

Public Health Directorate



House of Care: evaluation of GP practice staff acceptability

Report from practice staff voting and group
discussions

July 2016

1. Introduction

House of Care, developed by the Year of Care Partnership, is an improvement framework developed to enable services to embrace care planning as an approach to support self-management of people living with long term conditions. The House of Care framework comprises four interdependent components, with collaborative care and support planning conversation at the centre of the house. Collaborative care and support planning involves the person with a long term condition being engaged and informed, working with healthcare professionals who are committed to partnership working.

NHS Greater Glasgow and Clyde along with NHS Lothian and NHS Tayside are participating in a two year early adopter programme initiative in partnership with the Scottish Government, Health and Social Care Alliance and British Heart Foundation to apply the House of Care model in Scotland during 2015-17.

The following evaluation questions have been prioritised for NHS Greater Glasgow and Clyde House of Care evaluation:

- (a) What are the outcomes of the consultation for the patient in terms of self-management and relationship with practitioner?
- (b) To what extent do patients find the intervention acceptable and have patients identified a change in the quality of the consultation?
- (c) Does the House of Care framework improve the reach and participation of those from socio-economically deprived communities?
- (d) To what extent do GP practices find the intervention acceptable?
- (e) What has been the impact of training on Health Care Professional practice in delivering Chronic Disease Management (CDM)?

This report aims to contribute evidence to answer question (d) by exploring views and experience of the GP practice staff implementing the House of Care framework within their coronary heart disease (CHD) and diabetes CDM programme. Equity issues – contributing to question (c) – are explored here but these will be evaluated in more detail in a separate quantitative study. This report also provides some feedback on House of Care training, however, a more detailed analysis of question (e) is being undertaken by ICF as part of the national evaluation of House of Care early adopter sites.

2. Methods

A House of Care GP practice event was held on 20 June 2016. 11 out of 14 participating practices in NHS Greater Glasgow and Clyde attended the event with 8 practices represented by more than one member of staff and more than one job role. The event had the aim of providing an opportunity to share practice and planning for House of Care development. Time

was allocated at this event to seek the views of participating GP practice staff in order to contribute to the evaluation of House of Care.

Participating GP practice staff were assigned to break out discussion groups as follows:

Group A	Practice Managers and Health Care Support Workers
Group B	GPs and Practice Nurses
Group C	GPs and Practice Nurses

Where possible, where there was more than one member of staff attending from a practice, they participated in a different discussion group. Staff attending the event who were not employed in a House of Care GP practice (eg other stakeholders such as voluntary sector partners and Public Health staff) had a separate discussion group which is not included in the evaluation.

Each discussion group was supported by a facilitator and a note taker. The sessions were recorded to aid report writing with the agreement of participants. Facilitators used the following guide questions:

1. Thinking back to the House of Care training you attended, what was your experience of the training?

Prompts: What, for you, were the benefits of this training? What, for you, were the limitations of the training?

2. What has been your experience of implementing the House of Care, care planning pathway?

Prompts: What, in your view, has worked well? What, in your view, have been the challenges? We have had feedback from some practice that they have found it more challenging to implement care planning pathway for patients with CHD – what has been your experience?

3. Tell us about your experience of using the House of Care framework in the care planning consultation

Prompts: What is your view on the House of Care framework in improving your patients' ability to direct the goals of care planning? Explore main barriers to this if required.

In practice is a House of Care care planning consultation more, similarly or less professionally satisfying than routine CDM programme consultation? Explore reasons for responses.

Has this approach been equally suitable for all of your patients? (e.g. in terms of different socioeconomic groups, women /men, age groups, ethnic groups, different conditions?)

