House of Care
Care and Support Planning

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- British Heart Foundation House of Care Programme
- Arthritis Research UK's work on Care Planning
- Table discussion on implementation of care and support planning in practices.

What matters to you?

Ask what matters
Listen to what matters
Do what matters

'What matters to you?' day
Monday 6 June 2016

What is 'What matters to you?' Day?

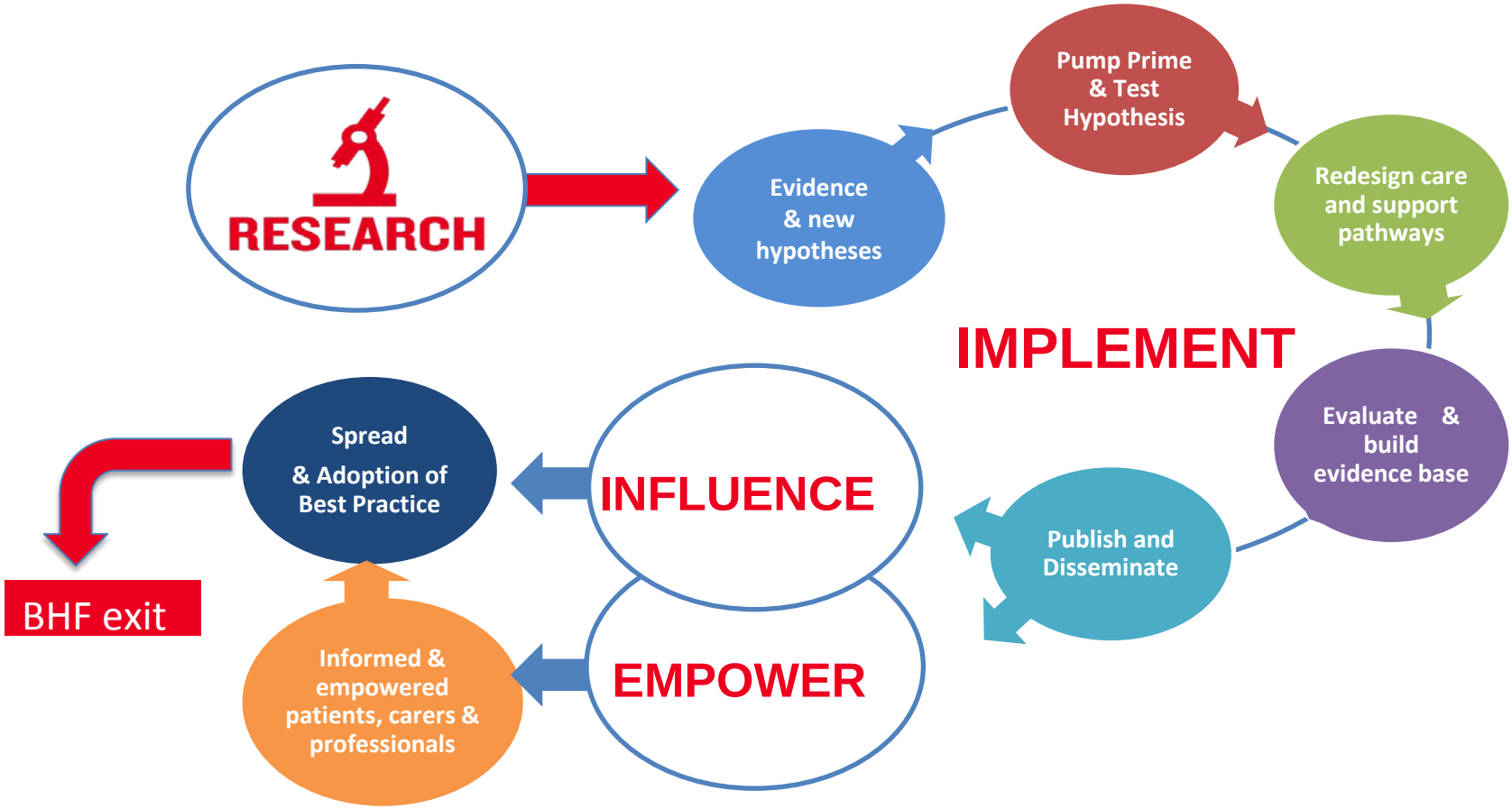
'What matters to you?' day started in Norway in 2014 with the aim of encouraging and supporting more meaningful conversations between people who provide health and social care and the people, families and carers who receive health and social care.

