Public Health Directorate

House of Care: evaluation findings

Summary of findings in relation to NHS Greater Glasgow and Clyde evaluation priorities 2016-17

May 2017

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.

NHS Greater Glasgow and Clyde – along with NHS Lothian and NHS Tayside – is participating in an early adopter programme initiative in partnership with the Scottish Government, Health and Social Care Alliance Scotland and the British Heart Foundation to apply the House of Care model in Scotland.

This paper summarises findings in relation to NHS Greater Glasgow and Clyde House of Care evaluation priorities. These priorities reflect the adoption of House of Care within the context of an already well established chronic disease management (CDM) programme. Findings are based on evaluation activities delivered during 2016-17. The paper also identifies limitations in the evaluation.

2. Evaluation priorities

2.1 What are the outcomes of the consultation for the patient in terms of self-management and relationship with practitioner?

Most of the patients we interviewed said that they had the information and skills they needed to manage their condition. Responses from the LTC6 Questionnaire distributed to patients also suggest confidence in self management is high. However, this was lower in comparison to other aspects of care measured in the LTC6. (We used the LTC6 Questionnaire to ask patients about their experience and understanding of the healthcare they have received over the last 12 months.)

Information sharing in advance of the care planning consultation was reported by patients and practitioners to initiate and facilitate discussion about health with relatives and carers as well as practitioners. Relatives were sometimes motivated by discussing results to attend the care planning and support consultation with patients. This support aided understanding and goal setting. Some GP practice staff reported that range targets included in the information shared may lack the personalisation necessary for patients to understand test results at home.

The care plan provided a structure for discussion. Reviews appeared to work best where the patient completed (or partly completed) the care plan at home, informed by their test results in advance of appointment. As part of care planning, patients were offered information and referrals to health improvement services. Some patients were referred to their GP for further consultation and treatment. These actions are in line with established chronic disease management practice. Many patients who were interviewed said they had experienced low mood, however, only one had been offered support.

2.2 To what extent do patients find the intervention acceptable and have patients identified a change in the quality of the consultation?

Overall participants in the patient experience evaluation felt that the review process was improved. They said they had more opportunity to discuss their condition(s). Components which marked improvements for patients were:

- Receiving written test results in advance of care and planning consultation. (Most patients said the test results were easy to understand, but some found some elements confusing.)
- Experiencing a more collaborative review.
- Having a written care plan.

No barriers to attending both appointments were identified by patients. They were generally motivated to attend.

2.3 Does the House of Care approach improve the reach and participation of those from socio-economically deprived communities?

House of Care does not specifically seek to address equity issues within the CDM population.

The percentage of patients who were exception reported[1] from House of Care eligibility rises with increasing levels of deprivation. This is statistically significant. Of those who were eligible, there was little difference by SIMD in the percentage invited. There was also little difference in participation; 70.2% of the least deprived group invited attended both the information gathering and care planning appointment vs 71.5% of the most deprived group. These differences were not statistically significant.

The paperwork in the predominantly oral culture of primary care was considered by some GP practice staff to be a potential barrier to participation. Staff also reported that socio-economic issues such as debt may influence whether patients opened mail and thus had access to information sharing prior to the care and support planning conversation.

Language and cultural issues were identified as potential barriers to reach and participation. For example, from the patient experience research, it was reported that test results and care plans had not been distributed in any language to those whose first language was not English. Interpreters were not always available. These are system issues for which solutions are available through translation and interpreter services within NHS Greater Glasgow and Clyde.

2.4 To what extent do GP practices find the intervention acceptable?

House of Care as a route to supporting self management for patients with diabetes and co-morbidities is positively viewed overall by participating GP practice staff. The approach involves new processes for which staff suggested it may take time for patients to get used to

[1] Exceptions are patients who are on the disease register, and who would ordinarily be included in the indicator denominator (after exclusions for defined reasons as per QOF guidance).

and fully engage in. When patients are engaged in the process, GP practice staff report HofC to be a professionally satisfying approach. It is less so when patients have not prepared.

House of Care was not necessarily considered by GP practice staff to be directly transferable to CDM programme conditions other than diabetes. For example, retaining flexibility in how the appointment process is structured may be important for adopting the approach for patients with CHD only.

2.5 What has been the impact of training on health care professional practice in delivering CDM?

Year of Care Partnership training was viewed positively but there is a perceived need among practitioners to widen this to more practice staff. The content of the training was considered by many participants to be an opportunity to refresh skills rather than to learn new ones. There was very limited use of cascading training or House of Care information within practices. House of Care is therefore currently restricted to those leading or directly involved in delivery in practices rather than being a whole practice approach.

Establishing House of Care processes in GP practices is reported by staff to be resource intensive. Support from the Primary Care Support staff and via cluster groups for local learning and implementation was valued and viewed as necessary for start up. We did not measure fidelity to the model but variations in practice were identified including the extent to which conversations covered all patients' conditions/concerns and the quality and range of information shared with patients.

Quality markers were used to self-assess GP practice progress against elements of care and support planning. Improvements were measured on repeat of the quality markers in the areas of: register of patients; clinic appointment system; and sharing patient results/assessments/ reflective prompts. Fewer improvements were identified for the following markers: people with long term conditions are informed and aware of the care and support planning process; goals and action planning; and reflective practice and ongoing review of team working.

3. Evaluation limitations

Evaluation activities have focussed on implementation, process and acceptability outcomes. An intended outcome of House of Care is that patients will have improved clinical outcomes and reduced morbidity. The timescale is too short to measure this and it may also be difficult to attribute any change to House of Care. This also stands for any reduction in health inequalities.

House of Care is intended to be a flexible framework. Evaluation priorities related directly to programme development and implementation. There was limited planning or activity identified in terms of developing links to secondary care within the evaluation period.

Engaging with community and voluntary sector groups and support was not costed into proposal. Through the existing chronic disease management programme, there was already a

related programme of activities including the development of a local Public Health Service Directory. We are not able to count health improvement referrals or to measure the impact of House of Care on patient access to these services. We do know, however, that some practices acknowledge the role of the Link Worker programme in making successful community referrals.

The patient experience evaluation was limited to those patients who participated in House of Care. This has helped us to understand potential drivers and barriers to full participation but we recognise that the views of those of who have not engaged fully may differ.

We are not able to conclude from the data available for this time period if House of Care improves or worsens engagement compared to routine care within the most deprived populations. 6 of the 9 participating practices are 17c therefore not required to undertake (and record) activity as defined within QOF and LES specifications. Due to data quality issues, it would not have been possible to undertake comparisons for these practices. It is recommended that NHSGGC House of Care programme team continue to monitor programme reach and engagement by SIMD at both a programme and practice level.

4. NHS Greater Glasgow and Clyde House of Care evaluation reports

- House of Care Evaluation Sub-Group. 2016. House of Care Early Adopter Programme Evaluation Framework.
- Public Health Directorate. 2016. House of Care: evaluation of GP practice staff acceptability. NHS Greater Glasgow and Clyde.
- Traci Leven Research. 2017. House of Care Patient Experience evaluation.
- Allerdice G, McGuire S and Carson C. 2017. House of Care Programme Evaluation Final Report (to BHF/ICF).
- Jarvie H and Allerdice G. 2017. House of Care Equity and Reach Report.