3. Introductory PPVote results

To serve as both an ice breaker and to introduce some of the issues to be explored in more detail in the discussion groups, GP practice staff were asked to respond to a series of statements by voting using a PPVote system. None of the responses were compulsory therefore response numbers vary between questions. The statements and voting results are below. See the appendix for a copy of the instant results shown to participants on the day:

Statement	Answer options	Votes
House of Care training has improved our CDM consultations	Strongly agree	0
	Agree	13
	Neither agree nor disagree	7
	Disagree	1
	Strongly disagree	0
	Don't know	0
	Total	21
Our links with community partners have increased after implementing House of Care	Strongly agree	1
	Agree	5
	Neither agree nor disagree	7
	Disagree	5
	Strongly disagree	1
	Don't know	2
	Total	21
The House of Care approach can help reduce inequalities in health outcomes	Strongly agree	0
	Agree	3
	Neither agree nor disagree	14
	Disagree	3
	Strongly disagree	0
	Don't know	0
	Total	20
The House of Care approach has equipped our patients to self-manage	Strongly agree	0
	Agree	9
	Neither agree nor disagree	9
	Disagree	2
	Strongly disagree	1
	Don't know	1
	Total	22

4. Findings from discussion groups

4.1 Training

4.1.1 Introduction

One practice participating in the discussion groups had not attended the training delivered by the Year of Care Partnership. Of those who had attended training, GP and Practice Nurses attended 1½ days of care planning training. Practice Managers and Healthcare Support Workers attended a half day information session.

It should be noted that participants in the discussion groups did not always separate Year of Care training from the other learning and development that was integral to implementing House of Care. Also, training was a less animated or dominant theme in the discussions than other aspects of House of Care.

4.1.2 Year of Care Partnership training

The training was viewed positively by participants in each of the discussion groups. There was broad agreement among participants who had attended that it was comprehensive. The interactive elements were considered to be helpful though one participant did say she did not enjoy role playing in any training. Others were comfortable with this aspect.

Participants indicated that some of the content had already been covered in recruitment or awareness raising sessions but this was not considered to be problematic. For those working in clinical roles, a number of participants suggested they were using the techniques already, particularly the consultation skills. These participants tended to view the training as an opportunity to refresh their skills:

"they did give us tips about how to start a conversation... I think it was probably a recap of good technique"

The opportunity to learn with peers was valued by practitioners. This was true for all practitioners and for those in Phase 2 who were able to learn from Phase 1 practices. One participant described the training as "quite process driven." Some participants expressed views that there was still a degree of uncertainty about the new model in practice which had some impact on the learning. Some of this related to the availability of House of Care systems and processes at a local level at the time of training delivery.

4.1.3 Whole practice involvement

Involving whole practices in the House of Care framework was discussed in terms of awareness, training, and cascading of training. There were limited places on the initial Year of Care Partnership care planning training (two people per practice). Some participants expressed the view that this was insufficient because it did not take account of practice size.

Opportunities to cascade training at practice level had also been limited. Time pressures were a factor in this. One participant, however, reported being able to raise awareness at an hour long practice meeting following the House of Care training.

"What is this mysterious House of Care? People get their results before their appointment and you think that can't possibly be what four days of training can involve, you know there must be more to it than that."

It was suggested that all practice staff should have had the opportunity to participate in the Year of Care partnership training particularly because cascading knowledge may dilute it. The interactive elements of the training and videos were acknowledged to be difficult to replicate.

One participant suggested it was useful to consider more broadly how House of Care fitted in to chronic disease management in the practice:

"The other thing we do is we meet every Wednesday morning all the GPs and practice nurses and we go through all the diabetics and we decide the drug treatment changes and that's not HOC that's medical... I think that's helped to involve everybody"

Practice Managers also varied in the extent to which they had been included in early involvement about House of Care and what it involved at practice level. For part time staff, access to external training was reported to be challenging. For example, some practices have limited hours for their Healthcare Support Workers and thus limited time for training. It was suggested that in-house delivery for this staff group make be more accessible.

4.1.4 Local support for learning and implementation

Implementing learning from the training and developing a House of Care framework at practice level involved peer support such as cluster group meetings. These were viewed positively. Visits from Primary Care Support staff were valued and viewed as very helpful in implementing the House of Care training. Support for practical issues such as the IT changes was particularly helpful; some participants suggested more support around this would be welcomed given that it was resource intensive.

4.2 Implementing the House of Care planning pathway

4.2.1 Initial responses

Participants were very positive overall about the House of Care framework despite some challenges around implementation.