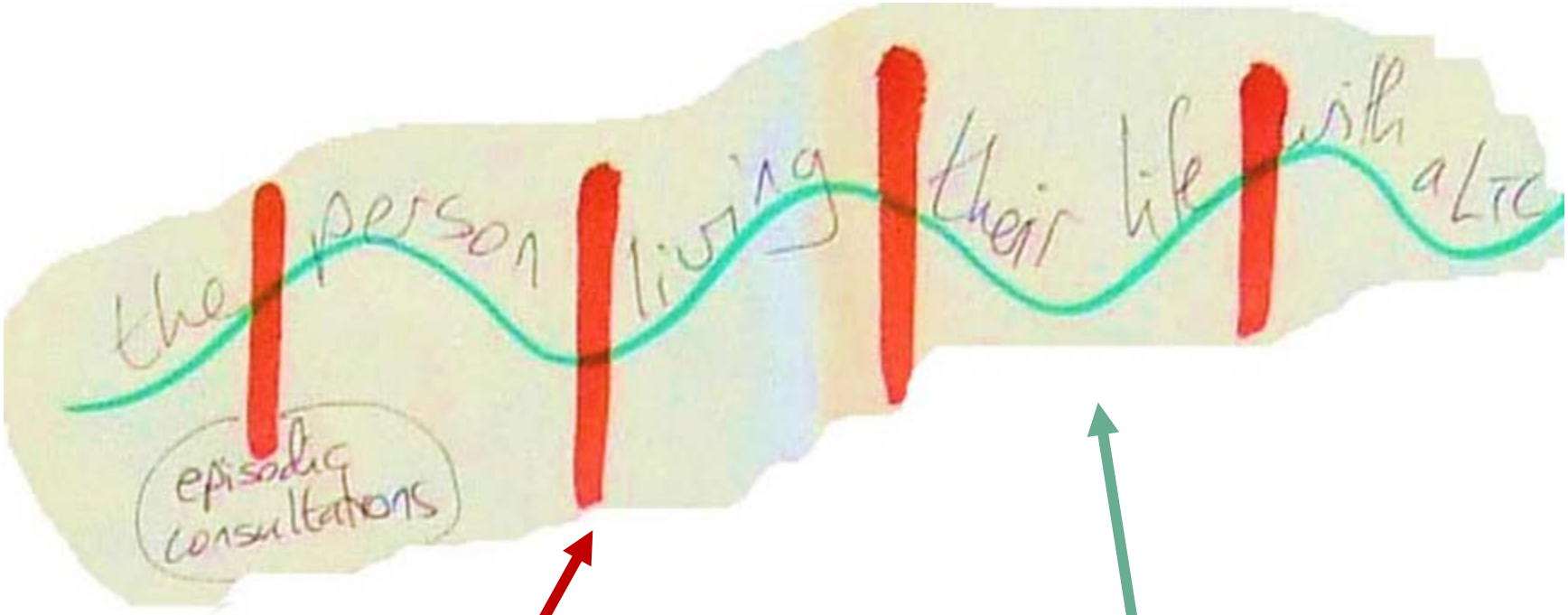
House of Care

- A framework to implement person centred care and support planning
- Supports a care and support planning conversation between an informed patient and healthcare professional in partnership
- Asks “what matters to you?”
- Encourages/supports self-management
- Outcomes can be clinical and social
- Integrates health and social care.

Ensure that everyone in the UK with CVD has access to high-quality, integrated health and social care services

