

House of Care Early Adopter Programme Evaluation Framework



Contents

- 1 Purpose of Paper..... 3**
- 2 Background 3**
 - 2.1 Chronic Disease Management in NHSGGC 3
 - 2.2 Keep Well Programme Legacy..... 3
 - 2.3 House of Care Early Adopter Programme 4
- 3 NHSGGC House of Care Programme 6**
 - 3.1 Programme Aims and Objectives..... 6
 - 3.2 Programme Logic Model 6
- 4 NHSGGC Evaluation Priorities 8**
- 5 Patient Experience 8**
 - 5.1 Quantitative Outcome Evaluation..... 8
 - 5.2 Qualitative Acceptability Evaluation..... 9
- 6 Programme Reach and Equity.....11**
 - 6.1 Patient Reach..... 11
- 7 Practice Implementation, Adoption and Acceptability.....12**
 - 7.1 Practice Implementation of HofC Approach 12
 - 7.2 Health Care Professional Acceptability & Adoption 13
- 8 British Heart Foundation Programme Level Evaluation13**
- 9 Budget and Governance14**
- 10 List of Appendices Error! Bookmark not defined.**

1 Purpose of Paper

- i. To describe the background to and key elements of NHS Greater Glasgow & Clyde (NHSGGC) House of Care (HofC) early adopter programme.
- ii. To propose an overarching evaluation framework for the programme, detailing distinct individual evaluation aims and methodology.
- iii. To propose a delivery plan for evaluation activities for 2016/17.

2 Background

2.1 Chronic Disease Management in NHSGGC

NHSGGC invests substantially in an extensive, well-established chronic disease management (CDM) programme, which delivers general practice based care for patients with five major chronic diseases¹. The CDM programme aims to provide person centred care for patients with any combination of the above co-morbidities. The programme has three distinctive assets:

- i. Decision support technology which supports and enables efficient delivery of evidence based clinical care and supports the practitioner in creating a workable, person-centred consultation process.
- ii. A 'whole system' ongoing development programme to ensure that all of the CDM programme content is fully up to date and reflects best practice in both clinical content and also 'softer' consultation content.
- iii. A proactive programme of workforce development which uses a wide range of evidence based knowledge management methods, working with NHS Education for Scotland and NHSGGC's Knowledge into Action team.

2.2 Keep Well Programme Legacy

The Keep Well programme in NHSGGC explicitly sought to strengthen functioning connections between primary care clinicians and wider stakeholders, and prioritise actions to systematically address health inequalities through sustained investment in planned systems for primary prevention. This included enabling co-production between general practices and area-based services via development of Community Orientated Primary Care (COPC) approaches, expansion of the online Health & Wellbeing Service Directory² to support social

¹ CDM programmes: Coronary Heart Disease (CHD), Type 2 Diabetes, Stroke/Transient Ischaemic Attack (TIA), Chronic Obstructive Pulmonary Disease (COPD), and Left Ventricular Systolic Dysfunction (LVSD).

² Health & Wellbeing Service Directory www.nhsggc.org.uk/hwd

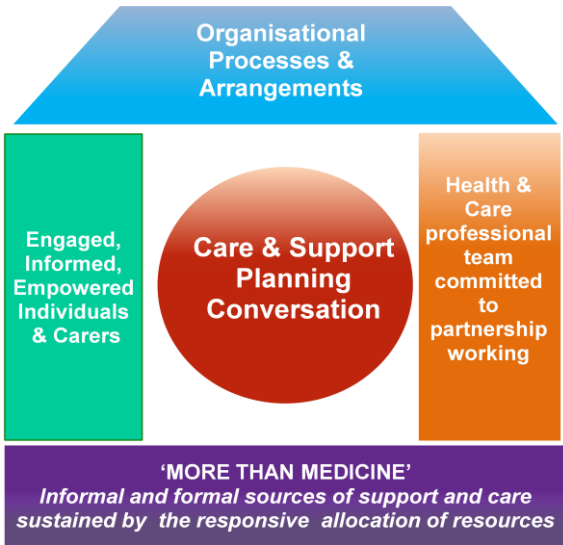
prescribing, and providing opportunities for general practice staff to participate in local community networking events.