"There was nothing negative about it other than the organisation and the time. Nobody could say that's not a good idea or that's not going to work... certainly as an idea and as a model for offering care to people, that's how you would want your mother or father, that's what you would want for them."

4.2.2 Changes from mainstream CDM practice

A number of participants discussed and were interested in how the House of Care framework differs from mainstream CDM management practice. This varied between practices. Most reported that they already delivered diabetes reviews on a two appointment basis and therefore, structurally, it was not substantially different. It was suggested that this may also be attributable to practice self-selection for House of Care.

"It's basically what you've been doing... the practices that are opting in at this stage are probably the practices that are most similar to doing that already"

One GP said House of Care did represent a change in practice but recognised that this was also partly driven by recent changes in staffing.

For some, the difference was in how patient/clinician time was used and the opportunity within the House of Care framework to create more space for discussion:

"You're almost protecting more time... you're allowing yourself instead of what have I got to do in this ten minutes... so you're actually sitting listening to the patient and it's what's important to the patient rather than what's important as a clinician"

For others, how and when information was shared was new:

"A lot of us have done motivational interviewing and self supporting... anyway to me it's the leaflet aspect that's different. All the other stuff is quite well established so, in a lot of instances, the patient's not really noticing a huge difference cos you're still doing it the same way apart from the leaflet and the results"

4.2.3 Information gathering

The information gathering appointment was recognised by some participants as an opportunity to engage patients in and prepare them for the rest of the process.

"It's how you sell it to them at that information gathering appointment."

Preparing the patient meant sharing information in advance of the care planning consultation but also providing the necessary information for the patient to explore:

"For us we always sent them results and we always had a card with everything on it but now giving them something that they feel they have to come in and ask you"

Some suggestions on preparing patients for the care planning consultation were offered by participants for this stage e.g. show patients a blank copy, explain the process and the cover letter in order that they know what to expect.

Participants viewed information sharing as the start of a process rather than an outcome:

"[previously] very prescriptive there you are that's what the results are and it's now turned it back to them... discussions we had with patients to prior warn them that this is coming that the way I would see the biggest change"

Examples of goal setting by patients could be identified at early stages of the process.

"This man has said I want to discuss my medication when I come back because I think I'm on too much so already he's got a goal"

The discussion group participants may be considered early adopters and they recognised that their own implementation of House of Care was in its infancy. This was deemed an important factor to consider in relation to how patients engage with the process and there is an expectation that it will improve over time:

"You're now getting to the point where you're going to do it for the second time and that'll be interesting to see cos it was their first experience and they didn't go to any lessons about how House of Care was or... we're trying to get the healthcare assistant to do that bit with them... they [patients] need to get a bit of practice"

4.2.4 Information sharing

It was reported that high numbers of patients had not prepared by reading or responding to their results though this varies between practices. The paperwork and possibly getting used to using paperwork in the predominantly oral culture of the patient/clinician appointment was considered by some participants to be a potential barrier to engagement:

"A lot of patients aren't keen to write anything on the form even though you are saying to them please write something... "I didn't want to write on it" the nurses are like no that's what we're wanting you to do... you know they're coming in with the points in their head but they don't want to write it on the form, it's just changing things round... "

For those patients who do prepare, it was reported that they engage well in the process, for example:

"around that kind of percentage have found it to be very worthwhile liked the information thought it was useful and started to jot their own notes down and again at consultation with the nurse bringing up issues and raising problems and questions that otherwise might not have been considered"

The opportunity for comparison of previous results was viewed positively and the range targets can provide an initial steer in the care planning. A number of participants, however, said providing range targets along with the patients had, in some cases, been worrying to patients, for example:

"I had someone come in one day, what's this I'm really upset about my kidney function and you would never have had that before"

Sharing information was, however, as likely to be a positive experience for patients:

"They like having their results, they like to know for coming in, they think it's better just having the chat and what they can do to help themselves and I tell them it's their diabetes not mine and they seem to take that on board"

Participants reported some discrepancy between range targets outlined in the House of Care patient leaflet for test results and the range targets recommended elsewhere. It was also suggested that these range targets lack the personalisation and context necessary for patients to understand their test results before seeing a practitioner.