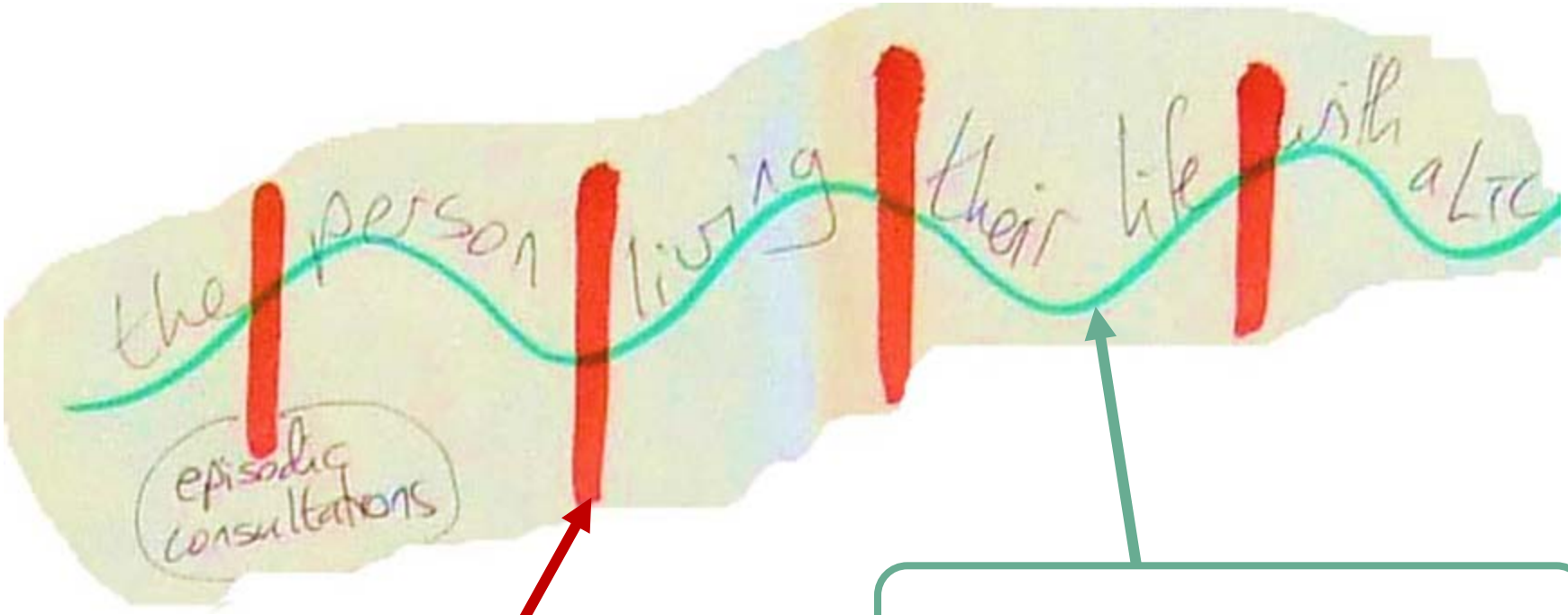
Implementation in Practice: the BHF approach





Hours with NHS professional = 3 in a year

Self care / management = 8757 in a year



More meaningful conversations

Support for self -management

NHS Five Year Forward View, 2014

“people wish to be more informed and involved with their own care, challenging the traditional divide between patients and professionals, and offering opportunities for better health through increased prevention and supported self-care”.

Scotland’s Chief Medical Officer’s Annual Report 2014-15

“People and professionals combining their expertise”.

The King's Fund
Ideas that change health care

Authors
Angela Coulter
Sue Roberts
Anna Dixon

October 2013

Delivering better services for people with long-term conditions

Building the house of care

Key messages

- The management of care for people with long-term conditions should be proactive, holistic, preventive and patient-centred. This report describes a co-ordinated service delivery model – the 'house of care' – that incorporates learning from a number of sites in England that have been working to achieve these goals.
- The house of care model differs from others in two important ways: it encompasses all people with long-term conditions, not just those with a single disease or in high-risk groups; and it assumes an active role for patients, with collaborative personalised care planning at its heart. Implementing the model requires health care professionals to abandon traditional ways of thinking and behaving, where they see themselves as the primary decision-makers, and instead shifting to a partnership model in which patients play an active part in determining their own care and support needs

People with long-term conditions work with clinicians to elicit their capacities, determine their specific needs and express informed preferences"