To support a lasting programme legacy, the main findings from the evaluation of Keep Well in NHGSGGC were translated into an *Anticipatory Care Toolkit*³ outlining improvement potential across three themes; optimising patient engagement and reducing DNAs, delivering person centred consultations, and supporting behaviour change and self management. Each theme contained a range of practical areas of improvement designed to enable practices to undertake a self-assessment and action plan within the context of their CDM programmes. Public Health, Primary Care Support and Health Improvement teams facilitated a series of collaborative networking opportunities to support sharing of learning, knowledge and approaches across participating practices during the 2014/15 contract year.

2.3 House of Care Early Adopter Programme

The House of Care model, developed by the Year of Care Partnership⁴, 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 (LTCs). The model comprises four interdependent components, with collaborative care and support planning conversation at the centre of the house (Figure 1).

Figure 1: The Care Planning House



The house acts as a metaphor as well as a framework, emphasising the importance and inter-dependence of each element; if one element is weak or missing the service is not fit for

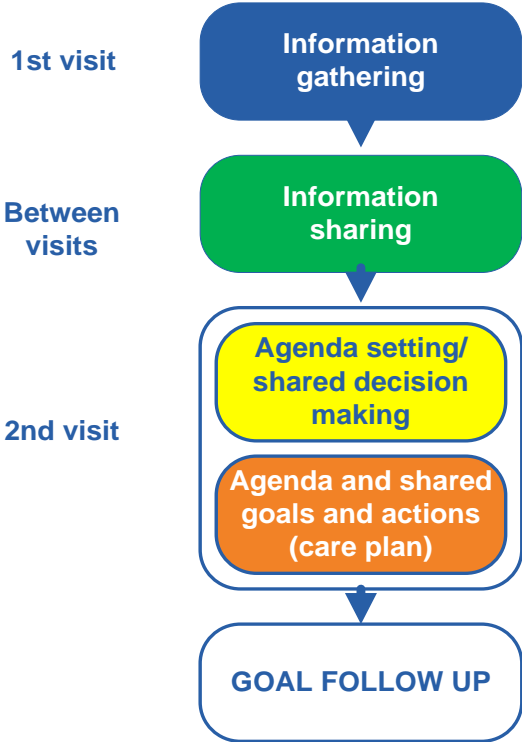
³ Anticipatory Care Toolkit <http://library.nhsggc.org.uk/mediaAssets/My%20HSD/269277%20Toolkit%20FINAL%20Published.pdf>

⁴ Year of Care Partnership www.yearofcare.co.uk

purpose. The key components are the person with a LTC(s) being engaged and informed, working with healthcare professionals who are committed to partnership working.

The common components of the HofC care planning approach are summarised in Figure 2. At the first 'information gathering' visit, the patient attends an appointment at their practice to have their appropriate 'annual review' tests (e.g. blood pressure, blood & urine tests, weight etc). The tests results are sent to the patient in a 'results letter' at least one week before the patient attends the care planning visit. The results letter also contains prompts and questions to encourage the patient to think about their results and aspects of their health/conditions, which they may wish to discuss at the care planning visit. At the care planning visit, the patient and the Health Care Professional (HCP) will jointly discuss the patient's results and any questions; support needs the patient may have; and an agreed care plan is developed (Figure 2).

Figure 2: Care Planning Approach



This approach has been endorsed by the Scottish Government to address the needs of people living with multiple LTCs and is aligned with Scottish Government's route map of deliverables to achieving its 2020 vision through developing New Models of Primary Care.

NHSGGC along with NHS Lothian and NHS Tayside are participating in a 2 year early adopter programme initiative in partnership with the Scottish Government, Health and Social Care Alliance and British Heart Foundation (BHF) to apply the HofC model in Scotland during 2015-17. Three further sites in England are participating in the BHF funded programme.

3 NHSGGC House of Care Programme

3.1 Programme Aim and Objectives

The HofC model offers a valuable opportunity to develop further and strengthen NHSGGC CDM programme, specifically in relation to:

- i. Connectivity between patients, communities, the third sector, primary and secondary care; and
- ii. Addressing variation in delivery of person centred consultations, particularly for patients with more than one long term condition.

3.1.1 Programme Aim

To develop, optimise and test a workable model of person-centred CDM for patients with multimorbidity, operating within a local 'total place' approach to prevention and care. This will include patients diagnosed with type 2 Diabetes and/or Coronary Heart Disease (CHD) as an exemplar group.