"It's getting more and more towards that you should be individualising targets so for an elderly person you shouldn't have the same target... but obviously this leaflet or what they get through the post it's this is a target whereas it is different for each patient"

Some participants suggested that the sharing of information prior to the appointment has increased the involvement of relatives in the care planning consultation. This can be helpful for aiding the patient's understanding and in identifying issues to raise.

"Often they come in with the form empty but there has been some conversation taken place... They're a bit more engaged in the appointment because their daughter said they don't like the number or make sure you ask about blood pressure"

It was reported that relatives tend only to get involved when there is concern over the results:

"Some [patients] they don't want to know some they're ticking along quite nicely and they just say no hen I'm fine they don't want to do anything different but occasionally they get their relatives along with them now because they've got a form in and the blood results and whatever and they are there and they're getting all worried about it"

4.2.5 Goal setting and action planning

Goal setting is not new to CDM reviews. Practitioners suggested the House of Care process does, however, afford patients an opportunity to identify goals and think about managing their disease in an informed way.

"An informed patient coming in the door, that's the biggest difference"

The collaboration in care planning consultation is affected by how much preparation patients have done before attending.

"It works fantastically well it's completely changed the dynamic if they've done it"

Participants discussed the extent to which information sharing influenced the patient's ability and willingness to engage in goal setting and action planning, for example:

"Some patients have clicked that the weight is an issue and I think that's probably been the biggest advantage of it... but it's maybe being told that in the middle of an appointment it

potentially washes over their head or that they feel that they're getting into trouble. That dynamic has potentially changed whether that results in significant weight loss time will tell"

Shifting the balance of power was acknowledged to be challenging when the patient has not prepared:

"When they've not done anything beforehand, it's changed from being patient agenda"

Some participants shared practice on how to engage patients, for example, by linking improvements in test results to potential improvements in patients' life goals or interests such as golf. Another suggested that agenda setting can be achieved if information sharing provides an opportunity for patients to reflect on what might be influencing their health.

"They've had a chance to come in with their own goals beforehand and results rather than come along to the clinic and be told you've gained 20 stone have you got any goals... they say I've gained 20 stone I've been thinking about that"

One practitioner suggested, however, that the structure of the goal setting was restrictive to less engaged patients:

"although there is goal setting it's still very focussed on blood results... that's an obstacle... cos I think that's why we're finding it difficult at the moment for them to engage with that it may just be that population we have they're not really that interested"

The extent to which goal setting and action planning should be negotiated or patient led varied between practitioners but all were expressed positive views of experiences of patients setting the agenda:

"They're setting their own goal before they come in... and I thought they shouldn't be doing that but if that's the way they want to do it there's no right or wrong way"

Practitioners described being able to use the goal setting process to point out achievements and discuss what might be done to improve results but also to discuss how improvements might impact positively on patients' lives. There was also positive feedback from participants on seeing patients who are less likely to set goals:

"You're always going to get the ones who are not going to engage no matter what you do they just want to come in they want to get their results tell me what to do what medicines do I need to take and leave me alone for another year. You're always going to get that patient particularly the ones who have been diabetic for 15/20 years, you know, give me metformin and let me out the door but I think we've had a fairly positive feedback just being able to come in and have a conversation with the nurse"

4.3 Involving patients with CHD

Participants were asked whether they had adopted or intended to adopt the House of Care framework with patients who have CHD only. For many, there was a well established routine of two appointments for diabetes T2 patients. House of Care was perceived by some participants to be directed to diabetes.

