carer and this was felt to be helpful.

Some felt they needed more information about diabetes, particularly among those who had recently been diagnosed.

Readiness to Self-Manage

Most patients felt that they had all the information and skills they needed to successfully manage their condition. Some acknowledged that although they felt well informed, they struggled with 'willpower' and did not always make the right choices regarding diet, exercise etc, despite knowing what they should do. However, having the review was considered a help as a reminder, and the written results were said to particularly give focus and motivation. The review process helped with self-management by:

- Providing information about diabetes;
- Providing test results, which gave feedback on how actions have impacted on health;
- Giving regular checks, - knowing that they would be monitored again in 12 months, was an incentive to patients to remain on track with blood sugars and weight etc.

A small number of patients commented on receiving conflicting advice from health professionals and felt that more consistent advice was needed.

Review Outcomes and Impacts

Reviews result in goals being set, referrals being made, or actions being taken in the following areas:

- **Weight Management:** Weight loss was the most commonly cited goal that was set among patients, and several patients said that they were offered a referral to weight management services at their care and support planning conversation appointment (some declined and some accepted). Some patients were given advice during their appointment about modifying their diet to lose weight. Most patients who had set a goal to lose weight indicated that they had implemented changes to diet/and or exercise, or at least intended to do so. Some felt they had already begun to lose weight.
- **Dietetic Service:** Some patients were offered referrals to a dietician either for advice about losing weight or for managing blood sugars and this was taken up.
- **Exercise:** Increased exercise or improved fitness was also a common goal among patients. Many felt comfortable working on this themselves and reported making changes including walking more. Four patients had been referred to an exercise programme.
- **Smoking Cessation:** One patient was re-referred to smoking cessation services.
- **Mental Health Services:** One patient who had been struggling with low mood/depression was given information about a service which could help, which he was invited to self-refer to if needed.
- **Changes to Monitoring Practices and Medication:** Some patients had their medication modified as a result of their review (either for their diabetes or other conditions). Some were asked to change the way they monitored their condition (e.g. with use of testing kits and diaries).
- **Identification of Other Medical Conditions:** Some patients were referred to their GP for further consultation and treatment for conditions identified in the course of the review (e.g. rashes, pain).

Suggested Improvements

Most patients were unable to think of any improvements and felt that the process met their needs very well. However, suggestions made by patients included:

- Reviews should be more frequent;
- Include previous years' results with their current test results;
- Give more general information about diabetes, including the risks and symptoms to look out for.
- Provide results electronically – by email or through an app/website.

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1 Introduction, Background and Method

1.1 Introduction

This report sets out findings of the House of Care Patient Experience Evaluation which was commissioned by NHS Greater Glasgow & Clyde (NHSGGC). This has been prepared by Traci Leven Research who conducted all the interviews and subsequent analysis for the evaluation.

1.2 Background

NHSGGC had made a commitment and extensive investment in its Chronic Disease Management (CDM) programme, providing GP-based care for patients with five major types of chronic disease – Chronic Heart Disease (CHD), Type 2 Diabetes, Stroke/Transient Ischemic Attack (TIA), Chronic Obstructive Pulmonary Disease (COPD), and Left Ventricular Systolic Dysfunction (LVSD). The CDM programme aims to provide person-centred care for patients with any combination of co-morbidities.

Recently a House of Care approach has been established for CDM. Funding from The Scottish Government and Social Care Alliance has allowed five sites in Scotland to begin to implement the House of Care approach, with NHSGGC being one of these sites. In addition, funding from the British Heart Foundation has been provided to three Scottish sites (Glasgow being one) to pilot the House of Care model for people with cardiovascular disease (CVD).

The House of Care model aims to embed care planning and support for self-management for those living with long term conditions. The 'House' is symbolic and encompasses the elements of the framework that are required for systematic and collaborative care approach, as shown below:



The model includes patients having two appointments:

- 1. Information Gathering** – during which all essential tests, tasks and assessments are completed and once available are shared with the patient, accompanied by explanations and prompts for reflection, prior to the second (consultation) appointment.
- 2. Care and Support Planning Conversation** - during which there is an opportunity to explore issues, concerns and ideas and jointly agree a plan (care plan).

In the NHSGGC area, there has been a staged approach to implementing the House of Care model, with eight GP practices introduced in the first wave (from early 2015) and a further seven in the second wave (from early 2016). The initial focus has been on diabetic patients (some of whom also have CHD), although there is an intention to move towards a multi-morbidity approach.

1.3 The Evaluation

NHSGGC commissioned an evaluation of the patient experience of the House of Care approach. This is one component of a larger overall evaluation of House of Care in NHSGGC and also the national programme evaluation. The overall stated aim of the patient experience evaluation was:

“to gain insight into whether the House of Care approach to CDM care planning is acceptable to patients, and whether patients have identified a change in the quality of the consultation”.

Specifically, the evaluation sought to answer the following questions:

1. Demographics: age; gender; postcode; employment status; occupation or last occupation.
2. Acceptability of House of Care appointment process
 - Awareness of change in review if new patient including views on two appointment process.
 - Use of information letter and test results.
 - Barriers and drivers to participation in information gathering appointment and care and support planning conversation.
3. Experience of both appointments (information gathering appointment and consultation/care support planning conversation):
 - Understanding of content; listened to; feel at ease; interested; opportunity to discuss concerns; joint decision making.
4. Self reported readiness to self manage including care plan and condition specific knowledge of when to seek support.
5. What difference has the review made:
 - General health and wellbeing
 - Actions from the review including referrals to and experience of secondary care
 - Access to local community services via GP, self or other identified
 - Experiences in relation to CHD and/or diabetes self management.

1.4 Method

Patients at all participating GP surgeries were asked, when attending their information gathering appointment, to complete an LTC6 questionnaire which comprised six questions about the care and support they received for their condition. In addition, patients were

asked nine questions about their condition and their demography, and contact details to complete if they were willing to be contacted in future to talk about their experiences. Contact details were sent to NHSGGC, but were separated from all other responses to the questionnaire.

Staff at NHSGGC contacted patients who had given their contact details by a mixture of methods, and in accordance with the patient's stated contact preference – post, email and telephone. An 'opt out' approach was used at this stage, given that patients had already consented to be contacted: those who were reached by telephone were given information about the evaluation and asked if they would be willing to be contacted and interviewed by the researcher; those who were contacted by letter or email were given information about the evaluation and informed that the researcher would contact them, but were invited to respond to NHSGGC if they did not wish to participate. Contact details for all patients who gave consent (or did not opt out) were passed to the researcher. Contacts made by NHSGGC ensured that no more than four patients per practice were included in the sample. Patients were then contacted by the researcher to arrange interviews.