Programme Aims

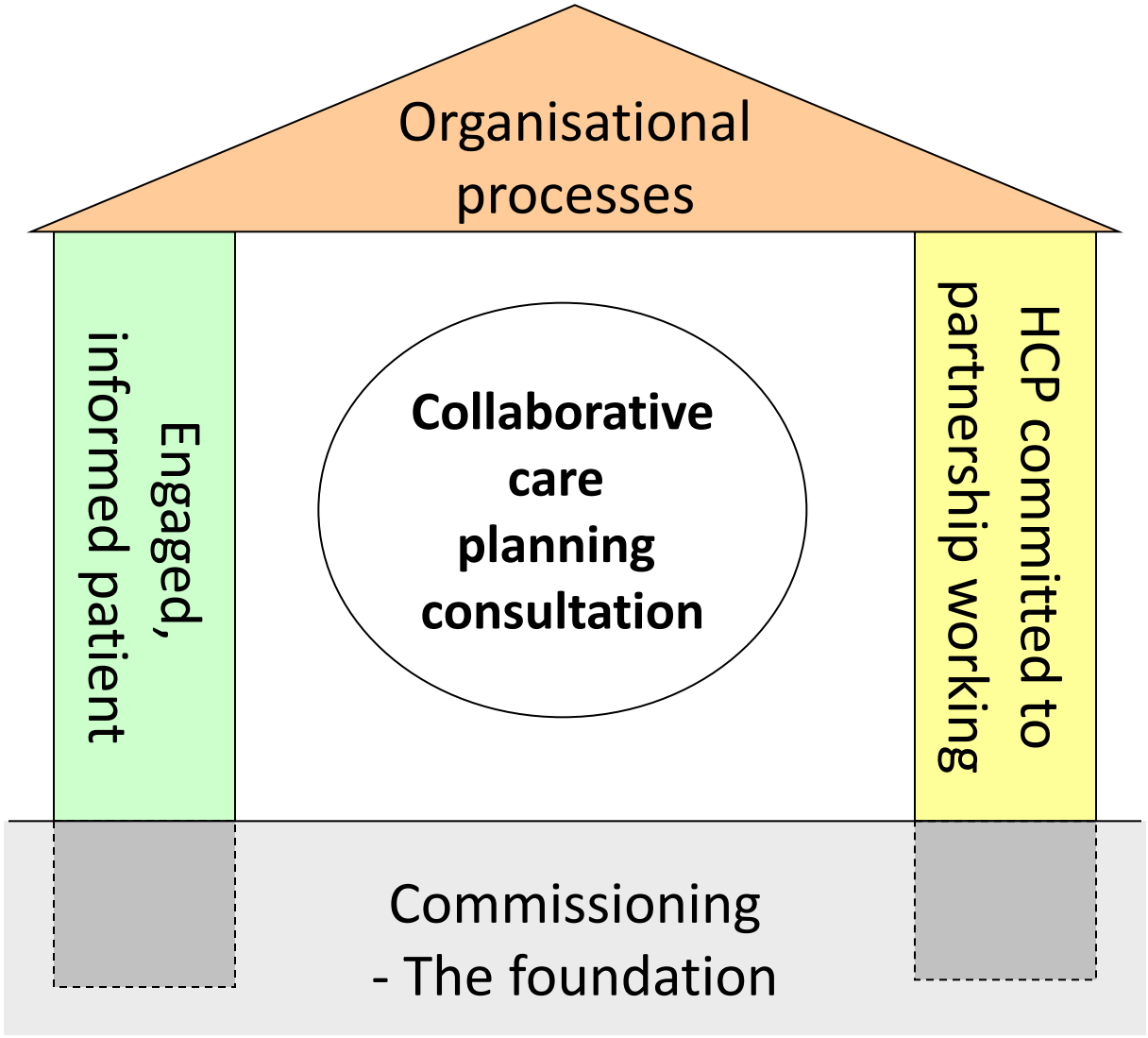
The three main aims of the programme focus on people with CVD recognizing that many will also have other co morbidities:

1. To introduce collaborative care and support planning as routine care, mainly within primary care, and develop a holistic review in place of the current tick box surveillance activities encouraged by QOF.

2. To redesign local pathways for cardiovascular disease services, driven by care and support planning.

3. To develop engagement with a wider range of activities to support self-management within the community, including the third sector.

What is the House of Care and how does it support a collaborative care and support planning conversation?