3.1.2 Programme Objectives

- i. Identify general practices who are interested in applying the HofC approach within their existing CDM programme.
- ii. Facilitate collaborative working with practices using a COPC approach to developing, delivering and evaluating HofC.
- iii. Identify target population of patients with diagnoses of type 2 diabetes and/or CHD.
- iv. Develop and deliver a model of person-centred care which meets the definitions of 'best practice' in HofC and the NHSGGC CDM programme.
- v. Engage and empower patients, their wider families and their social networks in sustained health improvement, making full use of existing community assets.
- vi. Systematically engage and support practices with creating a health promoting physical environment in their own premises.
- vii. Work with local HSCP teams and others to develop an appropriate range of community engagement approaches to identify and work collaboratively on addressing drivers and consequences of LTCs.

3.2 Programme Logic Model

BHF developed a national programme logic model in 2015 in collaboration with the six early adopter sites. NHSGGC has adapted this to reflect the local context and programme priorities (Figure 3).

Figure 3: NHSGGC Programme Logic Model

INPUTS	ACTIVITIES	SHORT TERM OUTCOMES	MEDIUM TERM OUTCOMES	LONG TERM OUTCOMES
<p>Programme funding 2015-17 £62k BHF £70k Scottish Government £45k NHSGGC</p> <p>Practice funding Protected income for NHSGGC CHD & Diabetes LES</p> <p>In-kind contribution Time, support, and input from: NHSGGC Primary Care Support; Public Health; Managed Clinical Networks; HI&T and HSCP staff</p> <p>Partner organisations: Diabetes Scotland; Health & Social Care Alliance programmes; Year of Care; BHF.</p>	<p>System level</p> <ul style="list-style-type: none"> Establish programme Steering Group and relevant sub-groups Recruit dedicated project manager Identify facilitators within Corporate & HSCP teams and delivery of facilitators training Identify eligible population and monitoring framework Establishment of READ coding guidance, data capture and data extraction process within existing CS system Tailor HofC resources to reflect NHSGGC clinical guidelines and integration within primary care CS system <p>Patient-level</p> <ul style="list-style-type: none"> Engagement with LTC Patient Forum Locality arrangements in place to identify and engage with community & voluntary sector groups and support Support in place to develop patient involvement good practice within primary/secondary care and programme activities <p>Health Care Professional (HCPs) level</p> <ul style="list-style-type: none"> Practice recruitment and development of SLA Engagement with secondary care sites Primary & secondary care HCPs participate in Care Planning training Facilitate support for programme implementation/care planning conversations for HCPs as required 	<p>Individual HCPs act in a more person-centred way, and conduct more collaborative care and support planning consultations</p> <p>Long term condition consultations are being conducted with changed practice</p> <p>Patients have been able to use results/reflection provided before consultations to help them make decisions about their own care plan</p> <p>HCPs and patients have a greater awareness of support available in their local area</p>	<p>Patients are engaging in more collaborative consultations</p> <p>Patients have an improved, more seamless experience of care</p> <p>Patients feel they have the knowledge, skills and confidence to be able to self-care effectively within daily life</p> <p>Patients know when to seek support</p>	<p>Patients experience more personalised, coordinated care</p> <p>Patients have increased self-efficacy</p> <p>Understanding and knowledge of collaborative care planning is improved</p> <p>Care and support planning established as routine care</p> <p>Improved partnership working with community and secondary care</p>

4 NHSGGC Evaluation Priorities

Following discussion with the NHSGGC HofC Steering Group and evaluation Sub-group, the following evaluation questions have been prioritised for NHSGGC HofC evaluation:

- i. What are the outcomes of the consultation for the patient in terms of self-management and relationship with practitioner?
- ii. To what extent do patients find the intervention acceptable and have patients identified a change in the quality of the consultation?
- iii. Does the House of Care approach improve the reach and participation of those from socio-economically deprived communities?
- iv. To what extent do GP practices find the intervention acceptable?
- v. What has been the impact of training on Health Care Professional practice in delivering CDM?

The following sections outline evaluation methodology to explore the above evaluation questions.

5 Patient Experience

5.1 Quantitative Outcome Evaluation

5.1.1 Aim

To measure change over time in patient self-reported experience of health care and self-management support within participating HofC practices.