In addition to the methods of patient recruitment above, a targeted approach was adopted in one practice to ensure that there was some representation of patients from minority ethnic groups/those whose first language was not English. Letters were sent to patients inviting them to attend the surgery on specific afternoon to be interviewed, with the assistance of an Urdu interpreter where required. This resulted in a further three interviews.

In total, 29 interviews were conducted from the 32 contacts given to the researcher (three were unable to be reached after multiple attempts). Two were conducted by telephone at the patients' request, with the others all being conducted face to face. Most were conducted at the patients' home, but others were conducted at suitable locations requested by the patient including cafes, workplaces and clinics (e.g. where patients were attending for an appointment). Four of the interviews were conducted with the patient together with their spouse/carer.

An interview schedule was drafted to guide the interview. This can be seen in the Appendix. Not all questions were necessarily asked, or asked in the order presented, as interviews were allowed to develop naturally and patients were allowed to raise and discuss relevant issues in their own way. The interview schedule was used to keep the discussions pertinent and ensure that all evaluation questions were addressed.

Interviews varied in length, but on average were around 25 minutes. Interviews were digitally recorded and subsequently transcribed. Analysis of interviews included sorting the data into themes (around evaluation questions) and subthemes, and highlighting areas of commonality and divergence.

2 Findings

2.1 Introduction

This chapter sets out the findings from the interviews with patients. The next five sections of this chapter set out the findings which relate to each of the five research questions (See 1.3), and an additional section presents suggestions that patients made regarding how reviews could be improved. Chapter 3 presents three illustrative case studies of individual patients' experiences.

2.2 Demographics

In total 29 patients were interviewed, from nine practices (six Phase 1 and three Phase 2 practices). There were no more than four patients from any one practice.

Of the 29 patients interviewed, most (23) were aged 55 or over. The age profile is shown in Table 2.1.

Table 2.1: Age Profile

Age Group	Number of Interviews
25-34	1
35-44	3
45-54	2
55-64	10
65-74	9
75+	4

There were more men than women interviewed (17 men and 12 women).

Most interviews were with patients in deprived areas. Patients' postcodes were used to determine their Scottish Index of Multiple Deprivation (SIMD) quintile – 22 of the 29 interviews were in the most deprived or second most deprived quintile.

Table 2.2: Interviews by SIMD Quintile

SIMD Quintile	Number of Interviews
1 (Most deprived)	13
2	9
3	0
4	3
5 (Least deprived)	4

Nine of the patients interviewed were working (six full time and three part time), three were unemployed or looking after family and 17 were retired. Patients were also asked for their occupation (or former occupation where retired), and categorised by NS-SEC group. The breakdown by NS-SEC group is shown in Table 2.3.

Table 2.3: Interviews by NS-SEC Group

NS-SEC Group	Number of Interviews
1. Higher managerial and professional occupations	0
2. Lower managerial and professional occupations	7
3. Intermediate occupations	3
4. Small employers and own account workers	3
5. Lower supervisory and technical occupations	1
6. Semi-routine occupations	7
7. Routine occupations	4
8. Never worked or long-term unemployed	4

Most (24) of the patients who were interviewed described their ethnicity as White Scottish, four were Asian, and one patient did not disclose their ethnicity.

2.3 Acceptability of the House of Care Appointment Process

Awareness of Change in Review

The term 'House of Care' was not used or recognised among patients. However, most patients had been made aware that the review process had changed prior to attending, or during, their information gathering appointment. Some patients said that the letter they had received inviting them to attend an information gathering appointment set out the changes to the review process. Others attended the information gathering appointment and were told then that the review process had changed, and that they could expect to receive their test results directly before attending a care and support planning conversation appointment. A few patients said that they were not aware of the changes until they received their test results, and were surprised to receive this.

Two Appointment System

The two-appointment system was similar to patients' prior experiences of their annual review – i.e. attending to have blood and urine samples, blood pressure and weight checks, followed by an appointment to get the test results. The key changes to the process observed by patients (in most cases) were:

- Receiving the test results in writing, and in advance of the care and support planning conversation appointment;
- Experiencing a more collaborative review;
- Completing a care plan.

Most patients were offered their review appointment by letter – most commonly giving an appointment time (and asking patients to call and rearrange if this did not suit), but some asked the patient to call the practice to make an appointment. Two patients said that they initiated the review themselves. In one case, the patient had been monitored for diabetes for several years, but had successfully controlled it to an extent that she was discharged from the review process. She had lapsed in her diet and lifestyle and was having symptoms indicating that her diabetes has returned, so she asked to have a review. Another patient said that she had not been called for her review, so had to make an appointment herself and the practice said that they were now putting the onus on patients to make appointments rather than reminding patients or sending appointments (see Case Study 3).

Information Letter/Test Results

The direct receipt of written test results was a key difference in the new review process which patients most frequently cited as a very obvious change in the review process and one which was very welcomed and appreciated by nearly all the patients who received them. Many enthused about this.

One of the most commonly mentioned benefits of receiving written test results before the care and support planning conversation was that patients felt that it helped them prepare for the appointment. They felt more informed and able to prepare questions for the nurse or GP.

"I think it's a better service. You don't have to wait for the results of your tests – you've got them before you back there for your review, and it gives you an idea of what you're going to speak about".

Patient

Patients also frequently felt that it made a significant difference having results in writing, compared to previous reviews where they had been given verbal feedback at their appointment. One patient described his slight frustration at previous reviews where his GP would verbally tell him his results from the computer screen, and the patient would try to furtively peer round to try to read the screen himself. Patients generally felt that having the written results made the feedback from tests very much clearer:

"I found it beneficial because it's alright them saying your blood pressure's up, it should be this, it should be that. But it's a big difference having to read it – especially as you're given the chart on the left showing where it should be. Then you can do the comparison yourself. I find it useful".

Patient

"If they're not written down it's much more likely that the practitioner will say, 'oh yes, that's fine'. But 'fine' can be a huge range of results. If you actually have the results in front of you, it's much easier to do your research and see what does that mean? Because 'fine' sometimes means ok, sometimes it means good and sometimes it means well, not great".

