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The HOUSE Journal

The newsletter for the Year of Care Community of Practice

Scotland's House of Care

Scotland's House of Care special edition

Welcome to The HOUSE Journal – guest editor Dr Graham Kramer

Chronic disease management, as it used to be called, had become a rather dissatisfying experience for both people and their healthcare professionals. An exercise of squeezing the multiple-shaped pegs of people's lives though the square holes of incentivised medical targets.

In Scotland, we were impressed by the work of Year of Care Partnerships. Specifically, it offered a practical way to provide good quality medical care alongside supportive and enabling personalised clinical practice. It grounded the rhetoric of person centred and self-management support policy into the conversations taking place in consulting rooms. In 2015 we made a bold decision to begin the adoption of care and support planning (CSP) in Scottish general practice. We set up Scotland's House of Care programme under a unique cross border partnership between Scottish Government, The ALLIANCE, Year of Care and the British Heart Foundation.

In spring of this year at the height of the pandemic the programme came to an end. This copy of The House Journal is dedicated to the work Year of Care and Scotland's House of Care community has done in Scotland. We hear from Dr Sue Arnott, GP and Alison Fox, practice manager on the impact it had for them in Lanarkshire and Edinburgh. We also hear from Dr Paul Baughan at the start of the CSP journey for his practice.

For me, having been involved as clinical lead it has been a deeply engaging privilege. Throughout my career as a GP there has been the unobtainable promise of a different paradigm. First articulated by George Engel and his biopsychosocial model in 1977, extended by Ed Wagner and his chronic care model in the 1980s and now further described by "Realistic Medicine". Shifting to a new paradigm is near impossible, especially when working against the prevailing forces of the established system during an existential crisis in healthcare.

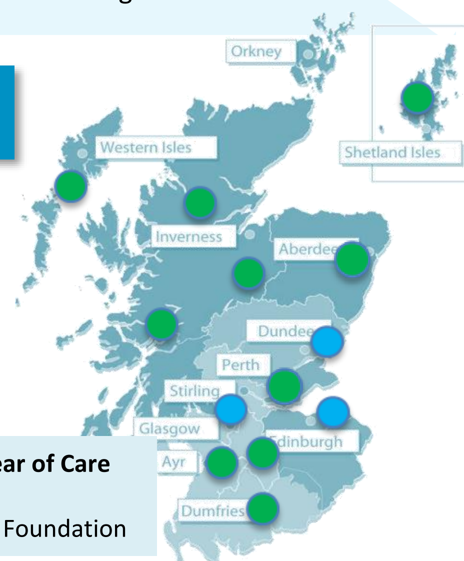
However, I truly believe that shift is taking place and unstoppable. Few talk about the care of people with long term conditions in Scotland without mention of CSP and the House of Care. This has been down to the shared and uplifting values, enthusiasm, and dedication of so many people, too numerous to name: programme managers, both national and across the regions; trainers; GPs; practice nurses; HCSWs; admin and reception teams; pharmacists; AHPs; links workers; policy makers; specialists; researchers; evaluators; The ALLIANCE and third sector organisations; communities and individuals living with long term conditions.

Whilst the formal program comes to a close, I have no doubt the principles and practice of CSP and the House of Care model will continue to flourish to become the new established system. Scotland's doors and arms will remain always open to Year of Care Partnerships and its inspiring team of innovators and trainers, and Scotland's House of Care community will continue to grow.

Year of Care training in Scotland

Across Scotland approximately 15% of practices are now adopting care and support planning as their usual way to deliver care for people with long term conditions. Whilst the overall sponsorship of the programme by Scottish Government has ended, the potential to spread this way of working still remains.

Site-based trainers and facilitators within Scotland are able to support their local area and Year of Care Partnerships continue to offer our core training and support package to any practice, GP cluster or health board to set-up and deliver the approach.



Sites in Scotland trained by Year of Care

Green	**Blue**
LTC and diabetes	British Heart Foundation

Scotland's House of Care celebration event – 17th August 2021

This event held on 17th Aug 2021 marked the closure of Scotland's House of Care Programme and was an opportunity to celebrate, reflect and learn from what had been achieved. It brought together many members of Scotland's House of Care community who had helped pioneer care and support planning.

There is a short summary of the event and a recording available here: https://bit.ly/3kXla2o

As part of the event we heard from George, a person with long term conditions, and Rebecca, a nurse in MacDuff, about their recent care and support planning conversation.

See their video here: https://bit.ly/2ZcdMI2

Stories from the Scottish front line

During the celebration event mentioned above we heard from some colleagues in primary care about their experience of House of Care. They shared their thoughts and learning and we have captured some of these in the following sections.