5.1.2 Methodology

The LTC6 Questionnaire patients with a LTC about their experience and understanding of the healthcare they have received over the last 12 months. It asks 6 questions about how involved people felt in decisions about their care and how well supported they have felt to manage their own health. The measure can be used to drive improvements at both the population and provider level. A copy of NHSGGC questionnaire, including background letter and demographic information request is provided in Appendix 1.

Practices will be requested to issue the questionnaire to all patients attending a HofC information gathering appointment. Patients may complete the questionnaire in the waiting area prior to their appointment or in the patient's own time. The questionnaire should take approximately 5 minutes to complete. A phone number will be available for patients who may have any questions about the questionnaire or who require support to complete (e.g. those with visual impairments or literacy issues).

Patients will also be invited to provide consent to be contacted to participate in qualitative interviews (see section 5.2).

5.1.3 Sampling

All patients attending their HofC information gathering/pre-consultation appointment during 2016/17 contract year appointment will be invited to complete a baseline LTC6 questionnaire. All patients completing a baseline LTC6 questionnaire will be invited to provide consent to be contacted.

5.1.4 Limitations of approach

- i. Process requires a degree of self-selection therefore returns may not be fully representative of participating patients.
- ii. Patients may have had a number of appointments and interventions in their practice in this period. Some of these contacts may have been with staff who are not trained in House of Care. This may affect the reporting of their experiences.
- iii. Risk of low return rates / consent for baseline and/or follow-up questionnaires.
- iv. Unmatched sample therefore unable to measure change at a patient level.
- v. No control group therefore unable to directly attribute any observed change to HofC intervention
- vi. Unable to determine if patient has had none, 1 or 2 care planning visits at the time of completing the LTC6.

5.1.5 Reporting timescales

Baseline information will be submitted by end of February 2017 to ICF International for analysis. A programme level report (6 sites) will be provided by ICF International by end March 2017. ICF are unable to provide site specific report.

5.1.6 Administration

See Appendix 2.

5.2 Qualitative Acceptability Evaluation

5.2.1 Aim

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.

5.2.2 Methodology

Externally commissioned qualitative (semi structured) interviews with patients who have recently (in last 2 months) attended a HofC care planning consultation. Interviews will be home based unless a patient expresses a preference for telephone or alternative venue. An interview framework will be developed by the external commissioned researcher in conjunction with the HofC evaluation sub-group. It will include the following elements:

- i. Demographics: age; gender; postcode; employment status; occupation or last occupation.
- ii. Acceptability of House of Care appointment process:
 - Awareness of change in review if new patient including accessibility of two appointments;
 - Use of information letter with test results;
 - Barriers and drivers to participation in information gathering appointment and consultation.
- iii. Experience of both appointments (information gathering appointment and consultation).
- iv. Understanding of content; listened to; feel at ease; interested; opportunity to discuss concerns; joint decision making.
- v. Self-reported readiness to self manage including care plan and condition specific knowledge of when to seek support.
- vi. 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.

5.2.3 Sampling

Findings will be presented at a whole programme level rather than practice level. The aim is for the successful contractor to undertake approximately 36 interviews subject to achieving level of data which is appropriate and necessary to undertake qualitative analysis. This equates to a target of 3 patients per active practice taken from the practices comprising Waves 1 and 2 of House of Care. Practices not seeing patients during the fieldwork time period will not have interviews included.

A protocol for consent management and providing patient contact details will be developed to support the research process.

It is intended that the majority of participants will be selected from those who have returned an LTC6 with consent to contact in future. There will also be an option to ask GP practices to help boost the pool of potential participants particularly in relation to socio-economic deprivation by seeking consent during consultation (for a limited period before fieldwork commences).

5.2.4 Limitations of approach

- i. Potential of practice patient and self-selection bias therefore returns may not be fully representative of participating patients.
- ii. Risk of insufficient number of patients consenting.

5.2.5 Reporting timescales

Patient recruitment: July – August 2016

Fieldwork: August – September 2016

Final report: end of October 2016

5.2.6 Administration

See Appendix 2.

6 Programme Reach and Equity

6.1 Patient Reach

6.1.1 Aim

To gain insight into whether the House of Care approach facilitates improved equitable uptake of CDM annual reviews, particularly in relation to socio-economic deprivation.

