House of Care

Interim Evaluation Report

April 2019

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Background

Increasing epidemiological challenges have resulted in a rise of individuals living with long-term conditions (LTCs). The consequential economic pressures mean alternative models of care delivery need to be considered. Addressing the needs of individuals living with LTCs through self-management support and collaborative care planning is emerging nationally. One model encapsulating these priorities is House of Care (HoC). The HoC model, developed by the Year of Care Partnership, is an improvement framework developed to enable services to embrace care and support planning (CSP) as an approach to support self-management of people living with LTCs. The model comprises of four interdependent components, with the collaborative CSP conversation at the centre of the house.

This evaluation describes the implementation and impact of HoC in the Grampian region during the first six months.

Methods

The model consists of two separate appointments: 1) an information gathering appointment, where the patient has their appropriate annual tests taken (such as blood pressure, blood & urine tests and weight). The tests results are sent to the patient at least one week before the patient attends the CSP appointment. 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. 2) At the CSP appointment, the patient and the Health Care Professional will jointly discuss the patient's results and any questions or support needs the patient may have. An agreed care plan is then developed.

A multi-level, mixed-methods evaluation framework was developed to understand the implementation and impact of the model in the local context. Service data collected included the number of patients and long term conditions targeted at each practice; patient's perception of professional empathy and enablement of self-management was assessed post CSP conversation. Practice staff perceived levels of confidence and knowledge of implementing the HoC model were assessed quantitatively. Qualitative interviews were conducted with practice staff to understand key implementation considerations to inform future service provision.

Results

Service data - Four practices commenced as part of the first cohort of HoC implementation: one in Aberdeen City; one in Aberdeenshire and two in Moray. Practices attended two days training prior to commencement. All practices focused on patients with diabetes and other multi-morbidity LTCs.

Practice populations combined totalled 26,221 patients, of which 4378 are eligible recipients of the model.

Patient data - Patients rated practice staff consistently high across constructs, for example letting them tell their story (85% of 113 responders either scored 'very good' or 'excellent') and showing care and compassion (88% of 110 responders either scored 'very good' or 'excellent'). There were 89% of 114 responders who thought that the professional was either very good or excellent in fully understanding their concerns. Of 114 responders, 72% felt more able to keep themselves healthy as a result of the CSP consultation. Approximately half of responders (55%) indicated that they were signposted to community services / groups for support.

Staff data - Practice staff overall rated HoC training as being 'very helpful' (≥80%), aspects rated most useful included goal-setting and consultation adjustment to improve patient care planning. However, staff commented on the relevance of aspects of the training to their role, for example administrative staff attending training regarding how to conduct the CSP consultation, however attendance to these sessions were not mandatory.

There were 97% of staff who agreed that CSP would be a valuable strategy to adopt. Of interviewees, a power-shift towards a collaborative consultation between professional and patient was described. The results letter patients received prior to the CSP consultation was highlighted as particularly valuable, allowing patients time to reflect and enter this session more informed and subsequently, empowered.

Practices utilising a birth of month recall system reported smoother implementation of HoC. Facilitators to implementation included practices willing to be agile in the delivery of CSP, for example having these consultations conducted remotely, or providing increased appointment lengths for patients with multiple LTCs. Further, practices having staff who assumed a project-coordination role appeared to aid its operation.

Staff reported differences in perceptions, confidence and subsequently, implementation of signposting patients to community services. Some interviewees described non-medical challenges such as financial concerns out with their areas of expertise, whilst others acknowledged the value of addressing these towards achieving holistic care.

Conclusion/Future Recommendations

The HoC model appears to be acceptable to both patients and practice staff. There are numerous aspects of interest that are likely to require longer-term implementation to evidence, including: 1) embedding of a social prescribing approach in General Practice; 2) clinical impact on patients; 3) a greater shift towards increasing patients self-perceptions of managing their own wellbeing; 4) system-wide impact on outcomes such as hospital admissions; 5) assessing the fidelity to which the CSP is being undertaken. It appears that tailoring the delivery of training to role-specific staff, assumption of a project-coordination role and willingness to be agile in HoC delivery will all facilitate its implementation within General Practice.

Key Points

- Notwithstanding logistical, capacity and recruitment challenges facing General Practices, it is feasible to implement the HoC model within the Grampian region
- CSP appears acceptable to both patients and practice staff
- Patients report CSP as superior to traditional care delivery towards self-managing their wellbeing
- Practice staff report CSP as a valuable method of delivery care to adopt
- Training to deliver HoC should be provided in a tailored way, ensuring that only relevant content is delivered to the appropriate staff
- Agility in delivering CSP (for example adapting the length and mode of consultations) may further reinforce a person-centred approach to care delivery.
- Implementation may be facilitated by practices assuming a project-coordination role
- Embedding a social prescribing approach in General Practice is likely to be a medium-to-longer-term outcome

Introduction

The population in the UK is getting older, with a predicted increase of 8.6 million people aged 65 years or over in the next 50 years. Over the same time period, the percentage of the population over 85 years old is expected to rise from 2% to 7%[1]. With an ageing population comes an increasing disease prevalence; with appointments related to long-term conditions (LTC) accounting for approximately 50% of General Practitioner and 64% of outpatient appointments[2]. The associated financial challenges resulting from the ever-increasing epidemiological challenges aforementioned mean that alternative models of delivering care are being considered.

Recently, there has been increasing emphasis on the importance of delivering care using an integrated and person-centred approach, characterised by putting the individual at the centre of the system and facilitating a shift towards empowering people to manage their own wellbeing[3]. Evidence shows that systems oriented around the needs of individuals and communities may be more effective, cost less and improve health literacy[4]. The challenge, however, lies in implementing and embedding such an approach within an integrated primary care context requiring cultural, system and organisational change for effective, economically-viable and sustainable implementation.

One model, which articulates the type of cultural, system and organisational changes required for the implementation of integrated and tailored care provision, is the House of Care (HoC) model. HoC is characterised by delivering person-centred care through collaborative care and support planning (CSP) conversations, helping individuals (living with LTCs) take an active role in the management of their wellbeing by identifying goals important to them. The model consists of two separate appointments: 1) an information gathering appointment, where the patient has their appropriate annual tests taken (such as blood pressure, blood & urine tests and weight). The tests results are sent to the patient at least one week before attending the CSP appointment. 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. 2) At the CSP appointment, the patient and the Health Care Professional will jointly discuss the patient's results and any questions or
support needs the patient may have. An agreed care plan is then developed (for more detailed information about the model, visit the work of Coulter et al. (2016)[5]. The model has demonstrated

[1] Office for National Statistics (2018). Living longer: how our population is changing and why it matters.
[2] Scottish Government. Department of Health. (2012). Long-term conditions compendium of Information: 3rd edition.
[3] Scottish Government (2010) NHS Five Year Forward View 2014.
[4] World Health Organisation -Global strategy on integrated people-centred health services 2016-2026: Placing people and communities at the centre of health services.

positive impact across several sites nationally[6] and locally, the decision was taken to test the feasibility of implementing such an approach.

This report explores implementation and impact of the House of Care Model in the Grampian Region.

[5] Coulter *et al*, (2016). *Building the House of Care for people with long-term conditions: the foundation of the House of Care framework*. Br J Gen Pract. 66 (645): e288-e290.
[6] British Heart Foundation - Evidence and findings from the BHF House of Care Programme.