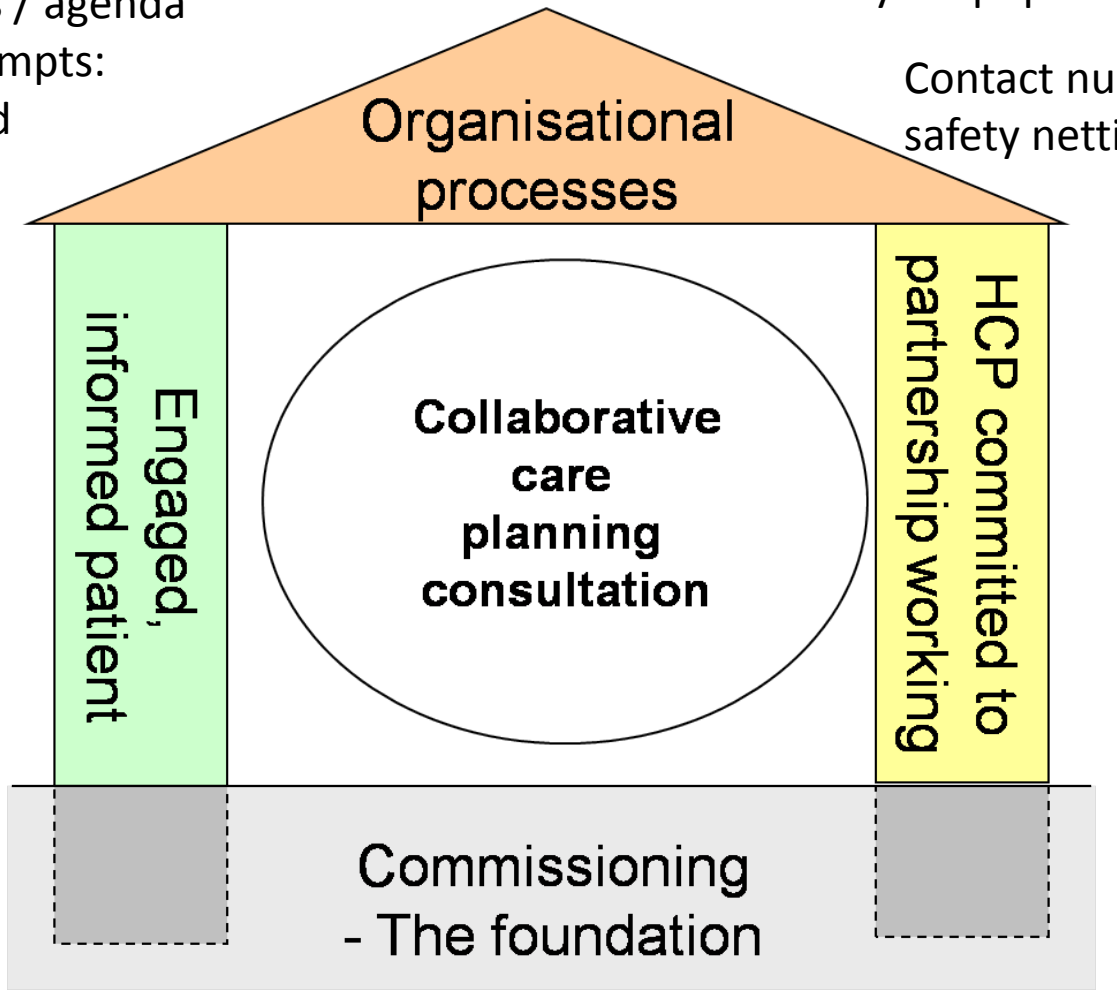

Organisational processes
Engaged, informed patient
Collaborative care planning consultation
HCP committed to partnership working
Commissioning - The foundation

IT: clinical record of care planning

Test results / agenda setting prompts: beforehand

Know your population

Contact numbers and safety netting



'Prepared' for Consultation

Information/ Structured education

Emotional & psychological support

Consultation skills / attitudes

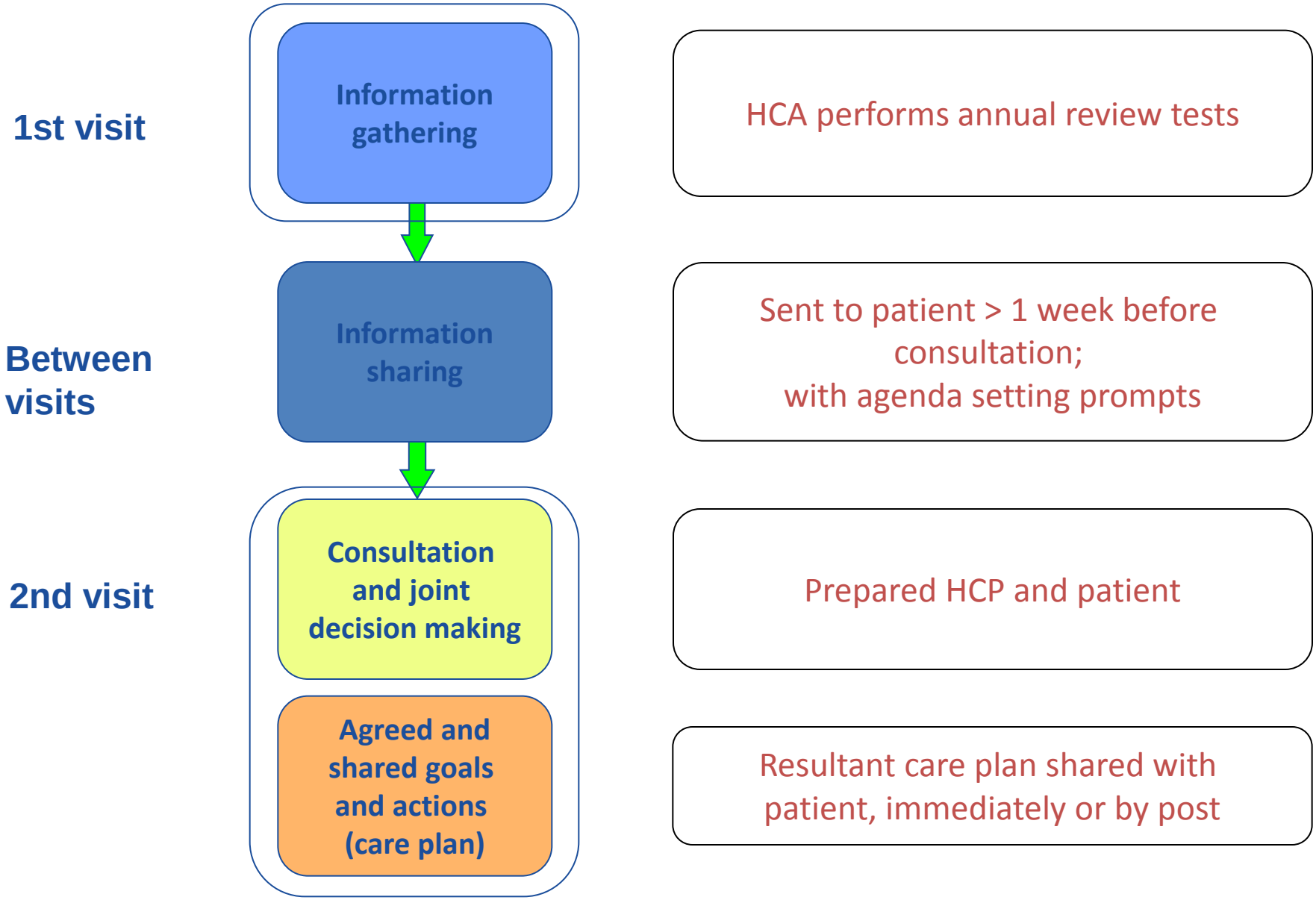
Integrated, multi-disciplinary team & expertise