"I think actually the training was all about diabetes cos the videos they showed were diabetics, the first software stuff that came out was all diabetic"

Participants acknowledged that their patients with CHD tended to have multimorbidities – and one practice said they specifically targetted patients with multimorbidities – but, for those who had CHD only, practices tend to see them for one review appointment only. Patterns of engagement also varied from those of patients with diabetes T2 and the change therefore would be more significant. There was also a suggestion that there is greater difference between patients with CHD:

"I found there's a greater range of patients across CHD so you've got very well fit but ones that are not coming back for two appointments"

Some participants said the adoption of a House of Care framework for CHD is restricted by available resources including cost and available appointments:

"The thing with us would be money... we would need to have more hours with the healthcare assistant to include the other cohort of patients just now the nurse if she has a patient with diabetes and CHD she is doing those patients though House of Care but not CHD patients on their own and definitely we would need more healthcare assistant time"

"we've all at some point had diabetic clinics that have been supported by dieticians, podiatrists so for all of us it's just been easier to scale them up... and a very valid point of scaling this up to another very large group of patients it's the time, the time and the money involved... it's finding that time within an appointment book with the current staff that you've got... we want to get it right with the diabetics cos we're half way there already"

The multidisciplinary support is demanding but there was also a sense of getting it right for one disease before applying it to another

"I don't think it's just a case of copy and paste over to another disease... I think there would be a lot more involved"

For those who were planning to adopt the House of Care framework for patients with CDM, retaining flexibility and being responsive to what works for patients was important:

"we're going to give them the option for the first year to have two appointments and then if they say I don't want to have that again then we might just send results out to them but not bring them back for a second appointment unless they want it"

"You can still do House of Care you still do it in one appointment you're still doing the rest of it you can still post them out their results you can still have that type of conversation but you don't necessarily do the two appointment approach... they still do their goal setting we've not done that yet but [that's the way we're thinking of it]... just for a sort of select few"

4.5 Equity

A number of equity issues were reported by participants in the discussion. It was also suggested that there was nothing inherent in House of Care to address existing equity issues.

"the people that don't come still don't come, the people that do engage are still engaging but there's nothing particularly about House of Care that's tackling that"

Many of the group participants accepted that it was easier to engage both the newly diagnosed and those who were already likely to engage. Some practitioners considered engaged patients to be in a minority. It was, however, acknowledged that there is potential for others to engage over time and to get used to the approach. For some, this might involve changing patient attitudes towards clinicians:

"There is that elderly population who do think the GP or nurse knows best and they devolve that responsibility"

Patients who are less likely to engage were perceived by some participants as those who have an established routine and an expectation that healthcare staff will make decisions for them:

"The ones that have been coming for years and years then I think it is very difficult... they still look to us to make decisions for them... but some patients, it's always going to be challenging especially in our areas"

Other reasons such as disability were cited as a barrier to the two appointment system:

"where there's learning disabilities and you've done two appointments and actually you maybe be better going back to a one appointment system because it's a bit of a trek to bring them down when there's not the ability to have that conversation and that's a learning point and that what we're doing now when we do CHD we've split that appointment as to who would benefit... we get them to opt out if it's clearly not beneficial"

Not engaging was also linked this to socio-economic factors including the area in which the patient lived and practice was based as well as life circumstances:

"I think sometimes they don't open official letters if they've got debt problems and things"

The accessibility of the printed information has had an impact on the equity of the service. It was suggested that the House of Care patient information suited some people but not others.

"I think some of them find the wee explanation leaflet too busy it's just too much to take in they look at it and think too many words in that so they don't bother reading it"

However feedback from one practitioner suggested some patients did like the information, though it wasn't clear whether format and/or content influenced this:

"Oddly we were utterly convinced the cloud one was rubbish when it arrived... clinician led decisions isn't always a good thing and we just thought it was absolute rubbish our patients won't read it... but the number that have liked it has quite surprised us... we thought it was too busy... but the patients liked it"

One practitioner had adapted the information to aid understanding:

"I simplify it and put green, red and amber stickers and they understand that"

House of Care was considered currently to be less accessible for speakers of languages other than English. While interpreters are bookable for appointments, printed materials including results in other languages are not yet available:

"in terms of language and that does cut across everything not just House of Care but it cuts across every engagement with primary and secondary care. I've had various discussions about interpreting services and they are actually ongoing but... the people who are not engaging and yet that can be the population that desperately need that kind of work and support... about 35% of our population don't speak English"