Patient

Furthermore, some patients expressed the view that having the results in writing was much more likely to be a motivator to make changes to address relevant issues. Having a written record of the results was, for some, a stark reminder of the effects of their diet or lifestyle and encouraged them to make changes to address their health:

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

Patient

"I think it's much, much better when the test results are committed to paper. I think as much as anything, you're going to take them more seriously because it reinforces them. It's easy to forget otherwise".

Patient

For other patients whose test results were very positive, having the results in writing provided valuable feedback that they were successfully addressing their diabetes. Some patients said that their results included historical test results from previous reviews (either one or two) and that it was particularly encouraging where they could see trends of improvements in their test results. Having previous test results provided a very useful context for patients understanding the direction and magnitude of change in results over the past year.

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

Patient

Another benefit of receiving written test results was that patients were more able to share the results with others. Many patients had shared the results with family members, and one patient said that he had given a copy to Occupational Health at his workplace.

Some patients said that their test results had been sent together with a leaflet explaining what the results meant, some said that an explanation was built into the presentation of the results themselves (e.g. showing where they were on a scale), and others said there was no explanation about the results.

Most patients overall felt that the test results were set out in a clear way and were easy to understand. However, some patients were unsure about what some of the results meant and they sought and received clarification of this at their care and support planning conversation. This included initials (HbA1c, ACR etc).

A specific cause of confusion for some patients was their blood sugars as measured by the HbA1c test. For patients who tested their blood at home, they were used to measuring blood glucose in mmol/l, and often they were confused that the units were different. Also, some patients said that the measurement was different to those they had had in previous tests at their surgery. Some patients said they had asked the nurse how the reading related to home tests or previous tests, and could you convert one to the other, but they felt they had not had this satisfactorily explained.

Two patients were interviewed (from the same practice) whose first language was not English, and neither of them had received written test results from their recent review. Both said that they were given their results verbally when they returned for their consultation appointment. Both would have been able to understand their written results in English (one could read English well and the other said her children would have read and translated the letter to her if she had received it).

Care Plan

There was some variation among patients in how care plans had been completed. The most common method was that patients were sent a care plan to complete together with their test results. Patients filled this in and took it to their care and support planning conversation appointment. Some found that they were unsure how to answer some questions, so only partly completed it before their appointment. Others were unsure whether they were expected to complete it before their appointment, and did not do so. At one practice, patients said they were given the care plan at the information gathering appointment and asked to complete it at home and bring it to the care and support planning conversation appointment. There were some patients who said they were not

sent a care plan to complete, but completed one in consultation with the nurse at their appointment. Those who had completed (or partly completed) it before their appointment said that the nurse went over the care plan with them during the care and support planning conversation and discussed each of the issues. This often included assessing needs and providing advice about goals. During discussions, some of the entries in the care plan could be added to or revised.

Some patients pointed out that the care plan provided a very helpful structure for discussions with the nurse during the care and support planning conversation, and ensured that all issues were covered. One patient contrasted the review appointment which was structured around the care plan with previous appointments which she felt has missed key areas:

"Sometimes I think when they've got a patient who they think is more knowledgeable they maybe tend to skip over things and assume you know – but that's not to say you don't want to get it all explained to you anyway. So I think having the care plan there means it's set out and you've got it all in front of you, so the nurse has got everything she needs to remind her what to cover. So that helps keep them right as well as you".

Patient

There were also some patients who said that they were not asked to make a care plan – where test results were good and did not indicate that any intervention was needed.

"There was no talk of a care plan. It was just a general chat about the results themselves. She just said it was excellent and stick to what you're doing. I don't need a care plan. I'm doing okay myself and the results are consistent".

Patient

"I didn't really have to go through the care plan because I am managing well and she was pleased with my results. So whatever I'm doing, I'm doing right, because from one year to the next I've been fine".

Patient

There were also one or two patients whose results/discussions did highlight areas for improvement, but who said there was no formal care plan written down (e.g. see Case Study 3).

Patients generally found it helpful to have their care plan in writing after their care and support planning conversation. In the same way as the having written test results, it was felt that it was beneficial to have the care plan in black and white and available to refer to:

"(The care plan) is a stark reminder. If it's out of sight, it's out of mind. If you go to the surgery they say to you, look this is what you need to do, and then you come away and that's it. But if you've got (the care plan) sitting there, then you have a look and you remember what you've got to do and why. So it's very helpful".

Patient

Barriers and Facilitators to Attending Appointments

No significant barriers to attending appointments were mentioned during interviews. Several patients had conditions which significantly impaired their mobility, but all said they were able to get to the surgery fairly easily, usually with the help of a carer/driver. All of

those who were in employment said that they were easily able to take time off work to attend appointments.

Patients were generally motivated to attend their review appointment in order to obtain feedback about their condition and monitor their progress or areas which required to be addressed.

2.4 Experience of Appointments

Overall, nearly all patients were very happy with their appointments and felt at ease and listened to.

Accounts of information gathering appointments suggest that there was often not much detailed discussion, but this was not expected. Patients viewed the information gathering appointment as somewhat perfunctory and not necessarily the time to raise questions or have discussions - patients had a good understanding of the nature of the two-appointment system and tended to wait until the care and support planning conversation to raise questions or initiate detailed discussions.

"It (information gathering appointment) was a relatively short appointment. Blood was taken, weight was taken, urine sample. I think that was really it. I saw that really as information gathering, not a discussion situation. I realised then, with the changes, that that was going to happen at the follow-up appointment once the results were in".

Patient

Nonetheless, patients generally felt that staff at the information gathering appointment were open and approachable and would be happy to answer general questions at that stage. Some patients said that their information gathering appointment involved some explanation of the new changes to the review process.

Most patients had their care and support planning conversation with a nurse, but some had it with a doctor, and some saw both a nurse and a doctor consecutively. Where patients had seen both a nurse and a doctor, the nurse spent time with the patient to review and discuss the test results and complete the care plan etc., and then the patient saw the doctor only if required (e.g. to discuss changes to medications).