Methods

Practice Recruitment

In January 2018, recruitment of General Practices in Grampian to participate in the delivery of HoC commenced. Eleven practices across the three Health and Social Care Partnerships (Aberdeen City, Aberdeenshire & Moray) were recruited to implement the model. Practices received training over two days (one full day and one half day) prior to go-live, with practice facilitation sessions (including process mapping and team engagement) being conducted onsite locally to understand current ways of working. All the practices received a bursary to help towards backfill to release staff for training and any other initial start-up costs.

This evaluation focuses on the first four practices that proceeded to 'live' implementation in Cohort 1. These practices have all been delivering CSP for a minimum of six months and targeting patients with multi-morbidities. Initially, eight practices were recruited for Cohort 1, however four withdrew from progression, citing staffing and time-associated challenges. As the data collection described within fell under the categorisation of service evaluation, ethical approval was not required.

Evaluation Design

A systematic process was followed in the development of the evaluation framework to support a local case-for-change. This framework was developed through an iterative cycle by an evaluation working group, which including experts in HoC delivery, self-management and public health research. The group used a combination of published reports, key learning from other health boards and gaps in the literature to develop and refine the framework.

A multi-level, mixed-methods framework was developed to delineate the data collection across the implementation of HoC. Evaluation metrics relevant to include in this report are visible below. It is important to note that several outcomes are to be reported on after 12 months and as such, are not described within. The primary aim of this evaluation is to determine whether the HoC model is feasible to implement within the Grampian region.

Staff Evaluation

Training – Practice staff from Cohort 1 who attended the HoC Training completed evaluation questionnaires at the end of each training day (one full day and one half day) (Appendix 1). Constructs measured included perceived value; clarity regarding implementation considerations and satisfaction of engagement. All forms were anonymous and returned to trainers at the end of training. One practice received tailored in house training.

Coherence and perceived engagement with the HoC model was assessed using an adapted NoMAD Survey[7] (Appendix 2). The tool, based on normalisation process theory, focuses on professionals' perceptions around implementing new complex interventions in a healthcare setting, specifically levels of confidence and engagement to change practice. The survey was completed before model commencement.

Perceived skill, knowledge and confidence to conduct CSP consultations were assessed using the Care, Support & Planning Consultation Questionnaire (CSPC-1)[8,] adapted from a Year of Care reflective tool (Appendix 3). This was completed upon completion of training by practice staff that would deliver the CSP conversation directly with patients.

Practice staff involved in the delivery and implementation of HoC were invited to participate in semi-structured interviews/focus groups to understand the implementation and impact of delivering HoC. The interview topic guides were semi-structured (Appendix 4). Interviews were audio recorded and transcribed verbatim and analysed thematically. Thematic analysis is useful towards understanding patterns occurring in the data in order to improve understanding on a particular topic[9]. Analysis followed the six step framework previously described by Braun and Clark (2006)[10], including: 1) familiarisation with the data; 2) developing initial codes; 3) searching for themes; 4) reviewing themes; 5) theme definition and 6) write up of results. The data were analysed independently by two researchers and then findings compared and adapted if required.

[7] Girling *et al*. (2018). *Improving the normalization of complex interventions: part 1 - development of the NoMAD instrument for assessing implementation work based on normalization process theory* (NPT). BMC Medical Research Methodology 18:133.
[8] Care, Support & Planning Consultation Questionnaire. Adapted from Year of Care V1.0 Sept 17
[9] Maguire, M. & Detahunt, B. (2017). *Doing a thematic analysis: practical step by step guide for learning and teaching scholars*. AISHE-J. 9(3).
[10] Braun, V. & Clark, V. (2006). *Using Thematic analysis in psychology*. Qual Res Psych. 3(2), 77-101
[11] Mercer, S. & Howie, J. (2006) *CQI-2 — a new measure of holistic interpersonal care in primary care consultations*. Br J Gen Pract. 56(525): 262–268.

Patient Evaluation

Patient-rated quality of the CSP consultation and perceptions of ability to self-manage their wellbeing as assessed using the Consultation Quality Index (CQI-2). The CQI-2 is a tool to measure holistic interpersonal care, with a specific focus on patient enablement, length of consultations and care continuity[11] (Appendix 5). The CQI-2 was administered once patients had received their second (CSP) appointment. Completed questionnaires were left in practice collection points and returned via mail to the research team, who inputted the data into an electronic database.

Results

The characteristics of Practices included in the first cohort of implementation are visible in Table 1.

Table 1. Cohort 1 Practice/Patient Demographics

Practice	Practice population	LTCs patient numbers	Staff description	Staff (N)	Training attendees	CSP delivered by
1	12,688	Diabetes M/M n=597	GPs	5	1	
			PM	1		
			OM	1		
			PN	4	2	Y
			HCA	1	1	
			Adm/Rec	N/R	2	
2	6,033	Diabetes M/M n=1786	GPs	3		
			Pharmacist	1		
			Physician Ass	1		
			PM	1		
			ANPs	2	1*	Y
			PNs	4		Y
			HCSW	1		
			Adm/Rec	10		
3	4,139	Diabetes M/M n=1245	GPs	2	1	
			PM	1	1	
			NP	2		Y
			PN	2	2	Y
			HCA	0		
			Adm/Rec	6	1	
4	3,361	Diabetes M/M n=750	GPs	2	1	
			PM	1	1	
			PN	2	2	Y
			HCA	N/R		
			Adm/Rec	N/R		

*One person from this practice attended the YoC training, but all practice staff received a tailored 'short' version of the training delivered at the practice.

LTCs = Long term conditions; N=number; N/R=Not Reported; M/M=Multi-morbidity; GPs=General Practitioners; PM=Practice Manager; OM=Operational Manager; PN=Practice Nurse; HCA=Health Care Assistant; NP=Nurse Practitioner; ANP=Advanced Nurse Practitioner; HCSW=Health Care Support Worker.; Adm=Administrator; Rec=Receptionist.

HoC Training Evaluation

Day 1 (Full day) **–** Table 2 reports the evaluation of the first day of training. Each construct was rated out of 10 and a total of 36 evaluation forms were completed, thus meaning constructs were scored out of a total of 360. Understanding of the CSP approach was the highest rated construct (91%), with understanding the consultation framework, core competencies and organisational requirements scoring lowest (83%).

Table 2 – Evaluation of training day one

Construct	Total Score Rating out of 360	Percentage (%)
Understanding the YoC approach to care and support planning	328	91
Reflect on your own approach/philosophy of care and how this fits with care and support planning	306	85
Understand the care and support planning consultation framework and the core competencies required	299	83
Helped you to be clear about the organisational requirements for implementing care and support planning in practices	298	83
How would you rate the overall session	317	88

Qualitative responses (direct quotations) that attendees regarded as most useful included:

- *'How to goal set/action plan, understand the HoC process'*
- *'How to adjust my consultations to improve patients care planning'*
- *'Watching and discussing consultations/role play'*
- *'Principles of HoC/Accessing tools to support HoC'*

Qualitative responses (direct quotations) that attendees regarded as requiring improvement included:

- *'Opportunity to hear and debate case analysis from different perspectives, ie, GP, Nurse, Administrator, Manager'*
- *'Day too long'*
- *'Separate session for admin would help/admin don't need to attend whole day'*

Day 2 (Half day) – Table 3 reports the evaluation of the second day of training. Each construct was rated out of 10 and a total of 26 evaluation forms were completed, thus meaning constructs were scored out of a total of 260. Reflection and planning CSP implementation was the highest rated construct (90%), with overall satisfaction of the session scoring lower (81%).