It was acknowledged that some issues arising in House of Care consultations apply to healthcare more generally, for example, in the following issue which has implications for both interpreting services and cultural sensitivity:

"it's just the same as any consultation we've picked out some very specific areas where certain religions can't have certain words being said and so the interpreter might say no I can't say that... we're trying to bottom out all of that just now and come out with some sort of alternative because that can cause issues"

Another practitioner suggested that it was the use of written information per se that was more problematic:

"You could say that about all written information, some people respond better to phone calls"

4.4 Links to community based services

For community services, discussion in the groups tended to focus on weight management. Again, participants were generally positive about this aspect of the House of Care approach:

"[patients who] want to lose weight they have the option of seeing the dietician and then they're proactively taking it up... rather than getting shuffled into the next room to be told what they eat wrong"

Some practitioners had reported an increase in referrals they had made to community services:

"I think our services that are available have been taking up more cos when I said how are you going to achieve that? Then they go right and I say, we can help you: waist winners or live active"

One practitioner reported having a greater awareness of community based services:

"I went to an event in the East for information gathering really good at letting you know what services are out there"

There were, however, a number of perceived issues in relation to making referrals to community services. This included accessibility of services:

"When people are working Glasgow Weight Management is not a great service for them... Waist Winners, that's where I send them to"

Participants also suggested that there was a lack of continuity in service provision and it was difficult to keep their knowledge of services up to date:

"You make a community referral and then you find out the funding's been cut"

"If you're trying to sell something to a patient it's much easier to sell if you know what you're talking about and I think that's where the difficulties lie and if you've got these ever changing names, titles, locations... and you're phoning them up going actually I was wrong it just undermines the whole thing"

The cost of some services was also identified as a barrier to participation:

"[Waist Winners] introduced a charge in Renfrewshire... I didn't know that. I found that out from a patient"

"Ours won't go if there's a charge"

Some participants were based in Links practices.¹ This was perceived by those practices to make the difference to successful community based both in terms of having a worker make the links, support the patient with accessing the service but also with improving the knowledge and awareness of staff in relation to community services.

"When we took on House of Care we had just become a Links practice as well so it all kind of tied in that was one of the reasons why we took on House of Care and yes so very much so for us because we have the Links practitioner there it's easy for our nurse to you know refer onto the community and links out there... Through the Links programme we have had a lot of the community services out there come to the practice"

¹ The Scottish Government Links Project aims to develop and test a sustainable local model to improve links between general practice and community support by signposting patients to local services. Links workers have a brokerage, advocacy and liaison role between practices and communities

4.5 Capacity and use of resources

Practitioners were interested in time as a resource. They sought an understanding of how long House of Care takes to implement and whether this varied from mainstream CDM review practice. It also mattered in terms of capacity to roll out the House of Care framework to other disease areas. This was important to practitioners in thinking about how much time they have with the patients as well as the impact on the appointment book and the potential to expand House of Care. Comparisons with mainstream CDM practice were made. Time estimates varied but were dependent on how components of care were included from seeing House of Care from 30 minutes contact time to up to an hour in total. How this time was used varied and was dependent on the balance of the two appointments and their specific content including foot care and how much support was needed if patients hadn't prepared for the care consultation. There was, however, widespread agreement that having time to spend on having a conversation with the patient was valuable.

"You're almost protecting more time... you're allowing yourself instead of what have I got to do in this ten minutes... so you're actually sitting listening to the patient and it's what's important to the patient rather than what's important as a clinician"

Establishing House of Care within a practice was considered to be resource intensive. This was an area where support was particularly valued.

"This wasn't funded and the time it takes to load up the letters... but they were so impressed by it both of them that they done it without funding"

When the patient has not prepared for the care planning consultation this was reported to be more time intensive.

4.6 Professional satisfaction

The opportunity to utilise clinical as well as advanced consultation skills was recognised as part of the House of Care process and was viewed positively by each of the participating professional groups.