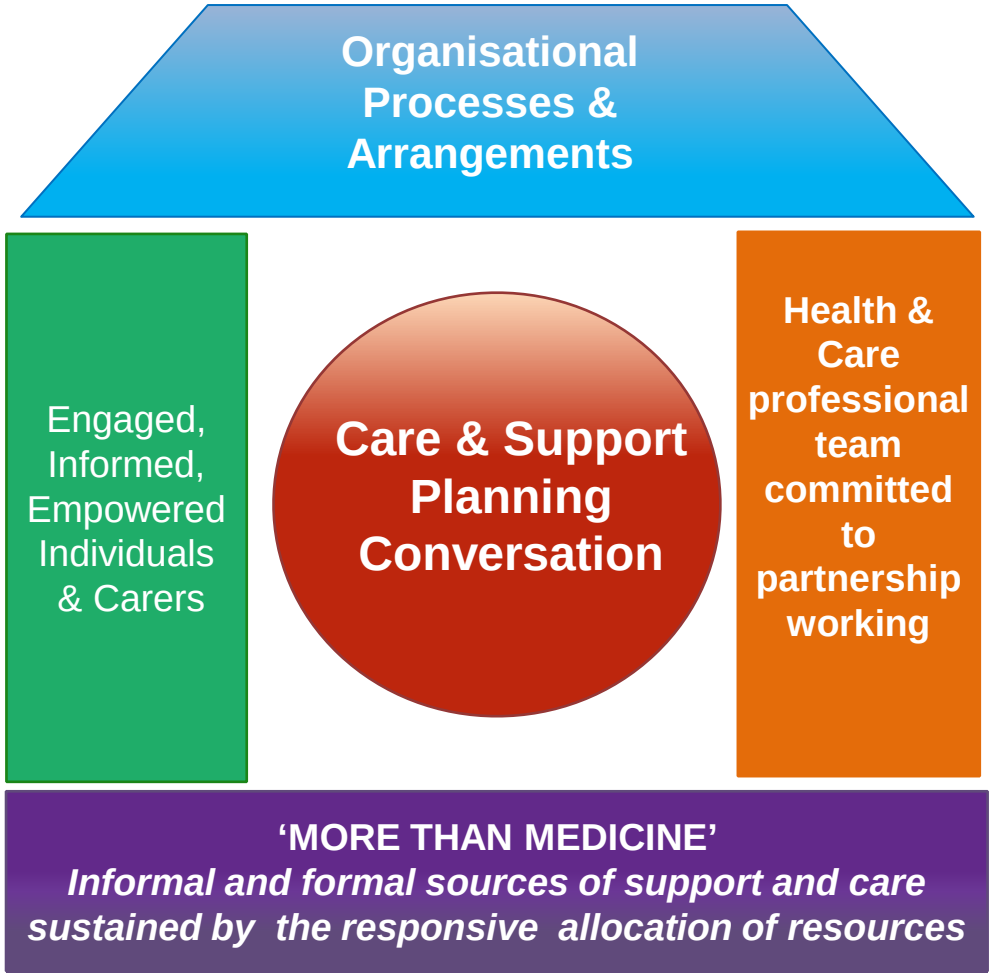
Senior buy-in & local champions to support & role model