Most patients described the discussions during their care and support planning conversation as focussing on the test results, with the practitioner often going over the test results in detail with the patient, ensuring that they understood what they meant and offering comment and advice on what the results indicated, often with reference to both previous tests and desirable levels. One patient described how he had received his test results prior to the care and support planning conversation, but they meant little to him until the nurse at his appointment showed him a graph on the computer screen which plotted his results over the previous 15 years, and showed where they lay compared to recommended targets. This allowed him to see in a visual and impactful way that his results, which had previously been in the green shaded area (safe/target), had gradually moved to less desirable levels:

"I went into the practice nurse and she brought the graph up for me on the computer and showed me how my diabetes wasn't under control to be honest. It was in the green on the graph for a few years and we talked about what was going on in my life at that time. She explained all that, explained the blood sugars. When she showed me the graph, I could see that it's been on the green for a wee while,

but it's now starting to creep up. I'd never been shown that before. They can tell you it's going up or down, or it's this or that – but until they show you on the graph, it doesn't sink in. I thought that was spot on. You can see your full history".

Patient

Most patients also described talking through the care plan with the practice nurse during the care and support planning conversation – either reviewing forms that had been completed in advance or completing it through consultation with the nurse during the appointment (see Care Plan section in 2.3 above).

Patients' accounts of their care and support planning conversations suggest a variation in approach across practices with regard to multiple conditions. Some appeared to discuss and consider all patients' health conditions and concerns, whereas others seemed to focus only on diabetes. There was a difference in opinion among patients too about whether they would wish to discuss all conditions and concerns. Some were surprised to be asked about whether other concerns were discussed at what they understood to be an appointment purely for diabetes:

"We didn't discuss my arthritis or spondylitis or anything because she's just the diabetic nurse. Anything else, you have to go to your doctor... She (the nurse) is only there for my diabetes, so I'm not going to say I've got this or I've got that".

Patient

However, patients who described care and support planning conversations which considered all conditions often saw the value in this and it was recognised that other conditions were interlinked with diabetic symptoms and/or goals set to address them. Examples included:

- Goals set to improve diabetic symptoms through exercise had to take account of limitations in mobility or respiratory problems caused by other conditions;
- Mental health problems (including depression and bipolar disorder) were associated with a likelihood of overeating, leading to increased weight and raised blood sugars;
- Goals set to address diabetic symptoms could improve other conditions – e.g. losing weight could improve blood sugars and also relieve joint pain/arthritis.

In a small number of cases, patients received advice about their other conditions. One patient, whose main concern was his arthritis rather than his diabetes, appreciated the comprehensive nature of the review and the fact that his arthritis medication was reviewed and changed as a result of his review. Another patient raised the issue of her desire to come off her medication for anxiety; this was discussed and she was referred to her GP to further review this.

There was, to some extent, discussion about mood/mental health in most care and support planning conversations because this was part of the care plan form. Many patients who were interviewed expressed some problems with low mood or depression. Frustration or despondency was frequently expressed because of the debilitating nature of their conditions or their declining health. However, only one patient interviewed had been offered information about services which could help with depression (see Case Study 1). Another patient, who was tearful during the interview, said he had been in tears during his

care and support planning conversation when they had been discussing his low mood. However, the nurse did not talk about services which could help – rather the patient said:

"She was a wee bit shocked at me crying. When I talk about things that depress me – the frustration at not being able to do things, I do get upset. She just gave me a hanky and said sorry. I said don't worry about it – I just get upset talking about it, I can't help it".

Patient

Most patients felt that their appointment for the care and support planning conversation was long enough to cover everything they wanted to cover, and that the nurse gave them plenty of time and showed a genuine interest in their condition and their goals.

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

Carer

However, there was a small number of patients who felt that the appointment was too short or hurried. One patient who set a goal to lose weight said that he was offered a referral to a weight management service but declined it – but after the appointment he regretted this and felt he would have benefited from a referral. He felt that the hurried nature of the appointment meant that this was not adequately explored:

"I don't think they were very pro-active. I think they're too busy. It was just – 'Do you want help with your weight loss?' 'No'. 'Fine'. Then move on. It wasn't like, 'Are you sure?', or 'Do you think we could try this?'. I don't think that's their fault - it's just that they've got someone else waiting outside".

Patient

Most patients felt that the care and support planning conversation was a very collaborative exercise. They felt that the nurse listened to their own concerns and priorities, and care plans or agreed actions reflected the patient's own goals and priorities. Overall, most patients felt that the new process was more collaborative and they had more of a say than in previous appointments to review their condition. Discussions centred around the patient's concerns and goals, with the nurse offering advice where relevant. In some cases, this included advice about modifying goals – for example where a nurse suggested that a patient's goal for their weight loss was over-ambitious or unrealistic, or advice about how to achieve goals. This included suggestions for modifying diet or lifestyles and offers of referrals to services which can help (see 2.6).

Two of the patients interviewed had attended the care and support planning conversation appointment with their spouse/carers. This was felt to have been helpful as it gave the spouse/carers first-hand knowledge of the test results and implications, more knowledge about the condition, and involvement/input in the care plan. For spouses involved in preparing meals or helping with medication, etc. this was particularly valuable. In both these cases, the patient felt that they would not have been able to remember everything that was discussed or have been able to impart the information to their spouse/carers if they had not been there. Indeed, some patients who attended alone said that they had struggled to remember everything and had been unable to share as much as they would like with their spouse after the appointment.

"I'll come back from the doctors and (my wife) will say to me, 'What happened? What did they say? and I've forgotten it all and I can't tell her".

Patient

However, those who had a written care plan after their appointment found this beneficial for sharing with their spouse.

Although care and support planning conversations were generally felt to have provided helpful advice, some patients felt that they needed more information. Those who had recently been diagnosed with diabetes felt that they would like more information about diabetes generally and also about symptoms and how to recognise and manage them. Some who had been diabetic for some time also felt that there was not enough discussion about the risks associated with diabetes.

One patient who was interviewed with the help of an Urdu interpreter said that interpreters were sometimes available at her surgery, but not always, and there was no interpreter available for her care and support planning conversation when she had her review. Further, this patient said that information and advice about diet did not take cultural differences into account. She said that she had declined a further referral to dietetic services because the last time she saw a dietician (before the House of Care review) she was advised to boil and steam food which is not how food is prepared in her culture, so she did not find the advice helpful.

2.5 Readiness to Self-Manage

Most patients felt that they had all the information and skills they needed to successfully manage their condition. Some acknowledged that although they felt well informed, they struggled with willpower and did not always make the right choices regarding diet, exercise etc. despite knowing what they should do. Some felt that it was important to have all the information and advice available, and this helped them make informed decisions, although they acknowledged that this did not mean they always followed the advice given:

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

Patient

Although some patients struggled with willpower or did not always make the best choices for their health, having the review was considered very helpful as a reminder, and the written plans were said to particularly give focus and motivation.