Table 3 – Evaluation of training day two

Construct	Total Score Rating Out of 260	Percentage (%)
Take stock and have an opportunity to reflect and plan the implementation of care and support planning for your practice teams	233	90
Reflect upon and practise care and support planning consultation skills	228	88
Consider strategies that might be useful for people with low levels of importance or confidence	231	89
Consider your next steps to implement care and support planning	215	83
How would you rate the session overall?	211	81

Qualitative responses (direct quotations) that attendees regarded as most useful included:

- *'Networking/ sharing ideas with other practices'*
- *'Techniques to deliver CSP role play'*
- *'Session better as not whole day'*

Qualitative responses (direct quotations) that attendees regarded as requiring improvement included:

- *'Clinical scenarios not relevant to admin staff'*
- *'Less role play'*

Practice evaluation results

Table 4 shows the NoMAD survey results for practice staff regarding coherence and cognitive participation (question completion ranged between 96-100 responses). The majority of staff agreed or strongly agreed that the method of CSP consultation made sense and that they would be involved and support the implementation of HoC in their practice (97%).

Table 4: NoMAD survey results – coherence and cognitive participation (% of responders)

Questions Relating to Coherence - Making sense.	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know
I can see how care and support planning will differ from the usual way of working	35	61	3			
Staff in this practice have a shared understanding of the purpose of care and support planning	32	65	3			
I understand how care and support planning will affect the nature of my own work	39	52	6	3		
I can see the potential value of care and support planning for my work	52	45	3			
Cognitive Participation - Becoming Involved						
There are key people who will drive care and support planning forward and get others involved	45	52	3			
I believe that participating in care and support planning will be a legitimate part of my role	50	29	18	3		
I will be open to working with colleagues in new ways to use care and support planning	64	37				
I will support care and support planning	67	30	3			

Table 5 shows the NoMAD survey results for practice staff regarding perceived skills and knowledge. There was large variance from responders regarding perceived difficulties in conducting the CSP conversation, however responders indicated confidence in their knowledge and skills to carry out the CSP conversation.

Table 5: NoMAD survey results - perceived skills & knowledge (% of responders)

Skills &Knowledge (0 = not at all, 5= somewhat, 10 = completely)	0	1	2	3	4	5	6	7	8	9	10
How challenging do you feel the CSP conversation/discussion is going to be?		14		3	3	21	3	32	17	5	3
How easy will it be to signpost people to support in the local area for the issues they identify?		9				12	21	21	24	5	9
I feel confident in my knowledge and skills to have a CSP conversation with my patients							15	33	26	26	
I feel confident in my knowledge and skills to support patients with 'goal setting' and developing 'action plans'	4		4			8	17	25	21	17	4
I feel confident in my knowledge of community services and assets to signpost patients accordingly		4				13	24	20	20	16	3

Table 6 shows staff responses from the CSPC-1. The majority of practice staff had a high level of confidence to carry out all aspects of CSP consultations including identifying patient's main concerns identify goals and develop positive relationships. Given that only a small cohort of staff were delivering the CSP consultation (and subsequently only these individuals completed this survey), the numbers are presented as individual responses as opposed to percentages.

Table 6 - CSPC-1 – Staff Perceived Confidence (recorded as the number of staff responses)

How confident are you that you can: (1 is 'not confident at all' and 10 is 'very confident')	1	2	3	4	5	6	7	8	9	10
Describe the purpose of a care and support planning consultation?							2		1	3
Work with the person to develop an agreed agenda?							2	2	2	2
Elicit the person's knowledge and beliefs about their condition?							1	1	3	1
Elicit the person's main concerns and priorities?							1	1	3	1
Explore and elicit the person's goals?							1	1	3	1
Facilitate the person to develop their own action plan?							2	2	1	1
Explore the person's barriers to achieving their goal and their own personally relevant solutions?							1	2	1	2
Develop a positive working relationship (rapport) with the person?								1	3	2
Check out with the person how they feel your conversation is going particularly when you think it might not be going well?						1	1	3		1
Tell when you are trying to persuade the person to do what you think is the right thing?							1	3		2
Allow the person to take the lead in the consultation						1	1	2	1	1
Express your concerns or challenge the person in a way that maintains your relationship and their autonomy?						1		2	1	2
I have a good range of open questions to use in consultations					1		1	1	1	1
I can confidently use simple and complex reflections					1	1	1	1	2	
I can demonstrate understanding and empathy using reflections					1		1		2	
I can use scaling questions to explore importance and confidence					1			2	3	

Practice Interviews

Table 7 provides an overview of the four themes that emerged from the thematic analysis: 1) Service operation; 2) External support; 3) Enablers and 4) Impact. The sub-themes embedded within these themes are described below. For the purposes of interviewee confidentiality, all quotations have been anonymised.

Table 7. Themes and subthemes derived from thematic analysis

Theme	Subtheme
Service operation	Appointment planning
	Care delivery
	Model agility
	Patient correspondence
External support	Networking
	Training
	Support
Enablers	Attitudes
	Structure
Impact	Patient impact
	Staff impact
	Service impact

Service operation

Appointment planning – To facilitate delivery the CSP conversation, practices could implement a month of birth recall system. Those practices who were utilising this recall method prior to delivering HoC reported smoother implementation, with this approach providing a beneficial structure to both professionals and patients: *"From our point of view people would say, I think I am due my annual review and before you would have to go through the notes to see when they last had an appointment, whereas now you can go what is your date of birth, you will be due March time or whenever their birth month it. That makes it a lot quicker for us and from our point of view it is a lot more streamlined".* To avoid confusion and aid a systematic approach to delivering CSP, interviewees described the value of utilising a colour coding system for appoint coordination: *"All practices will do it differently but the way we do it works really well for us, like I say because we colour code the appointment and then we colour code the slips that they bring us out. They come out with a piece of paper that says a thirty minute appointment with [Staff name] ticked, we cannot really go astray with that, neither can the patients because it is quite clear what they need to do. That works really well".*

Care delivery – The HoC model was delivered over two main appointments: 1) the initial data collection meeting, which was used for: *"gathering information, blood tests, blood pressure, weight checks …"* and 2) a follow up action planning appointment: *"after they have already seen the data gathering, they [patient] come and we go over things and then we set goals together".* Participants described the implementation of the CSP conversation and discussed the value of providing a holistic appointment to ensure that agreed decisions moved beyond a sole improvement in clinical outcomes: "*we had a lady who had chill blains which … were stopping her from walking so much, so [Staff name] addressed the chill blains and she was given advice about more comfortable socks and creams for wrapping up well just to get her out. If she is walking more, her wellbeing is better and she might lose*

weight. You have to address what the real issues are and it is maybe not the time for weight loss but if you have addressed their needs, you will gain trust."