Commissioning the menu (including Non Traditional Providers)

Commissioning care planning

Metrics and monitoring


1st visit
Information gathering
HCA performs annual review tests
Between visits
Information sharing
Sent to patient > 1 week before consultation;
with agenda setting prompts
2nd visit
Consultation and joint decision making
Prepared HCP and patient
Agreed and shared goals and actions (care plan)
Resultant care plan shared with patient, immediately or by post


Organisational Processes & Arrangements
Engaged, Informed, Empowered Individuals & Carers
Care & Support Planning Conversation
Health & Care professional team committed to partnership working
'MORE THAN MEDICINE'
Informal and formal sources of support and care sustained by the responsive allocation of resources

Care and support planning benefits

- Links clinical care with support for self-management
- Signposts and links people to community resources / ‘social prescribing’
- Improves co-ordination across providers (for example, with specialists, with social care and with the third sector)
- *“The [CSP] process worked best when it included, preparation, record-sharing, care co-ordination and review, involved more intensive support from health professionals, and was integrated into routine care.”*

Scotland (27+ practices)
•Greater Glasgow, Lothian, Tayside

Gateshead (32 practices)

Hardwick (16 practices)

Improve outcomes for people with CVD & LTCs:

- Implement care and support planning as routine care
- Service redesign, driven by care and support planning, and including integration of cardiovascular disease services
- Development and support for self-management services including third sector

Programme Inputs and Partnership Working

- Provision of training **and** ongoing support for implementation and embedding CSP from Year of Care Partnerships
- In partnership with the Health and Social Care Alliance Scotland and the Scottish Government.
- Support to self-evaluate (ICF International)

Current Progress

- >50 GP Practices across the five sites
- Each practice has at least two healthcare professionals who have attended YoCP House of Care training.
- 14 Local trainers/clinical champions identified to support embedding HoC locally
- Approximately 3500 CVD patients participated in care and support planning conversations
- BHF has extended the programme to 2018.

Extension

Additional funding of all sites by BHF.

- Embedding care and support planning as routine care in existing practices, with a focus on cardiovascular disease.
- Sustainability planning.
- Extending timescales for evaluation, two or more care and support planning conversations with patients.

Evaluation

- Site visits including stakeholder interviews.
- Quantitative data collection
- Local patient interviews
- LTC6 Questionnaire
- CQI2 Questionnaire
- Quality Assurance via YoCP Quality Mark
- Local facilitation and trainers

Recommendations from the second interim evaluation report: Implications for the programme

- Steering groups: critical to implementation; need ongoing support, especially as their role transitions (from set up, to implementation, to sustainability planning)
- Culture change: this is principally a culture change programme; BHF and YOCP has a role in emphasising the importance of this and sharing learning
- Poorly served groups: an area for development, needs a more explicit focus; patient engagement in programme design may be a vital to making progress
- Fidelity: striking a balance between fidelity to the model, and allowing local practices flexibility to shape the House to their contexts
- Implementation: sites are anticipating challenges (eg. time, how to engage all practice staff); how to support them to address these?

Challenges

- CVD and multi-morbidity
- Fidelity vs. flexibility, Are the CSP conversations taking place?
- Infrastructure required for “more than medicine’
- Clinician confidence in conversation.
- Capacity to train and flexible training options for established practices
- Attrition rate or DNA, requires investigation
- IT

What do patients say?

“I feel like I can ask the questions rather than just being questioned” ….

“*They were interested in how I felt” …*

“*I got a chance to ask things rather than being asked” …*

“I learned a lot”

LTC Patients, Gateshead

“Seeing it all here in front of me has given me the impetus to plan what I am going to do next (made 2 goals with specific & realistic actions). I felt able to express concerns about things I had not been able to discuss before.”

CHD Patient, Tayside.