"I've been diabetic for years, so I have all the information. But just having the care plan and the test results there helps to keep it in mind, because it's easy to forget and just indulge yourself".

Patient

Some patients used online resources such as My Diabetes My Way and internet forums to get information and help manage their condition better. One patient said that she was asked during the care and support planning conversation whether she would like to be registered for SCI Diabetes so that she can check her results online – an offer she accepted, and she was waiting for login details in order to start this.

One patient summarised three ways in which the review process helped him to self-manage his condition:

- Receiving information about diabetes;
- Receiving test results which showed that 'what you're doing is working'

- Knowing that he would be monitored again in 12 months, which is an incentive to ensure he remains on track with blood sugars and weight.

There were, however, two patients who had been recently diagnosed who felt that they were not well informed at all and did not know how to manage their condition. For example, one recently diagnosed patient said he did not know how to recognise when he was having a hypo. Recently he had been feeling a little dizzy and decided to eat some chocolate in case it was a hypo but that both identifying whether it was a hypo and knowing how to treat it were both guesswork. He was waiting to attend a course which would give him more information, but he felt that he should have had more basic information along these lines on diagnoses and at his recent review.

A small number of patients commented on receiving conflicting advice from health professionals – with variation in advice given from staff within the same practice or between primary and secondary care practitioners. It was felt, for example, that some gave advice about following a strict diet, whereas others said it was perfectly fine to treat yourself now again. Generally, it was felt that more consistent advice was needed.

While some patients were issued with testing kits and habitually tested their blood sugar levels, others had been told these were not routinely issued to patients with Type 2 diabetes or that their diabetes was not severe enough to warrant testing at home. Some, though, felt that they would be able to manage their condition much more effectively if they could get feedback on their blood sugar levels:

"They don't give you the sticks because they're too expensive. And that's a gripe because if there's times when you get up in the morning and you don't know what your blood sugar level is. You have breakfast because that's what you do. Or during the course of the day I might be out and about and I think can I have a coffee? Can I have a small piece of chocolate? There's no way of knowing what your blood sugar's like".

Patient

One patient had bought testing strips himself in order to monitor and manage his condition:

"The NHS won't give people like me a blood testing meter. But what I've learned is, if you want to manage your diet, if you take a reading before you have a meal and a reading two hours after it and it's below 6 then your diet's working. It gives you that feedback. That feedback is telling you you're on target. If you don't have that feedback on a day-by-day basis, you don't know where you are. I've had to buy test strips which are expensive, but I only use them once a day, mostly for the main meal".

Patient

2.6 Review Outcomes and Impacts

House of Care reviews resulted in goals being set, referrals being made, or actions being taken in the following areas:

Weight Management

Weight loss was the most commonly cited goal that was set among patients, and several patients said that they were offered a referral to weight management services at their care and support planning conversation appointment. Some patients declined the service but three had accepted a referral. Some patients were given advice during their appointment

about modifying their diet to lose weight, including portion control. Most patients who had set a goal to lose weight indicated that they had implemented changes to diet/and or exercise, or at least intended to do so (some were waiting to start a weight management/exercise service before making any changes). Some said that they were confident they had already begun to lose weight.

Dietetic Service

Some patients were offered referrals to a dietician either for advice about losing weight or for managing blood sugars and this was taken up.

Exercise

Increased exercise or improved fitness was also a common goal among patients. Many felt comfortable working on this themselves and reported making changes including walking more. Four patients had been referred to an exercise programme. In the case of one patient, a direct referral could not be made because he had angina and was referred to a hospital for tests to confirm he was suitable for an exercise programme. At the time of the interview he had received the hospital appointment but had not yet attended, and was hopeful that he would be able to be referred for the exercise programme as he was motivated to improve his fitness and lose weight. Another patient accepted an exercise referral, but was never contacted (see Case Study 2).

One patient said they were offered advice on how to manage high blood pressure by taking less exercise/taking periodic rests, and that this advice was being implemented and was effective.

Smoking Cessation

One patient had previously dropped out of Smoking Cessation services. At her review appointment, the nurse gave her the contact details to contact Smoking Cessation again and advised her to recontact them as she would probably be allowed to re-join the service without another referral. The patient was motivated to stop smoking and intended to make contact with the service, but had not done so at the time of interview (a few weeks after the consultation).

Mental Health Services

One patient who had been struggling with low mood/depression was given information about a service which could help. He was invited to self-refer to if needed and his spouse/carer intended to ensure that this was taken up if his mood declined (see Case Study 1).

Changes to Monitoring Practices and Medication

There were examples of patients who were issued with a new type of testing kit, and patients who were asked to test their own blood sugar levels for the first time. As noted above, one patient was offered the online tool SCI Diabetes to gain online access to her test results in order to monitor her condition, and she was awaiting login details to be able to do this.

Several patients' reviews lead to a change in their diabetes medication. For example, one patient had been experiencing hypoglycaemia and her morning insulin was reduced. She was asked to keep a diary of her blood sugar readings for several weeks after the review, in order to monitor her symptoms. There were also examples of patients who had

medications for other conditions (arthritis, anxiety) reviewed and adjusted as a result of their review.

Identification of other Medical Issues

Some patient's reviews included identifying other medical issues including skin conditions, painful joints and swelling. These resulted in patients being referred to their GP for further consultation and treatment.

2.7 Suggested Improvements

All patients were asked whether they had suggestions for how the review process could be improved. Most were unable to think of any improvements and felt that the process met their needs very well. However, some patients suggested that reviews should be more frequent – with six monthly rather than annual reviews suggested. It was felt that there could be some significant changes in the space of a year and more frequent reviews would help patients stay on track or identify problems. Nonetheless, all felt that their practice was approachable and that if they had any concerns they could initiate an appointment themselves for a check-up.

Some patients who had not been given previous years' results with their current test results suggested that historical as well as current results would be helpful so they could see the trends.

Some patients suggested that it would be helpful to have more general information about diabetes, including the risks and symptoms to look out for. This was particularly the case for recently diagnosed patients.

One patient suggested that it would be helpful to receive test results by email as it was easy to lose paper and simpler to retain information sent electronically. He also suggested that ideally he would like to have access to an app or a website where he could see his results together with all historic test results to monitor his progress.

3 Illustrative Case Studies

3.1 Introduction

This chapter presents the experiences of three different patients of their recent House of Care reviews.