A fundamental change in this model compared to traditional care delivery was the mailing of results letters to patients prior to follow-up appointments: "*the big difference being that they got stuff on paper that they can see before they come in … previously they would just come in and I was giving them their results verbally".* The model also had a strong emphasis on the 'More than Medicine' approach and utilising community-based assets to support self-management. Here, participants described signposting patients to local, non-medical services they felt could be of benefit: *"Getting up to speed with what facilities are out there, now we are referring to agencies which you maybe knew of them but were not used to referring to them, money issues , we are only used to dealing with health issues and I know a lot of other things come into it also but it is just getting your head round what is available locally and doing a lot of work to get that information".*

Model agility – Interviewees described numerous adaptations they made to the model to ensure it was congruent with the local context. For instance, individuals with several LTCs required more discussion and consequently, more time allocated to their appointments (which was not initially envisaged). Changes to the appointment lengths in these circumstances reduced the subsequent stress on practice staff: *"There was a few times because we are seeing respiratory patient and diabetic patients at the same time, not enough time was allocated for both, so we realised that we needed more time to do the data gathering and the goal setting, we realised that we needed longer for those appointment that try to cover both big areas was just too much, we were running really late and getting stressed by it. Once the templates were changed so you were getting double, it just changed things completely."* Despite these changes in appointment lengths meaning the appropriate documentation also had to be adapted, this was not perceived as a particularly burdensome task: *"we did have to change all our templates for the appointments but this was reasonably easy enough to do. A bit time consuming trying to work out what you wanted to do, but once it was done, it was done".*

Further adaptations that were made to the model in by some practices included the mode of CSP delivery. Whilst typically, this model is delivered face-to-face, instances were described whereby these conversations were had remotely. Pre-existing relationships between the professionals involved in HoC and practice-attached nurses provided an efficient channel to ensure even housebound patients could engage: *"What we did, we printed out her care plan [results letter] and the district nursing team took it out to her. It was done over the phone, so you can do it remotely and that lady is so much happier, even when you speak to her on the phone her whole voice is different".*

Patient correspondence – Staff commented that the invitational letters encouraging patients to engage in CSP may have been more appealing than how they traditionally contacted individuals, particularly for those who did not attend practice for regular condition reviews: *"I have found that patients who have not come for a long time come, maybe it is the way the letter is worded as it is more detailed and it is worded different to our previous letters"*. There were some challenges reported with different modes of correspondence, such as virtually, which resulted in data loss: *"There were just a few teething issues with people who wanted the results emailed, I think sometimes they went into junk mail and there was some people who did not receive their results".* However, participants did not feel all patients would be appropriate to offer this model to and subsequently, developed inclusion criteria for whom they would choose to invite: *"Certain patients are maybe on the palliative list have complex medical health problems would all be removed at that point and then they would not be invited".*

External support

Training – Staff involved in the CSP conversation attended two training days prior to delivery to understand how it would be delivered in practice. Overall, feedback was positive, with attendees describing the value of having several members from the practice attending to gain a shared understanding and vision for this model: *"I think it was really good to the whole team involved. It was mainly a nurse led approach and to educate the nursing team and all the team about the care and support planning".* However, the structure of the training received mixed views, with some staff questioning the relevance of particular elements. For example, Health Care Support Workers discussed that the second day of training focused on the CSP conversation (however it was not mandatory to attend this session), which was undertaken by nurses and subsequently, not applicable to their role: *"The first one I thought was really good, it was explaining about House of Care … but the next one was more vocally about what we would tell the patients, I thought 'I do not do any of that'".*

Differences were also evident in the intensity of training delivery. Some interviewees felt overwhelmed with the quantity of information being given to them in a condensed period of time: *"I felt that one day was really intense and a lot to think about when you left … it was really hard going by the end of the day".* However, this contrasted with another participant who felt that particular components of the training could have been explored in greater depth, such as the action planning element with patients: *"I did struggle a wee bit at the beginning, being an older kind of nurse … I think I would have benefited from more training but some of the people found it adequate but I would have like to have had more training on my consultation skills. I am not a great role player and I think that is probably why I struggled with it because that format is not always for everyone".*

Networking – A perceived opportunity for future implementation was visiting other sites to gain an understanding of how the model worked in practice: *"It would have been good in hind sight to see how it was working in other practices and to see how there are doing their reviews. That is an option but then it was only [Practice name] then but now there is more and they would also like to meet with other practice nurses as well, especially the practice nurses and Health Care Assistants, sort of bouncing off thoughts and ideas especially around the care support planning conversations"*. However, other interviewees responded that, whilst this may be useful, they cited capacity issues as a barrier to networking opportunities: *"time is an issue, we most of the time struggle to fill the appointments, we are always very busy".*

Support – Participants were able to provide examples of a variety of different colleagues who were able to support them during the early stages of implementation, whether this was condition-specific queries, or issues related to IT: *"Anything we have needed, we have been able to get, so we have had support from Respiratory people, also from Vision people this has been great help and anything we need to ask any questions about things, it has always been answered".* The individuals who had delivered the training visited practices: *"a few times, before and after the training"* to provide any ongoing support that may be provided, however most interviewees felt this was not required: *"not for me, I do not feel that I was needing any [ongoing support]".*

Enablers

Attitudes – In making a significant change to how patient care was delivered, interviewees highlighted the value of having commitment from across all General Practice staff in order to make this change successful: *"I think we just thought sod it, it was a really good idea and we were really busy and we were passionate about it. When you are passionate about something you get going. When we went to the taster session and then the first day, they said this is what we want you to do, so that is what we did".* It was also felt that staff had to be open for asking for help and advice from others when necessary, understanding that it would be a learning process for everyone involved: *"Someone who communicates with someone quite well and ask for input, I do not think there would be a problem".*

Structure – Given the changes in delivery necessary for several members of General Practice, one pragmatic decision taken at one site that aided the delivery of the model was to assign an individual to a project management role to provide an oversight of implementation: *"You also need to have a dedicated clinic coordinator. I do not think it could be done by numerous people, I think someone needs to take the lead for it and have the overall responsibility, almost like a practice project manager as such that oversees all the different parts along the way to make sure it is running.* Further, thought had to be invested to ensure that clear delineating of roles and responsibilities for each staff member

was apparent: *"I think probably everyone has their own role in things from like admin setting it up, sending out letters, everything just kind of goes. I think because our admin team are going great with their job, so when patients come to me, they know a little bit about House of Care, they receive their letter and things. I do not think it has been a challenge".*

Impact

Patient impact – The majority of interviewees felt HoC had a positive impact on their patients' wellbeing. For example, they discussed the value of sending results to patients ahead of their goal-setting appointment, helping them feel more informed and taking ownership of their health: *"Say their Hba1C had gone up from 50 to 64, they are getting time to look at this and process the information, so when they come in for their review they can ask the questions that probably before they were coming in getting their results from the nurse and did not really want to ask much questions, so they are kind of in control".* In particular, the use of colour to highlight areas of their health that could be improved was seen as a motivator to promote positive behaviour change: *"I have had quite a number of people saying this is great, this is really good and they are really engaging with it. It has motivated them. I had one bloke I had been seeing for two years who has been obese for all that time, he gets his form back it is in the red and he sees that he is obese, he thought oh well I better do something about that then".*

Whilst the majority of interviewees reported positive impact on patients, particularly due to the results letter they received prior to the CSP appointment, this was not unanimous. Some professionals felt these results letters were not operationalised in an effective way due to issues with both length and content, however it should be acknowledged that this practice adapted the standard template: *"The results sheet going out is way too wordy and we have an awful lot of patients saying 'it does not make any sense to me, I cannot make head nor tail of this'".*

Staff impact – Participants described an overall improvement in their job satisfaction through delivering this model, commenting that it facilitated a holistic approach to care provision compared to a traditional emphasis on disease: *"It has been very fulfilling and I think in years to come, this is just six months it, it is very much person centred and you are dealing with issues that might not have nothing to do with chronic disease but we have a directory we use now that [Staff name] updates it and we are using it"*. The focus on multiple morbidities led to the upskilling and professional development of some staff, particularly nurses, some of whom had not dealt with particularly diseases prior to implementation: *"The respiratory side is really new to me, I have only done that within basically the last year, so since we started talking about House of Care, developing a new skill at the same time was quite difficult but I am much more confident in that now".*

Service impact – This model was a much more efficient way of delivering care. In particular, having one appointment to collect all of the patient's data, especially if they had multiple conditions, was more streamlined than the traditional approach of separate visits: *"The main difference is they are getting everything done at that appointment. Before they used to just get a blood test and then you would send them to see [Practice Nurse] for everything else. Now they are seeing me for bloods, blood pressure, weight checks".* Whilst some appointments may take longer, it was thought that this would ultimately reduce the overall number of appointments that an individual would have to attend throughout the course of the year, subsequently reducing pressure on primary care: *"they do not have as much appointments in a day".*

Patient data results

Table 9 shows the empathy, enablement and continuity constructs of the CQI-2. Responders rated the professionals delivering the CSP consultation consistently high across interpersonal constructs, including 'showing care and compassion' (88% either scored 'very good' or 'excellent') and 'letting you tell your story' (85% either scored 'very good' or 'excellent').