"My practice nurse loves it she can't be here but she wanted me to tell you that. She's a natural empowerer anyway... she just likes giving ownership"

An important aspect of the approach is that the appointment allows the nurse to spend more time on the patient's agenda:

"Our practice nurse likes the care planning aspect of House of Care she feels she can really focus on what's available... she's got a way in now I think that's been good for her"

One GP described House of Care as allowing nurses to work "at the top of their licence". Other participants highlighted the enhanced role of the Healthcare Support Worker and the enhanced team working:

“he's getting to do advice and clinical and things like that now the healthcare assistant does the phlebotomy and the bloods and blood pressure”

“Ours changed a lot because our healthcare assistant started doing it so that completely changed the dynamics cos we previously had the nurse doing the full... I think to be separating out the two that was really helpful so that the nurse was freed up some time and the healthcare assistant got quite a lot from that ... cos she's really enjoyed the training and I think that she's probably the one that's completely changed practice and she's also the one that would sell filling in the form... our patients are not too bad [at filling in the form] but I think it's our healthcare assistant that's done that”

Practice Managers described their role in introducing House of Care processes to the practice and bring others on board:

“Well our nurse did want us to do it with so many patients and I had to talk her round saying what's the point of that we need to just change the process totally”

There are, however, a number of caveats to the reported satisfaction with the House of Care approach. Some participants suggested that House of Care is only rewarding professionally when patients are fully engaged in the process:

“[when it doesn't work] I don't think it's a satisfactory consultation for anybody”

There were also some concerns that if House of Care is already being delivered at capacity:

“it's important that people who are not in practice understand the impact it has on the administration of practice... we all see that it's positive but to upscale this, we can't. I can't see how we can do it with the resources that we've got and I mean just from admin staff down to the appointment book to fit any more of that in I'd love to put more of it in”

One practitioner expressed concern that if House of Care was expanded beyond the current CDM portfolio this would go beyond the professional knowledge of nurses, particularly in being able to answering patient questions and would be likely to cause stress.

4.7 Feedback at the event

Participants were also asked to agree on points to report back from the discussion groups on the day. Points were as follows:

Group A: Practice Managers and Health Care Support Workers	Practice level support is most valued.
	House of Care lends itself well to diabetes – more challenging for CHD due to practice and patient factors.
	Positive experiences reported from both patients and staff including examples of patients highlighting issues that would not necessarily have been identified. Also seen as more satisfying.
Group B: GPs and Practice Nurses	Restriction on training places was a problem. It was difficult for those not able to attend training to catch up.
	Some patients engage well and the second visit goes better. For those who don't engage, more time is lost and the visit is harder.
	House of Care works well with co-morbidities. There is a positive spin off for the other condition e.g. CHD.
Group C: GPs and Practice Nurses	Practices would like to see more on what is happening with the rest of the House of Care framework.
	Better continuity is needed in the provision of community based services.
	House of Care allows Healthcare Support Workers to work effectively.
	Resourcing getting started: Funding could be made available for activities such as letters printing etc. and IT could be improved.

5. Summary

- Year of Care Partnership training was viewed positively but there is a perceived need to widen this to more staff in participating practices.
- Support from the Primary Care Support staff and via cluster groups for local learning and implementation was valued.
- The House of Care framework as a route to supporting self management for patients with diabetes and co-morbidities is positively viewed.
- House of Care involves new processes which may take time for patients to get used to and fully engage in.
- Establishing House of Care processes in GP practices is resource intensive.
- Information gathering provides an opportunity to set out expectations and prepare patients for the House of Care care planning consultation.
- Information sharing in advance of the care planning consultation gives patients the opportunity to discuss results with relatives, which can aid understanding and prioritisation.
- The paperwork in the predominantly oral culture of the patient/clinician appointment was considered by some participants to be a potential barrier to engagement.
- Range targets may lack the personalisation necessary to understanding test results at home.
- House of Care is not necessarily directly transferable to other CDM programme conditions.
- Retaining flexibility in how the appointment process is structured may be important for adopting the approach for patients with CHD only.
- House of Care does not specifically address equity issues within the CDM population.
- There are equity issues yet to be addressed through House of Care.
- When patients are engaged in the process, GP practice staff report House of Care to be a professionally satisfying approach. It is less so when patients have not prepared.