3.2 Case Study 1

SIMD Quintile: 1
NS-SEC: 7 (Routine occupations)

This patient had multiple conditions in addition to his Type 2 diabetes, which had been diagnosed two to three years ago. These included COPD, angina, narcolepsy and sleep apnea as well as several pain conditions such as sciatica. He was also partially sighted and had just recently had a second cornea transplant. He identified that COPD was his main concern and the most limiting of his conditions. The patient was interviewed together with his wife who cares for him and attends his appointments with him.

The patient did not recall being informed of any changes to the review process. He had a copy of his test results, but could not recall whether they had been sent to him or whether he had received them at the surgery. However, his wife confirmed that the test results were sent directly to their home prior to the care and support planning conversation.

Both the patient and his wife enthused about the care they received at both appointments. They felt that the practice nurse showed interest in the patient's health, listened to their concerns and took their views into account. They felt that the appointments were long enough to discuss everything they wanted to discuss:

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

Patient

Prior to House of Care being implemented, it had already been established that review appointments would be best conducted with both the patient and his wife/carer:

"Once the nurses and doctors realised that when he was going, he was saying he was fine when really he wasn't, then we decided that I would be in each appointment and anything that was wrong with him could be discussed with all of us there".

Carer

The patient also agreed that the review appointments were most effective when his wife/carer was part of the discussions. Both the patient and carer felt that during the care and support planning conversation the nurse treated this situation appropriately, with questions and discussions focussed on the patient himself, but with the carer being brought into the conversation as appropriate.

The patient viewed the care and support planning conversation as purely a diabetes review, but his carer noted that although the primary focus was diabetes, the appointment very effectively considered his other conditions. For example, he was asked about his mobility and to consider what had the most impact on him on his journey to the surgery that day, and this identified that his COPD was his most limiting condition. The care and support planning conversation included a full review of the patient's test results.

The blood tests and blood pressure results showed an improvement on the previous results and the patient felt reassured by this. His weight had stayed the same and the nurse suggested that this was something he should seek to address as he is overweight.

Although the patient recognised he was overweight he said 'it doesn't really bother me to be honest – I've been heavy all my life' and did not appear particularly motivated to lose weight. His wife, however, felt that he should be losing weight and was encouraging him to do so. He had previously attended a weight management service (some years ago). The nurse offered to refer him again, but he did not wish to attend. His wife felt that they would jointly be able to make some progress towards his weight goal by modifying his diet.

The care and support planning conversation also included a discussion about the patient's mood and through this a problem with depression was identified. His carer was particularly grateful for this discussion as she recognised that he would never have raised the issue otherwise. The nurse gave the patient leaflets and information with a telephone number for him to call if he feels that he needs or want to use a service to address his depression. His carer said she would encourage him to do this.

A further need identified in the care and support planning conversation was to do with a rash which had developed at the base of the patient's ankle due to swelling and water retention. The nurse referred him to the GP to have this treated.

Thus, overall the review highlighted three actions which were agreed by the patient and his carer:

- Aim to lose weight – referral to weight management was declined, but the patient's carer is adjusting diet to achieve some weight loss;
- See GP for treatment for rash – this has been done and has been effective;
- Information for self-referral to mental health service for depression – carer feels reassured that they can self-refer if required.

The patient considered the review very helpful. He felt reassured that his test results were 'quite good' and felt that it was reassuring that 'they keep tabs on you, make sure you're alright'. His carer felt that a key benefit was having a whole-person approach to the review and considering a wide range of needs:

"I think it's fantastic because although you might be there to review one medical issue, it brings in everything – which I think is great. And there can be goals there for you to pinpoint, or for the GP or nurse to pinpoint. If the review didn't take place, it would not have highlighted the depression, so I think it's a good way for the GP and nurses to see if there are other issues as well".

Carer

3.3 Case Study 2

SIMD Quintile: 1

NS-SEC: 3 (Intermediate occupations)

This was a 55-64 year old man who was in full time employment. He was diagnosed with Type 2 diabetes about eight years ago and has no other health conditions apart from a current knee injury.

When he was first diagnosed he had reviews every three months for a period, then annual reviews. He said that following diagnosis, 'I was very strict with myself and lost two stone in weight'. He was sent on a two-day course to learn about Type 2 diabetes, which he found very helpful. He described the diabetic nurse in his practice as being strict with him, and 'keeping him on the straight and narrow', which he found valuable. He felt he got his diabetes under control by 'doing what the nurse told me'. He spent the first five years after diagnosis following a strict diet with no sweets, chocolates, cakes, etc. He then gradually

allowed himself the occasional treat. During the last year he has lapsed somewhat and has been indulging in bags of sweets etc.

For his last review, he was sent a letter inviting him for his review appointment. This stated that there were some changes to the review process and this would be explained at his first appointment. When he attended the information gathering appointment it was not the usual diabetic nurse, but another nurse who he understood to be more junior. She took blood samples etc. and explained to him that he would be sent a letter with the results. She also gave him the care plan form to take away and complete and asked him to bring it to the care and support planning conversation appointment two weeks later (Note: this was the only interview which stated the care plan was issued at the information gathering appointment). He completed the care plan at home before receiving the test results.

The test results arrived by letter two days before his care and support planning conversation. He felt it was helpful to have all the results in writing and was much better than the usual way of receiving the results verbally. However, he was confused by the results for sugar levels:

"It was a bit unclear with the way they had the blood sugar levels. I wasn't sure how to work that out in relation to the way I normally calculate my sugar levels – it was a bit different. I think I kind of figured it out, but I wasn't sure so I had to ask when I went back".

The results he was sent were only for his most recent test. He felt that if he had been shown his previous test results, he would have at least been able to ascertain whether his blood sugar levels had risen.

He had his care and support planning conversation with his usual diabetic nurse. She talked through the test results with him, and explained that his blood sugar levels were higher than usual, and asked whether there would be a reason why. The patient knew he had lapsed from his previously careful diet and explained this. The nurse offered to refer him to a dietician, but he declined because he felt confident he could get back on track, as he had done so before. He felt that having seen the results, he became determined to get back to the way he had previously managed his condition. The nurse reaffirmed the importance of doing so.

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

The nurse also offered to refer him to an exercise service. He accepted this, because he felt his fitness level had declined due to his knee injury, and he was hopeful that a fitness programme which took his injury into account would help him resume some form of exercise routine. The nurse said he could expect a call from the service within a week. However, when he was interviewed, this was five to six weeks after his appointment and he had still not heard from the service. He indicated he would try to get back in touch with the nurse to chase up the referral.