Table 10 shows the perceived enablement of self-management constructs of the CQI-2. Of responders, 72% felt the CSP consultation had made them more able to keep themselves healthy compared to traditional consultation methods.

Table 11 shows the information sharing and signposting constructs of the CQI-2. Of responders, 91% of patients agreed that receiving the results letter prior to the CSP consultation was beneficial, with just over half reporting that, during this discussion, they were signposted to local support services.

Table 8 – CQI-2 Consultation Quality Index - Empathy, enablement and continuity

CQI-2 Question	Total responses	Options	Percent %
Letting you tell your "story"……		Poor	0
		Fair	1
	113	Good	12
		Very good	33
		Excellent	52
Fully understanding your concerns……		Poor	0
		Fair	0
	114	Good	9
		Very good	36
		Excellent	53
Showing care and compassion….		Poor	0
		Fair	1
	110	Good	5
		Very good	28
		Excellent	60
Explaining things clearly……..		Poor	0
		Fair	0
	115	Good	5
		Very good	31
		Excellent	63
Helping you to take control……		Poor	0
		Fair	1
	80	Good	4
		Very good	24
		Excellent	40
Making a plan of action with you with agreed 'goals'		Poor	0
		Fair	0
	79	Good	7
		Very good	21
		Excellent	47

Table 9 – CQI-2 Consultation Quality Index - Patients Perceived enablement of self-management

Questions	Total responders	Options	Percent %
Able to cope with life…	115	Much/better more	19
		Better/more	41
		Same or less	28
		Not applicable	11
Able to understand your condition(s)…	115	Much/better more	27
		Better/more	43
		Same or less	27
		Not applicable	3
Able to cope with your condition(s)…	113	Much/better more	22
		Better/more	40
		Same or less	34
		Not applicable	3
Able to keep yourself healthy…	114	Much/better more	21
		Better/more	51
		Same or less	24
		Not applicable	3
Confident about your health….	114	Much/better more	22
		Better/more	45
		Same or less	30
		Not applicable	1
Able to help yourself….	114	Much/better more	23
		Better/more	47
		Same or less	26
		Not applicable	3

Table 10- CQI-2 Consultation Quality Index – Information sharing/signposting

Consultation Quality Index - Information sharing/signposting Questions	Total responses	Options	Percent %
How useful was the letter you received with your test results in helping you to prepare for the care and support planning conversation?	70	Not at all useful	0
		Not very useful	0
		Somewhat useful	24
		Very useful	67
		Did not read	3
During your care planning conversation today, did you discuss services and supports based in your local community (for example, support groups, or patient organisations)?	78	yes	55
		no	12

Discussion

As part of the HoC model practice staff attended a 1.5 day training on the process of implementation in practice. Overall, training seemed acceptable with a high satisfaction rate (84%). Elements of the training that staff found particularly enjoyable included action planning, goal setting and how to adjust consultations to improve patients care planning. Interviewees did however have the view that elements of the training were not relevant to all staff members. For example the second day of the HoC training has a particular focus on the CSP consultation, which was not relevant to administrative staff or HCSWs. It is recognised that staff need to receive the correct training to ensure they can deliver best practice[12], however with ever decreasing resources in primary care[13] and associated time constraints[14] there is a need to ensure that available resources are used efficiently and effectively. Therefore, an alternative and potentially more efficient means of delivering HoC training to practice staff would be to tailor training so that the content included the relevant components to the appropriate Practice staff[15].

The HoC model is of a house built around a care planning conversation between people and the healthcare professional, the fundamental principles is that CSP focuses on a person-centred approach[16]. Patient consistently rated their CSP consultation experience with practice staff highly across all constructs of the CQI-2 questionnaire. For example, they felt that they were able to tell their story (85% of responders either scored 'very good' or 'excellent') and showing care and compassion (88% of responders either scored 'very good' or 'excellent') and with a high percentage of respondents (89%) who thought that the health professional was either 'very good' or 'excellent' in fully understanding their concerns. There is evidence that people who have the opportunity and support to make decisions about their treatment and care in partnership with their health professional(s) are more satisfied with their care, have improved clinical outcomes and have improved adherence to medication[17]. These findings are consistent with others in Scotland and reinforce its relevance locally, demonstrating that the model has high acceptability to patients. Although it is too early to evaluate clinical outcomes at this stage of

[12] NICE (2007). National Institute for Health and Clinical Excellence (NICE) (2007). *How to Change Practice. Understand, Identify and Overcome barriers to change*. London: NICE
[13] Audit Scotland (2017). NHS in Scotland. Edinburgh: Audit Scotland.
[14] Scottish Government (2016). A national clinical strategy for Scotland. Edinburgh: Scottish Government.
[15] Gesme *et al*. (2010). *Essentials of Staff Development and Why You Should Care*. J Oncol Pract 6(2).
[16] Scottish Government (2016) *Person-centred Care: What Non-Executive Directors Can Do* https://www.gov.scot/publications/person-centred-care-non-executive-directors/pages/1/
[17] The Health Foundation (2016). *Why person-centred care is important*. https://personcentredcare.health.org.uk/person-centred-care/overview-of-person-centred-care/why-person-centred-care-important

implementation, evidence elsewhere suggests that high acceptability is likely to lead to improved clinical outcomes.

The model appears highly acceptable to patients regarding aspects of perceived self-management, with the majority of patients reporting the CSP consultation to be better than previous consultations conducted in the traditional model. For example, patients reported a high score on elements of empathy, where they felt that the health practitioner let them tell their story (85% of respondents scored either 'very good' or 'excellent'), fully understood their concerns (89% of respondents scored either 'very good' or 'excellent') and explained things clearly (94% of respondents scored either 'very good' or 'excellent'). However, it is interesting, yet potentially unsurprising to note, that the constructs around self-management score consistently lower than the empathy constructs highlighted previously. A move towards self-management in healthcare requires a change in the collaborative exchange between health professionals and patients with LTCs. The process of building patients knowledge, skills, and confidence necessary to manage their condition(s) effectively in the context of their everyday life may be a longitudinal outcome[18]. This is reinforced by CSP being a relatively new model emphasising a shift towards self-management in health care, and consideration should also be given to that, at the time of analysis, all patients had only received one CSP consultation. Considering this, these findings are a positive first step towards indicating that the model may be valuable to implement at scale, however longer-term follow up is required with this cohort to ascertain whether patients report greater self-management.