6.1.2 Methods

- i. Routine monitoring
NHSGGC Information Service will provide monthly programme-monitoring reports will be developed in line with BHF reporting requirements, including:
 - Eligible number of patients.
 - Number of eligible patients invited to attend information gathering appointment.
 - Number of eligible patients attending information gathering appointment.
 - Number of eligible patients attending care planning appointment.

The above indicators will be broken down by; practice, diagnosis (CHD, Type 2 Diabetes) and patient SIMD quintile.

- ii. Programme level analysis
A programme level analysis will be undertaken to explore reach/equity of uptake of CDM annual reviews within participating HofC practices, including:
 - Patient demographics including; age, SIMD, gender, ethnicity.
 - Comparison with practice 2014/15 CHD & Diabetes LES achievement data.

NHSGGC Information Services and Public Health will undertake programme level analysis and reporting respectively.

6.1.3 Limitations of approach

Completeness of routine data dependent on practice implementation of defined CDM and HofC programme READ codes, particularly in light of discontinuation of Quality and Outcomes Framework from 1st April 2016.

6.1.4 Timescales

- i. Monitoring reports
 - Monthly monitoring reports will be provided for NHSGGC programme implementation group.
 - Quarterly Monitoring reports will be provided in line with BHF reporting requirements.
- ii. 2015/16 Programme level analysis
 - Analysis: during May 2016
 - Report: end June 2016
- iii. 2016/17 Programme level analysis
 - Analysis: during May 2017
 - Report: end June 2017

6.1.5 Administration

See Appendix 2.

7 Practice Implementation, Adoption and Acceptability

7.1 Practice Implementation of HofC Approach

7.1.1 Aim

To explore practice implementation of HofC approach.

7.1.2 Methodology

The *Year of Care Quality Marker Self-Assessment and Action Planning Tool* (Appendix 4) was developed by Year of Care Partnerships to support practice implementation of the HofC approach and continuous quality improvement.

Practices participating in the NHSGGC HofC early adopter programme are required to complete the Quality Marker (QM) self-assessment tool at two stages:

- i. Following completion of day 1 of the 1½ day Care Planning training
- ii. 12 months post training.

Analysis of NHSGGC baseline and 12 month QM self-assessment tool will be undertaken by the HofC development lead (with support from ICF International) to describe practice level implementation of the HofC approach at baseline (wave 1 & wave 2 practices) and at 12 months post training (wave 1 only). Emerging themes from the analysis will be explored further explored in practice focus groups (see section 7.2).

7.1.3 Limitations of approach

Variations in completeness, quality and process of practice completion of QM self-assessment tool may limit ability to identify common themes.

7.1.4 Reporting timescales

Analysis of baseline (wave 1 & 2 practices) & 12 months (wave 1 only) practice QM is to be undertaken during April-May 2016, with report available by end May 2016.

7.1.5 Administration

See Appendix 2.

7.2 Health Care Professional Acceptability and Adoption

7.2.1 Aim

To explore HCP acceptability of HofC approach, and their experiences of adopting this approach in practice as well as the impact of training on health care professional practice in delivering CDM.

7.2.2 Methodology

Facilitated group discussion with participating primary & secondary care staff.

A discussion guide will be developed by Public Health collaboration with NHSGGC HofC steering group & evaluation sub-group.

7.2.3 Limitations of approach

Practitioner availability to attend session – seek representation from range of practice staff.

7.2.4 Reporting timescales

Facilitated group discussion: June 2016

Final report: end August 2016

7.2.5 Administration

See Appendix 2.

8 British Heart Foundation Programme Level Evaluation

In addition to the outlined NHSGGC evaluation, ICF International have been commissioned by BHF to evaluate the HofC programme at a national level. The focus of the evaluation is both formative and summative. It will: support the monitoring of projects and the sharing of lessons learned between sites; support individual sites to self-evaluate; and undertake a programme-level impact evaluation, including economic analysis. The first report is currently

available. A second interim report based on site visits during implementation will follow shortly, with further reports due in 2017 and 2018 (depending on extension). NHSGGC / Scotland data will be available in addition to potential learning from other sites.

9 Budget and Governance

A maximum budget of £15,000 is available for the NHSGGC HofC evaluation.

NHSGGC HofC evaluation sub-group will oversee the delivery of the evaluation activities outlined in this paper. Quarterly progress reports will be provided to NHSGGC Steering Group.