Since his care and support planning conversation, he had resumed a more healthy low-sugar diet and had recently had his bloods retested. When he was interviewed, he was about to visit the receptionist at his surgery to find out the results of his blood tests, and he was confident that these would show a positive change.

Overall, he felt that the review was very helpful in flagging up the effects of his lapse in diet and motivated him to make significant changes. He suggested that it would be more helpful to have reviews twice a year in order to ensure he stayed on track.

3.4 Case Study 3

SIMD Quintile: 1

NS-SEC: 2 (Lower managerial and professional occupations)

This was a 55-64 year old woman who had been diagnosed with diabetes seven years ago. She also has osteoarthritis and is awaiting a hip replacement. After moving house, she joined her current GP practice five years ago. She received annual reviews until last year when she was not called, and again this year she had to initiate the review appointment herself:

"Last year I met the nurse in the waiting room when I was in for something else and I said 'Look, I've not been called for my annual check up' and she said, 'That's ok, because you're not one of my priorities'. But she said she would call me, but she didn't and I had to make an appointment. And in actual fact my blood sugar had risen and they had to put me on additional medication. And then the same thing happened this year – I wasn't called, so I phoned and made an appointment...At the appointment I said, 'This is the second time in a row I'm having to be proactive and chase you for an appointment' and they said 'well, yes, the system has changed in as much as we're not calling you – we're putting it into your own hands and making you responsible for your own health, and you have to come to us to get appointments'. I thought that was kind of odd for diabetes".

Although she is in a lot of pain in her joints, it is her diabetes that causes her the most concern because 'it's a bit invisible – but it has the potential to cause so many complications'.

Following her information gathering appointment, she was sent her test results. However, she found the blood sugar measure confusing and did not understand what it meant, and whether it was a good or bad result. When she went for her consultation appointment, she asked the nurse to explain the blood results in terms of previous results she knew, but the nurse was unable to explain this:

"When I got the letter I didn't understand the numbers. I had to ask the nurse. I used to go and they would say your blood sugar's up to eight, but now it's some number like five hundred or something, so I'm like, 'Well, what does that mean?'. I asked the nurse and she didn't know either and she didn't have a chart to convert the two types of reading or anything".

At the care and support planning conversation appointment, the nurse tested her feet, although the patient felt that the nurse did not do this well, as she applied too much pressure and differed to the way it had been done in other appointments. The nurse discussed her blood results with her and felt that they were reasonably good. They also discussed her weight, which had increased since her previous review. The nurse also asked the patient about her joint pain, and the patient raised the issue that she was on medication for anxiety that she felt she no longer needed to take. The nurse asked her to see the GP to discuss coming off the anxiety medication. The patient said that they did not discuss or complete a care plan or agree on any actions other than going to see the GP about her medication.

Although there was some discussion about weight – and it was recognised that losing weight would improve both the diabetes and the joint pain, the patient was not offered a referral to any services which would help with this. The patient said that she had never been offered an appointment with a dietician, which she found surprising. When she was interviewed, the patient had just joined Scottish Slimmers and was motivated to lose some weight to improve her health, but this had been something she had initiated herself. She did feel that seeing the increase in her weight at the review was a motivator to change.

She felt that it would be helpful to have had more discussion about the risks of diabetes – e.g. kidney damage, fatty liver disease etc. She thought that if there was more discussion about the risks, patients would be more likely to take responsibility and make more effort to get their condition under control.

4 Discussion and Implications

4.1 Introduction

The chapter brings together and discusses the key messages from the findings presented in Chapter 2.

4.2 Comparison with Previous CDM Processes

Overall patients felt that the review process was much improved, compared to previous reviews of their condition. For patients, the key components which marked improvements were receiving written test results, experiencing a more collaborative review and having a written care plan. Many patients enthused about the difference these had made.

4.3 Test Results

It was clear that patients have found it very valuable to be given their results in writing. This appeared to lead to a sense of clarity and also ownership of the results. An illuminating anecdote was the patient who contrasted walking into the review appointment with his test results in his hand, with previous consultations where he was trying to peer round the GP's monitor to see his results as the GP commented on them. This illustrates the empowerment of the patient by providing the written results in advance of the consultation.

The written test results were shown to be valuable in providing feedback to patients – either reassuring them that they were successfully monitoring their condition, or providing something of a wake-up call for those whose condition was not being well controlled. A frequently cited observation was the difference it made to patients having the results in black and white and appeared to be a much stronger motivation to change, where required, than receiving verbal feedback.

There was some variation in the format of test results and the nature of explanatory notes, but the most effective formats appeared to be those which included historical results for context, and also a clear indication of where results lay on a spectrum including target/ideal levels.

4.4 Care Plan

Patients' accounts show a wide variety of approaches to the completion of a care plan, including:

- Issuing the care plan to the patient at the information gathering appointment for completion prior to the care and support planning conversation;
- Issuing the care plan to the patient with the written test results for completion prior to the care and support planning conversation;
- Providing the care plan during the care and support planning conversation, and completed with the patient and practitioner together;
- Not providing a care plan at all.

The reviews generally appeared to work best where the patient completed (or at least partly completed) the care plan at home, informed by their test results, prior to attending the care and support planning conversation. This helped to ensure that the patient had considered for themselves the implications of their results and what they hoped to achieve. The care plan could then be reviewed, and if necessary revised, through consultation with the practitioner to set realistic goals and with advice regarding how to achieve them.

4.5 Collaboration and Patient Ownership

Where patients were in possession of their test results and had completed (or partly completed) their care plan prior to attending the care and support planning conversation appointment, this appeared to give patients a sense of ownership and control of their condition and its management. Accounts of care and support planning conversations showed a very collaborative process and there was no suggestion of nurses being highhanded or patients feeling they were being told what to do.

4.6 Self Management

The review was helpful in improving patients' ability to self-manage their condition by providing valuable feedback on their health indicators, by engaging patients to become involved in planning their own care, and overall inducing an increased motivation to make positive changes.

The inclusion of carers or spouses, where relevant, in the review process could have a positive effect on the patients' ability to self-manage their condition. As seen in Case Study 1, a spouse/carer who was actively involved in monitoring the condition, preparing meals and handling medication, clearly benefited from being involved in the care planning process.