As with patients, the model appeared to be highly acceptable to staff; one element highlighted as particularly enjoyable was a shift from talking "to" patients, to having more of partnership dialogue between the two. Partnership dialogue, characterised by patient's being involved in making decisions regarding their own health, has been shown to increase patient empowerment which in turn leads to patients improved self-management of their health[19]. One mechanism reported that was particularly beneficial towards attaining this shift was the results letter patients received prior to the CSP consultation. Providing patients with their results prior to their consultation facilitates patient education by allowing appropriate opportunity for reflection through discussion with significant others, potentially increasing a sense of empowerment over their health[20]. Therefore, this is likely to be an integral step towards

[18] The Health Foundation (2015). *A practical guide to self-management support: Key components for successful implementation*. https://www.health.org.uk/publications/a-practical-guide-to-self-management-support
[19] Nygårdh *et al* (2012). *The experience of empowerment in the patient–staff encounter: the patient's perspective*. Journal of Clinical Nursing. 21(5-6)
[20] Henwood *et al* (2003). *'Ignorance is bliss sometimes': constraints on the emergence of the 'informed patient' in the changing landscapes of health information*. Sociology of Health & Illness. 25(6) 589–607

achieving self-management. Presenting patient results visually, using the traffic light systems, has been shown to promote wellbeing across public health initiatives including enhanced diet from colour-coded food labelling[21], a particularly important consideration the association between LTCs and health illiteracy[22]. This is reinforced by 91% of patients highlighting that they agreed that results letter was somewhat to very helpful. However, it was acknowledged in one practice that they felt it was too much writing, therefore practices may prefer to tailor the content deemed appropriate for their local practice whilst retaining the beneficial principles of the letter (such as use of colour).

One of the main pillars of the HoC model is a whole system approach to provision of services, including social prescribing / signposting to services. However, there were differences in perceived knowledge of local services (only 3% of respondents indicating they thought it would be completely easy to sign post to services; 3% completely confident in their knowledge, most indicating they were somewhat or slightly greater in their confidence or knowledge of services) which likely impacted on the level of signposting patients to community services. This may explain why only 55% of patients reported that they were signposted to community assets, although it should be acknowledged that signposting may not be appropriate for all patients. Whilst some practice staff recognised the value of addressing non-medical patient challenges, such as financial concerns, other interviewees were hesitant to address these, citing they were out with their areas of knowledge. Lack of social prescribing may be attributed to a lack of awareness of available services, however with other local initiatives specifically focusing on social prescription, such as the Aberdeen Links Service, these are likely to directly contribute towards the upskilling and awareness-raising of practice staff regarding local community services and assets relevant to their patients. Introduction of a similar service across Grampian would contribute to an embedding of a links approach, however this is likely to be a longer-term outcome.

Regarding the implementation of the model, there appeared to be numerous facilitators that went beyond the staff acceptance and belief (97% of practice staff agreed to strongly agreed that they supported and could see the potential value of CSP) that a change of practice would be to the benefit of patients[23]. For example, practices reported smoother implementation if they were already using a birth of month recall system, as this was congruent with the method of inviting patients to attend the CSP consultation. Further, practices emphasised the importance of clear delineation of roles and

[21] Cecchini & Warin 2016). *Impact of food labelling systems on food choices and eating behaviours: a systematic review and meta-analysis of randomized studies*. Obesity Reviews: 17 (3).
[22] Panagioti *et al* (2018). *Effect of health literacy on the quality of life of older patients with long-term conditions: a large cohort study in UK general practice*. Quality of Life Research 27(3)

responsibilities towards successful delivery of the model. In particular, one practice contained an individual who assumed a project-coordination role to oversee the implementation. Notably, this practice appeared to report the highest acceptability of the model comparative to others. A change in health care practice can be aided through strong leadership, knowledge, understanding and skills[23], therefore this may be a particularly important consideration for future practices aiming to implement this model.

Other implementation considerations include the length of appointments. There was a consensus from practices that, depending on the cohort of patients, appointment lengths were not suitable. For example, patients with multiple LTCs required additional time to be able to discuss all concerns, whereas those with one LTC required less time, albeit there may be exceptions to this association. As a consequence, some interviewees described rushed appointments and running over time. However, other practices decided to adapt their appointment system and, in these scenarios, provide longer appointment lengths to patients who needed them. A person-centred focus, an integral component of the HoC model, aims to meet the needs of the patient rather than the needs of the service therefore, flexibility in care delivery should be championed if possible[24]. One practice took the implementation of HoC further by adapting the delivery of the CSP consultation to include remote patients. This was achieved by conducting CSP consultations virtually, making links with community staff who facilitated goals/action plans to patients. These examples outline the importance of adapting the model to ensure it is tailored to and is beneficial to local circumstances.

There were a number of limitations to consider. First, the fidelity of CSP consultation delivery is unknown, which future research should investigate. Further, it is too early to demonstrate whether CSP consultations improves patient outcomes or wider system-level outcomes (for example reduced prescription costs); this should also be examined in future work. Although the primary aim of this evaluation was not to determine the level of social prescribing, consideration should be given to this and the level of patient attendance of social prescribing in the future.

Conclusion and Recommendations

Notwithstanding the logistical, capacity and recruitment challenges facing General Practices in Grampian, it appears that it is feasible to implement the HoC model in the region. Particularly, the challenges

[23] National Institute for Health and Clinical Excellence (NICE) (2007). *How to Change Practice. Understand, Identify and Overcome barriers to change*. London: NICE

[24] NHS England. (2018) *House of Care – a framework for long term condition care*. https://www.england.nhs.uk/ourwork/clinical-policy/ltc/house-of-care/

highlighted as reasons for withdrawal of practices from Cohort 1 appeared evident within the practices who proceeded to implementation, demonstrating this re-design of care delivery is achievable. Further. the HoC model of patient centred care and CSP consultation appears to be highly acceptable to both patients and staff. In particular, the model allows for patients to have meaningful conversations about their wellbeing in an informed and empowered way and also allows practice staff to take the time to move from talking "to" patients, to having more of a partnership dialogue. It was acknowledged that for some practices the transition to this new model of care may be easier, if certain system processes are already in place, for example month of birth recall, therefore the process of change may be more complex for practices. It appears that tailoring the delivery of training to role-specific staff, assumption of a project-coordination role and willingness to be agile in HoC delivery will all facilitate its implementation within General Practice.

It would be beneficial if future work aimed to assess the fidelity of the CSP consultation, what is being delivered and how, and whether the content has an impact on patient outcomes (long term); clinical impact on patients; embedding of social prescribing ethos in General Practice and evaluation of uptake (specifically health related behaviour change); a greater shift towards increasing patients self-perceptions of managing their own wellbeing; In addition, the aim would be carry out an evaluation of service impact including; unscheduled hospital admissions, prescription costs and emergency hospital admissions.

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Appendix 1

Year of Care Partnerships
Evaluation Form Day 1

Trainers: **Date:**

On a scale of 1-10 (1 being 'did not help at all' and 10 being 'very helpful'). How much has the training helped you to?

	Rating of 1 - 10
1. Understand the Year of Care approach to care and support planning	
2. Reflect on your own approach/philosophy of care and how this fits with care and support planning	
3. Understand the care and support planning consultation framework and the core competencies required	
4. Helped you to be clear about the organisational requirements for implementing care and support planning in practices	

What aspect of today's session did you find particularly useful?

What could have been improved?