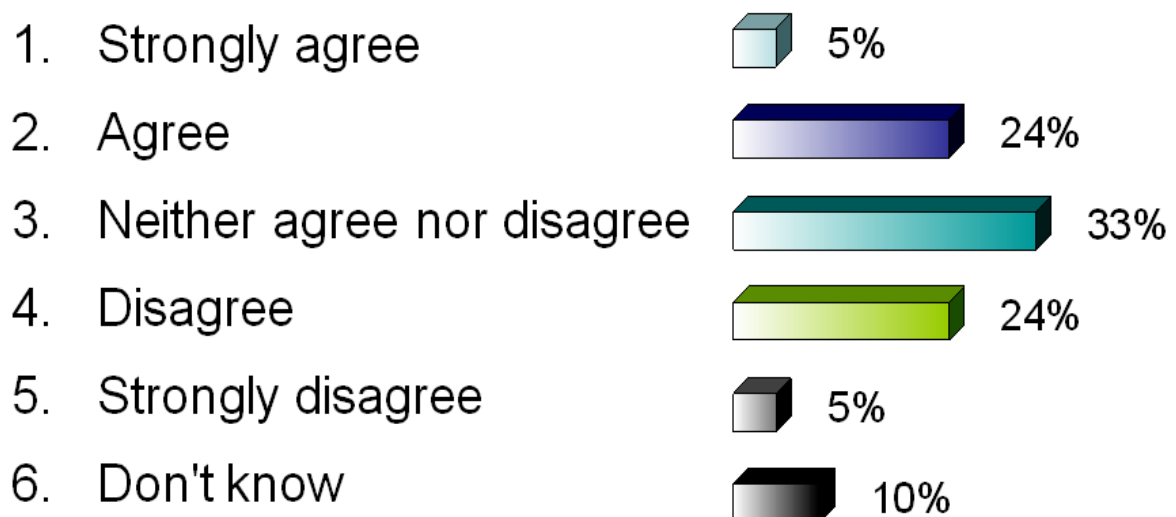
Appendix: PPV vote

On the day, participants were able to view instant results on screen as shown below.

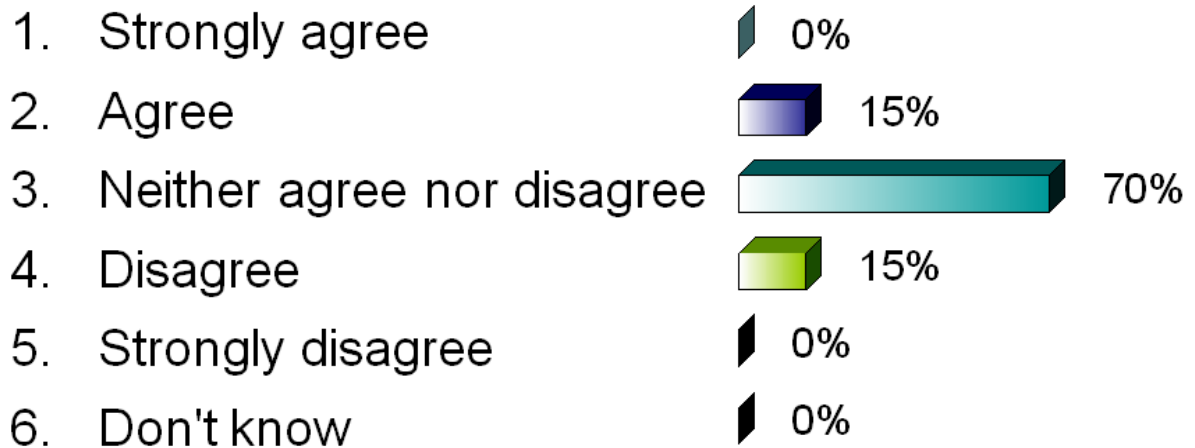
House of Care training has improved our CDM consultations



Our links with community partners have increased after implementing House of Care



The House of Care approach can help reduce inequalities in health outcomes



The House of Care approach has equipped our patients to self-manage