Some patients undoubtedly had an appetite for as much information as possible to be able to monitor their condition. Some would like to be able to test their blood sugars at home but were frustrated that these were not issued on the NHS for patients like them – although one patient had resorted to buying his own. While one patient suggested it would be helpful to have access to online data showing all his historic test results, this was something that another patient had apparently been offered via SCS diabetes.

4.7 Multiple Conditions and a Whole Person Approach

There appeared to be variation in practice regarding the extent to which care and support planning conversations considered all patients' conditions or concerns. While some described their review as purely focussed on their diabetes, others described a review which considered all conditions and practitioners asked open questions to elicit information about patients' concerns and priorities. A broader, whole person approach often highlighted the links between diabetic symptoms, treatments, or goals with other conditions or concerns and there were instances where the primary outcomes or identified goals related more to other conditions than to diabetes.

4.8 Referral to Other Services

The interviews identified many offers of referrals to various services including weight management, exercise, dietetic and smoking cessation services, and also information given about services to encourage self-referral where appropriate. Some referrals were accepted while others were declined. There were, however, examples of patients who would have appeared to have benefited from referrals who were not offered them, one example of a referral to an exercise programme which had not been followed through, and one example of a patient whose immediate reaction was to decline a referral but who subsequently felt that if this had been pursued more enthusiastically by the nurse then he would have accepted it.

4.9 Equity, Language and Cultural Issues

NHSGGC patients are entitled to an interpreter and translated written materials. However, it is notable that neither of the Urdu speakers who were interviewed received their test results in writing nor completed a care plan. It is not known whether this was due to difficulties preparing translated materials or a perceived lack of accessibility to written English, but both patients said that they could understand written English – either directly or with the help of a family member. These patients therefore did not receive the same service as patients in other practices. Also, although the patient who required an Urdu interpreter for the interview said that she was able to cope with the care and support planning conversation without an interpreter, it was clear from the degree to which the interpreter was required during the interview, that communication in the consultation must have been significantly constrained. A further difficulty was the perceived lack of awareness of cultural differences in diet when discussing dietetic advice.

4.10 Outcomes and Impacts

The interviews took place typically between a few weeks and two months following the review, and therefore the scope to examine the impacts of the reviews are somewhat limited. However, there were many examples of patients who, as a result of their review, had a new or renewed motivation to make changes in order to improve their health. These frequently involved managing diet, losing weight and improving fitness. Some were already accessing services to help them with these goals, and others were independently addressing them. A number of reviews also resulted in modifications to medication and/or monitoring practices and patients, at the time of interview, were already reporting positive changes as a result of these.

Not all patients had identified goals other than 'keep doing what you're doing', but their reviews had proved valuable to them in giving them reassurance that they were successfully controlling their diabetes and motivation to stay on track.

4.11 Concluding Comments

The findings have been useful in highlighting patients' views and experiences and implications for good practice for those delivering House of Care reviews. These will be considered together with findings from the other components of the NHSGGC House of Care evaluation.

Appendix: Interview Schedule

House of Care Patient Experience Evaluation – Topic Guide

1. Introduction

Your GP practice has recently changed the way it delivers review appointments for people with long term conditions like diabetes and coronary heart disease (CHD). The approach they are using follows a model called 'House of Care'. You should recently have been offered two appointments:

- 1 Information gathering appointment (where, for example, you would have your weight and blood pressure measured).

After this, you should have received an information letter and your test results (SHOW EXAMPLE).

- 2 Consultation appointment, where you would have discussed the results and agree a care plan (SHOW EXAMPLE).

Check – are these familiar to you? Were you aware there had been a change?

When, roughly, did you have these appointments?

2. Nature of Condition(s) and Previous Reviews

Can I check, what long term condition or conditions do you have?

PROBE: How long since you were diagnosed? How did this condition affect you or limit what you can do?

IF MORE THAN ONE CONDITION: Which condition would you say most concerns you or affects you most?

Before the new appointment process, how was your condition/s reviewed?

3. Views on House of Care Appointment Process

I now want to talk through the process of having your recent appointments.

The first one was the **information gathering appointment**, where you would have had tests.

How was the appointment offered to you? (e.g. letter/phone call).

What information (if any) were you given before this appointment about what to expect and the purpose of the appointment?

How easy or difficult was it for you to attend this appointment?

What happened during your appointment and what was discussed?

How did you feel during the appointment?

PROBE – Did you feel at ease? Did you understand everything that was happening? Did you feel listened to?

Did the health practitioner - explain things well, answer your questions, appear interested in your health/condition.

After this first appointment, you should have received your **test results** (SHOW EXAMPLE).

How helpful were the test results? PROBE:
Layout/format
Easy/difficult to understand
Usefulness for preparing for consultation appointment
Did you share the results with others?

The next stage would be having your **consultation appointment** to review your results and develop a care plan.

CHECK – Did you attend this appointment?

How was the appointment offered to you (e.g. letter/phone call).

What information (if any) were you given before this appointment about what to expect and the purpose of the appointment?

How easy or difficult was it for you to attend this appointment?

What happened during your appointment and what was discussed?

How did you feel during the appointment?

PROBE – Did you feel at ease? Did you understand everything that was happening? Did you feel listened to?

Did the health practitioner - explain things well, answer your questions, appear interested in your health/condition.

Was a care plan developed? Did you feel that decisions were made jointly between you and the health practitioner? Did you feel you had as much of a say as you should? Why/why not?

Was there enough time/opportunity to discuss your concerns during the appointment? Did your review adequately address all of your conditions, health concerns or any other concerns you may have had which would affect your health or wellbeing or our ability to manage your condition?

4. Self-Management

How confident are you in your ability to manage your condition?

PROBE – Knowing when to seek support, and where to seek support from; managing medication; use of care plan.

5. Outcomes

What actions (if any) have been made from the review? PROBE – Referrals? (what was experience of secondary care?)

What changes (if any) have you made to the way you manage your condition as a result of the review?

Have you accessed any local community services following your review (e.g. community groups, support groups etc)? IF YES – How identified/accessed, views of services.

What difference (if any) has the review process made to your general health and wellbeing? Or what difference do you think it will make?

6. Reflections

Overall, how do you feel the new review process

- Compares to previous reviews
- Is worthwhile/helpful
- Meets your needs

What (if anything) would make the process better?

7. Demographics

Can I just check your:

age (SHOWCARD)

whether work (full time, part time, retired)

occupation/last occupation

ethnicity (SHOWCARD)