How would you rate the session overall?											
Poor	1	2	3	4	5	6	7	8	9	10	**Very Good**

Would you recommend this training to a colleague embarking on care and support planning?	**Yes** ☐ **No** ☐

Appendix 2

Please cite as: Finch, T.L., Girling, M., May, C.R., Mair, F.S., Murray, E., Treweek, S., Steen, I.N., McColl, E.M., Dickinson, C., Rapley, T. (2015). NoMad: Implementation measure based on Normalization Process Theory. [Measurement instrument]. Retrieved from http://www.normalizationprocess.org.

Survey Instructions

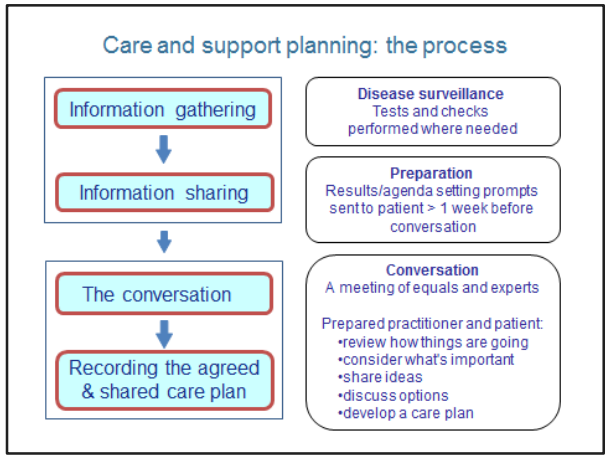
Care and support planning – practice team survey

This survey is designed to help get a better understanding of how to apply and integrate new technologies and complex interventions in health care.

This survey asks questions about the implementation of **care and support planning.** We understand that people involved with **care and support planning** have different roles, and that people may have more than one role. This survey is designed to allow you to reflect on your role in the team.

Your role in care and support planning in the practice team

Implementing care and support planning involves different people taking on different roles within the care and support planning process.



A successful care and support planning process relies on the work done by the whole team, how things happen at each stage in the process can make a big difference – understanding your role in this process is important to its success in the practice – this means administrators, receptionists, managers,nurses, healthcare assistants and doctors all make an important contribution.

Completing the survey

This survey is anonymous and should take about 5-10 minutes to complete. Please take the time to decide which **answer best suits your experience for each statement and tick the appropriate circle**. There is the option of indicating if a question isn't relevant to you.

Development of this survey was funded by the Economic and Social Research Council; Study Grant RES-062-23-3274. The core NPT items (20 construct items & 3 normalisation items) are Copyright © Newcastle University 2015.

Name of practice:

Part A: About yourself

1. How many years have you worked for this practice*? (If your practice has merged with another or changed its name, please include in your answer all the time you have worked with this practice and its predecessors)*

○ Less than one year ○ 1-2 years ○ 3-5 years ○ 6-10 years ○ 11-15 years ○ More than 15 years

2. How would you describe <u>your professional job category</u>?

○ Receptio ○ Administration ○ Practice Manag ○ Doctor ○ N e ○ HCA

3. My role in care and support planning will be to deliver or support activities to: *(tick more than one if relevant)*

○ administer processes, including dealing with questions about appointments and sending out results

○ complete the disease surveillance checks and help prepare people

○ have the care planning discussion/conversation with people at the second appointment

○ none of these

4. **From the statements below please choose an option that best describes what your main role will be in relation to care and support planning:**

- ○ I will be involved in leading or overseeing care and support planning
- ○ I will be involved in delivering or supporting the delivery of care and support planning
- ○ I will not be directly involved

For this survey, please answer all the statements from the perspective of this role. Depending on your role or responsibilities in care and support planning some statements may be more relevant than others.

Part B: General questions about care and support planning

I can see the value of patients being prepared in advance of care and support planning (by sending test results and agenda setting sheets)

Not at all **Somewhat** **Completely**

0 1 2 3 4 5 6 7 8 9 10

How "challenging " do you feel the care and support planning conversation/discussion is going to be?

Not at all **Somewhat** **Extremely**

0	1	2	3	4	5	6	7	8	9	10

How easy will it be to signpost people to support in the local area for the issues they identify?

Not at all **Somewhat** **Very Easy**

0	1	2	3	4	5	6	7	8	9	10

Part C: Detailed questions about care and support planning

For each statement please select an answer that best suits your experience.

Making sense of things

Section C1		Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
1.	I can see how care and support planning will differ from the usual way of working	○	○	○	○	○	○
2.	Staff in this practice have a shared understanding of the purpose of care and support planning	○	○	○	○	○	○
3.	I understand how care and support planning will affect the nature of my own work	○	○	○	○	○	○
4.	I can see the potential value of care and support planning for my work	○	○	○	○	○	○

What are the main differences you anticipate in this way of working compared to how things work now?

What do you feel is the main purpose ?

For each statement please select an answer that best suits your experience.

Becoming involved

Section C2		Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
1.	There are key people who will drive care and support planning forward and get others involved	○	○	○	○	○	○
2.	I believe that participating in care and support planning will be a legitimate part of my role	○	○	○	○	○	○
3.	I will be open to working with colleagues in new ways to use care and support planning	○	○	○	○	○	○
4.	I will support care and support planning	○	○	○	○	○	○

I can see the value of patients being prepared in advance of care and support planning (by sending test results and agenda setting sheets)

Not at all					Somewhat					Completely
0	1	2	3	4	5	6	7	8	9	10

How "challenging " do you feel the care and support planning conversation/discussion is going to be?

Not at all					Somewhat					Extremely
0	1	2	3	4	5	6	7	8	9	10

How easy will it be to signpost people to support in the local area for the issues they identify?

Not at all					Somewhat					Very Easy
0	1	2	3	4	5	6	7	8	9	10

Part D: House of Care Training – I attended the House of Care Training (please circle)	Yes	No

Yes, I attended the House of Care Training and I feel confident in my ability to support CSP within my practice

Not at all **Somewhat** **Completely**

0 1 2 3 4 5 6 7 8 9 10

No, I did not attend the House of Care training, but I feel well supported by my practice to support CSP within my practice

Not at all **Somewhat** **Extremely**

0 1 2 3 4 5 6 7 8 9 10

If you will be delivering CSP with patients, please answer the following questions:

I feel confident in my knowledge and skills to have a CSP conversation with my patients

Not at all **Somewhat** **Completely**

0 1 2 3 4 5 6 7 8 9 10

I feel confident in my knowledge and skills to support patients with 'goal setting' and developing 'action plans'

Not at all **Somewhat** **Extremely**

0 1 2 3 4 5 6 7 8 9 10

I feel confident in my knowledge of community services and assets to signpost patients accordingly

Not at all **Somewhat** **Very Easy**

0 1 2 3 4 5 6 7 8 9 10

SURVEY CONCLUSION

Thank you for completing our survey.

Appendix 3

NHS Grampian

Care, Support & Planning Consultation (CSPC-1)
Identifying my skills and areas for development

YEAR OF CARE PARTNERSHIPS

Practice Name

.....

Now that you have completed the Care and Support Planning Training we would like you to reflect on your skills and level of confidence to carry out care and support planning in your consultations.

We will ask you to repeat this exercise from time to time to ensure you are making the improvements you had hoped for and to identify any areas that you would like additional training or support with.

All responses are anonymous and data will be kept in a password protected folder that only the project team will have access to and will conform to General Data Protection Regulation (GDPR) (Regulation (EU) 2016/679).