Dr Sue Arnott

Alison Fox

Dr Paul Baughan

What benefits has CSP brought to the practice? Dr Sue Arnott

"We had heard of House of Care and were looking at models to support our primary care transformation programme for the GMS 2018 contract. We were keen to instil a cultural shift in the way we delivered long term condition care, moving away from treating people as a series of diseases to a more holistic and person-centred approach.

I've now worked in two practices that have implemented the approach and am about to work in a third; it's fair to say they all come at it from a slightly different place. We've never gone down the contractual route, it has been more about winning hearts and minds – tapping into the dissatisfaction that many clinicians feel about the QOF approach, and we now have over a quarter of general practice teams in Lanarkshire signed up.

In general we have found this to be a more satisfying way of working and it put us in a good position to continue to deliver person centred care for people with long term conditions during the pandemic.

Separating out tasks and tests from the care and support planning conversation creates time to talk for patients and professionals - unfussed and not distracted by computer templates. The assessments are coordinated during one visit and the conversation is then held remotely - the benefit of existing relationships creates continuity for the patient.

This approach has also created a way to integrate links workers and strengthened the value of more than medicine approaches – it's been a really good way of joining up these elements of care. We've included colleagues in new roles in training (e.g. pharmacists) so they see the difference in the conversation. Colleagues in specialist services have also begun using this model and our aim is that patients experience a consistent approach as they transition between services.

There are some critical success factors when you implement the programme. This work needs to be endorsed at corporate level but often straddles several workstreams so it may not be helpful to put it within one area of transformation. It has strong links to a range of policies and programmes and these need to be made apparent to both strategic teams and practices alike. You need champions, early adopters and a strong practice leader who is the anchor for the whole team.

I remain excited and confident about the House of Care model and I see it as something we can build on as our preferred model of care as we remobilise within Lanarkshire."

Sue Arnott – GP, Burnbrae Medical Practice and clinical lead for House of Care NHS Lanarkshire

If you would like to read more about CSP at Burnbrae Medical Practice take a look at this case study.

What benefits has CSP brought to the practice? Alison Fox

"We were lucky to be one of the first wave practices in Scotland implementing the House of Care approach and it has been up and running in the practice since 2015. For us it was a leap of faith at the start, but it's now an established part of our practice and we're delighted with how it works and how adaptable it has been.

Post-QOF we wanted to move to a more person-centred approach that fit the sentiment of Realistic Medicine. Whilst we liked the structure of the QOF approach we felt we were recalling people for their separate conditions and offering uncoordinated care that focused on the individual disease rather than the person.

CSP gave us a method and structure for disease and medicines monitoring whilst bringing back focus to what matters to the patient. We also saw this as an opportunity to move away from a "one size fits all" approach which didn't work well and focus more time on our most vulnerable patients.

It's important that everyone understands the benefits to both the practice and patients, also that this is a team approach and everyone has a role to play. QOF was often seen as something the practice nurses did in isolation but this has had a positive impact on team building and cohesion.

We embedded the approach pre-pandemic and the ethos stood us in good stead throughout. It has also given us structure as we move forward out of the pandemic. It aligns well with the new roles in primary care and the 'more than medicine' focus offers opportunities to work with our link workers.

I'm passionate about the approach – it works for us and our patients – the feedback has been hugely positive."

Alison Fox - Practice Manager, St Triduana's Medical Practice, NHS Lothian

If you would like to read more about CSP at St Triduana's Medical Practice take a look at this case study.

Embarking on House of Care - what's involved? Dr Paul Baughan

"Our practice has just started to implement CSP. We have always had a good tradition of trying out new ways of working, however sometimes this has been a little ad-hoc or uncoordinated, making it difficult to know if any changes we make actually result in improved care. We are therefore now using a 'Value Management' approach to evaluate the CSP work, and are collecting data and information as we begin this process.

We were tempted to simply adopt the various 'Year of Care' resources and just jump in by sending these letters to patients. This could have been a quick way of getting back on track with our chronic disease management which has stalled during the pandemic. However, we decided to take a step back, and invest time in planning this change carefully.

We met as a whole practice team to do a process mapping activity, supported by Year of Care, which allowed us to see just how complex a task it was to undertake chronic disease management reviews - work that had previously been allocated to nurses with little input from other team members. It became evident that this activity was uncoordinated, inefficient from an administrative point of view, but most importantly inflexible and impersonal for many of our patients – it was often about our agenda and at a time that was convenient to us.