	How confident are you that you can:	Please circle (1 is 'not confident at all' and 10 is very confident')									
1.	Describe the purpose of a care and support planning consultation?	1	2	3	4	5	6	7	8	9	10
2.	Work with the person to develop an agreed agenda?	1	2	3	4	5	6	7	8	9	10
3.	Elicit the person's knowledge and beliefs about their condition?	1	2	3	4	5	6	7	8	9	10
4.	Elicit the person's main concerns and priorities?	1	2	3	4	5	6	7	8	9	10
5.	Explore and elicit the person's goals?	1	2	3	4	5	6	7	8	9	10
6.	Facilitate the person to develop their own action plan?	1	2	3	4	5	6	7	8	9	10
7.	Explore the person's barriers to achieving their goal and their own personally relevant solutions?	1	2	3	4	5	6	7	8	9	10
8.	Develop a positive working relationship (rapport) with the person?	1	2	3	4	5	6	7	8	9	10

9.	Check out with the person how they feel your conversation is going particularly when you think it might not be going well?		1	2	3	4	5	6	7	8	9	10
10.	Tell when you are trying to persuade the person to do what you think is the right thing?		1	2	3	4	5	6	7	8	9	10
11.	Allow the person to take the lead in the consultation		1	2	3	4	5	6	7	8	9	10
12.	Express your concerns or challenge the person in a way that maintains your relationship and their autonomy?		1	2	3	4	5	6	7	8	9	10

In this exercise you might want to reflect briefly on your core consultation skills

My micro skills										
I have a good range of open questions to use in consultations										
Disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Agree
I can confidently use simple and complex reflections										
Disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Agree
I can demonstrate understanding and empathy using reflections										
Disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Agree
I can use scaling questions to explore importance and confidence										
Disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Agree

For a moment, in order to help you focus could you think a little bit about the areas where you scored yourself at less than 7? Which skills would you consider to be most important to focus upon?

What might need to happen to help you to increase your score?

Are there others ways to improve your skills and confidence in using these skills flexibly?

*(adapted from Neenan 2009)

Appendix 4

HoC Interim Report

(Interviews to include GPs and Practice managers as appropriate)

Background

House of Care is characterised by the delivery of person centred care through collaborative 'care and support planning' conversations between health care professionals and patients. NHS Grampian recruited GP practices to trial 'this new way of working'. GP Practices recruited in Cohort 1 have now been delivering Care and Support Planning with identified patient groups for 6 months.

Evaluation Question

The aim of this interim report is to identify what, if any, changes, barriers or facilitators practice staff may have encountered whilst implementing' care and support planning over the last 6 months within normal practice.

Introduction

Introduce yourself....

The purpose of our interview today is to get your perceptions of how you feel the implementation of HoC has gone in the last 6 months, to give you a chance to describe the processes you have implemented within your practice, to share with us what has worked well and why and also to describe any problems you may have encountered and why they may have occurred. Your perceptions are what matter. There are no right or wrong or desirable or undesirable answers. I would like you to feel comfortable saying what you really think and how you really feel.

As previously mentioned I would like to audio record our interview, the purpose of this is not to identify you but to enable us to transcribe the interviews so we can identify any key themes which may arise. I have a consent form here for you to sign. On the form you will note that all recordings will be handled as per ***General Data Protection Regulation*** *(****GDPR****). All files will be anonymised, encrypted and stored securely with access restricted to the HoC research team.*

Appendix 4

Interview Topic Guide

"Understand the experience of supporting the delivery of and delivering person centred care through collaborative 'care and support planning' conversations between health care professionals and patients"

Introductory Questions

1. Tell me about your experience of being involved in the delivery of HoC - care and support planning?
2. How has this model differed to what your practice delivered previously?
3. What is your impression of the HoC model so far?
4. How do you think patients have found this new way of practice?

Positives of working in this way/Enablers

5. What has worked well in the delivery of HoC?
6. Was there anything that helped to make this new way of working successful?
7. What have you/are the (enjoyed-benefits-positives) about this way of working?
8. Were these positives common for all staff at the practice?

Negatives of working in this way/Barriers

9. What have been the (biggest) challenges to this new way of working?
10. How did you try and overcome these? Was this successful?
11. Were there any barriers that stopped you overcoming these challenges?
12. Did practice staff face different types of challenges?

Considerations for future GP practices

13. If a new GP practice were to enrol to deliver HoC (care and support planning), what advice would you give them to work in this new way?
14. What resources do you think are needed to successfully implement HoC in practices?
15. What qualities do practice staff need to successfully deliver HoC in practices?
16. In what way do you think the HoC training could be improved to support HoC delivery in Grampian?
17. If you were to start HoC (care and support planning) delivery again, what would you do differently?
18. Is there anything else you would like to tell me about your experience of implementing HoC (care and support planning) at your practice?

When discussing staff, this would include all levels – e.g. PM, GP, PN, Admin

Evaluation of the House of Care in Grampian

As part of the evaluation of the delivery of House of Care in Grampian you are invited to take part in face-to face discussions where you will be asked your views and experiences on delivering House of Care in your practice.

Information collected by the research team will be handled as per **General Data Protection Regulation** (**GDPR**). All files will be anonymised, encrypted and stored securely with access restricted to the House of Care research team.

Your participation is entirely voluntary. You have the right to change your mind about taking part at any time.

Please indicate whether you are willing to take part in an audio taped discussion by initialling the appropriate boxes below.

	Please **initial** each box you agree with.
I have read the paragraph above and have had the opportunity to ask questions. **I agree** to take part in discussions about the delivery of House of Care in my practice.	
I give permission for the discussions to be audio taped.	
I understand that my participation is voluntary and that I am free to withdraw at any time.	

Name: …… **Job title:** ……..…..

Signature: …… **Date:** ……..

Interviewer: …… **Date of interview:....**……..

Appendix 5

	Poor	Fair	Good	Very Good	Excellent	Does Not Apply
Letting you tell your "story"…… *(giving you time to fully describe your illness in your own words; not interrupting or diverting you)*	☐	☐	☐	☐	☐	☐
Fully understanding your concerns…… *(communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything)*	☐	☐	☐	☐	☐	☐
Showing care and compassion…. *(seeming genuinely concerned, connecting with you on a human level; not being indifferent or "detached")*	☐	☐	☐	☐	☐	☐
Explaining things clearly…….. *(fully answering your questions, explaining clearly, giving you adequate information; not being vague)*	☐	☐	☐	☐	☐	☐
Helping you to take control…… *(exploring with you what you can do to improve your health yourself; encouraging rather than "lecturing" you)*	☐	☐	☐	☐	☐	☐
Making a plan of action with you with agreed 'goals' *(discussing the options, involving you in decisions as much as you want to be involved; not ignoring your views)*	☐	☐	☐	☐	☐	☐

	Not at all useful	Not very useful	Somewhat useful	Very Useful	Did not read
How useful was the letter you received with your test results in helping you to prepare for the care and support planning conversation?	☐	☐	☐	☐	☐

	Yes	No
During your care planning conversation today, did you discuss services and supports based in your local community (for example, support groups, or patient organisations)?	☐	☐

	Much better	Better	Same or less	Not applicable
Able to cope with life…	☐	☐	☐	☐
Able to understand your condition(s)…	☐	☐	☐	☐
Able to cope with your condition(s)…	☐	☐	☐	☐
Able to keep yourself healthy…	☐	☐	☐	☐
	Much more	**More**	**Same or less**	**Not applicable**
Confident about your health….	☐	☐	☐	☐

Able to help yourself….	☐	☐	☐	☐

As a result of your consultation today, do you feel you are *(please tick one box in each row)*