The Year of Care team delivered and facilitated a series of virtual training sessions, sharing resources and expertise, and we were able to develop our practice approach to the care of people living with long term health conditions.

It's so much more than a multiple disease-based annual review. We have changed how we invite people for an annual review, no longer defining people simply by their medical condition, but taking a more holistic and person-centred approach. Most importantly we want to ensure we support conversations which keep people and what matters to them at the centre.

With this in mind we have involved patients in the planning of this change and have developed written and video communication to inform people of this new way of working. We are seeking feedback from patients and staff about their experiences as we go along, as well as collecting other data on the uptake of appointments, workload and certain disease-specific outcomes. We are confident that this new way of conducting annual health reviews will transform the way that people receive their care, and we should soon have the data to back this up."

Paul Baughan – GP, Dollar Health Centre and National Clinical Advisor for Ageing and Health

Kirsteen Coady - What training and support do nurses need to fully embrace the principles and practice of CSP?

Care and support planning (CSP) may seem daunting to nurses who are seeking to deliver this person-centred model of care for those living with long-term conditions, particularly when it is applied as a single CSP process for all the conditions that people live with.

Attending formal Year of Care training sessions on CSP undoubtedly sets the scene and grounds a common understanding of the approach. In our practice we have complemented formal training with interdisciplinary learning to enhance practice by sharing our experiences.

I have found that confidence in adopting CSP is maximised if nurses shadow those who have experience in CSP and then in turn are observed in practice and given feedback. It is also reassuring to nurses if there is support and supervision in the practice should any problems arise.

For nurses who are used to single disease reviews common fears are "I don't do diabetes..." or "I'm an asthma nurse – I'm not very confident...". This was the case in my own practice as one of my nurse colleagues felt underconfident in delivering CSP as her expertise lay in respiratory conditions. However with the right training and support she embraced CSP with gusto for those with any long-term condition and has great satisfaction as a result, feeling that she "makes a difference". NHS Education for Scotland (NES) have planned long term condition courses to support nurses which will also help confidence.

As a results handler in my own practice I write my observations in an entry on the individual's clinical notes which also increases confidence in those who are less experienced when delivering CSP, and increases patient safety within the practice.

In Scotland all student nurses on the NES Practice Nursing programme complete formal training in CSP which is currently delivered via Microsoft Teams. This ensures that moving forward, all novice practice nurses have studied a module on CSP, have knowledge of the core principles and an awareness of how this can be actualised within their own practice. The sessions are interactive and experiences are shared to enhance interdisciplinary learning.

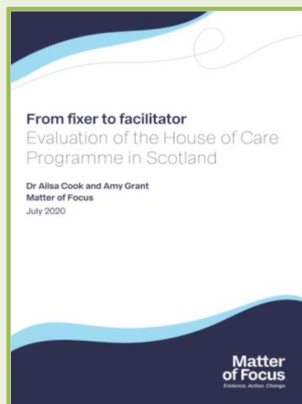
Preliminary talks are being planned for a module on CSP to be available to all nurses online which seems to be the way forward to support nurses at any stage in their career.

In summary, for nurses to fully embrace the principles of CSP support is needed. Education and practical support such as shadowing, robust triage of results and feedback on CSP consultations seem crucial elements in maximising nurse confidence in delivering CSP for any individual with any condition.

Each general practice is unique and will have different systems but if support for the CSP process is in place it can drive confidence to become a reality; ultimately benefitting those with long-term conditions to self-manage within our communities.

Kirsteen Coady - Queen's Nurse, NHS Education for Scotland Educational Advisor and Supervisor for GPNs, NHSG Trainer for House of Care and Nurse Consultant

Matter of Focus report – From Fixer to Facilitator



In 2019-20 Matter of Focus worked with eleven health boards in Scotland alongside Scottish government, Social Care Alliance Scotland and Year of Care to gather and assimilate evidence from sites that had implemented the House of Care model. The report 'From Fixer to Facilitator' concluded that House of Care had been successfully implemented and "people with LTCs were leading better lives" as a result.

It highlighted 3 key factors that contributed to this success:

1. Leadership and facilitation to support implementation
2. High quality training and facilitation
3. Ongoing support to practices

Improved outcomes:

- People with long term conditions enjoyed the approach and felt more prepared and empowered.
- Professionals felt more confident in engaging with people with long term conditions around setting goals.
- People reported they were able to take control and keep themselves healthy compared to more traditional consultations.
- Evidence that practices continue to embed the approach so it becomes the normal way of care.
- Some evidence that House of Care is mitigating health inequalities but further work to investigate this is necessary.

See the full Matter of Focus report here https://bit.ly/2ZfvMkN.