Musculoskeletal health

- Arthritis Research UK is a national charity which invests in breakthrough treatments, the best information and vital support for everyone affected by arthritis
- Around 10 million people in the UK have a musculoskeletal condition
- There are inflammatory forms (such as rheumatoid arthritis), conditions of musculoskeletal pain (osteoarthritis, back pain) and conditions of weak bone (osteoporosis)
- These are often long-term conditions, with symptoms that fluctuate in severity: self-management is vital for people to maintain their health and wellbeing

Care planning and musculoskeletal health (2014)

Arthritis Research UK

CARE PLANNING AND MUSCULOSKELETAL HEALTH

- Prompted by concern that the musculoskeletal perspective was missing from discussions about the House of Care model

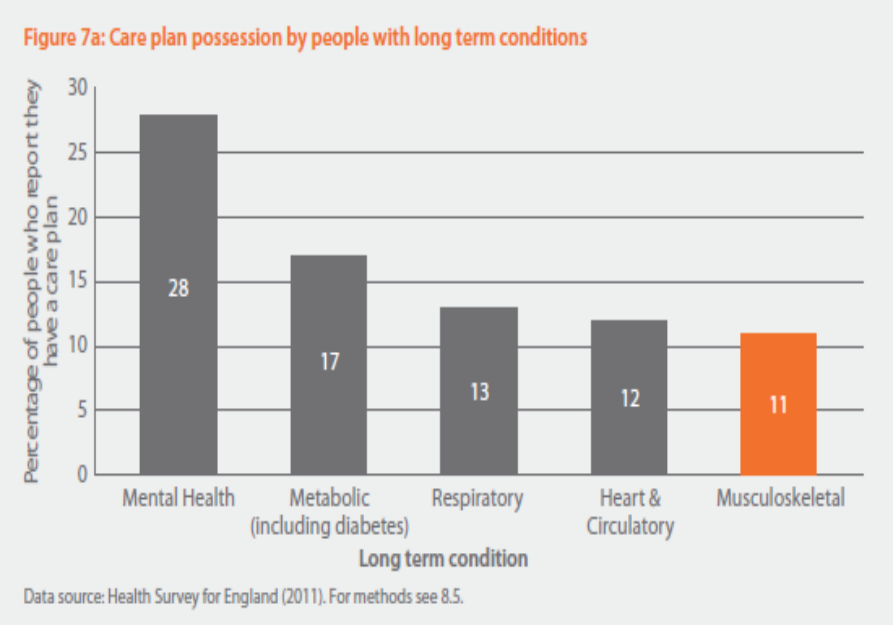
- Our policy report developed from:
  - An expert workshop
  - Desk research (including clinical guidance)
  - Survey data
  - First person experience (also HCPs)
  - Stakeholder consultation & external review

Policy findings:

Only 12% of people with a musculoskeletal condition say they have a care plan, many more could benefit

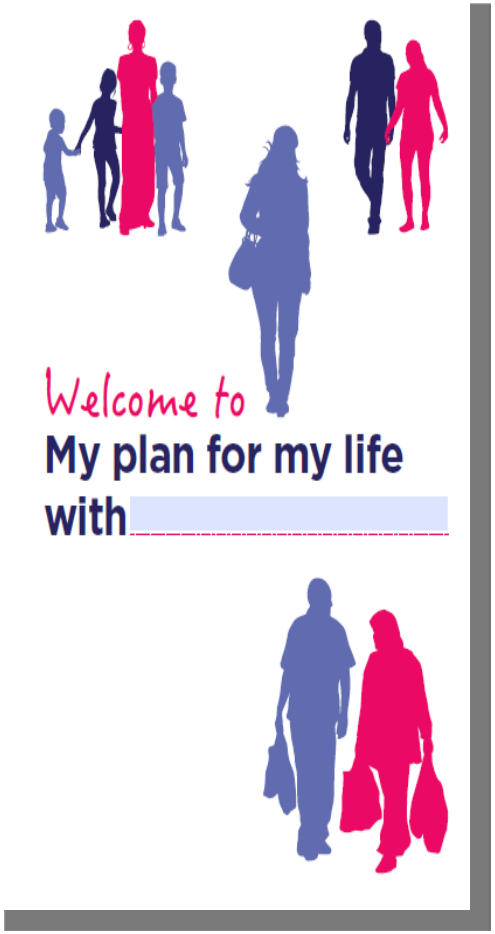
Recommendations:

1) Commissioners should make care planning available to people with musculoskeletal conditions
2) Care planning should identify and address musculoskeletal needs in people with other long-term conditions
3) HCPs involved in care planning should be trained in musculoskeletal core skills



4) Local services and facilities should be provided to help people achieve musculoskeletal health goals
5) Further evaluation of the care planning approach among people with musculoskeletal conditions
6) National data on care planning use among people with musculoskeletal conditions

Activities to support care planning: My plan for life



Developed by the Fit For Work UK coalition with several musculoskeletal sector charities

'My plan for life' is a notebook designed help people think about what matters most to them, in relation to their musculoskeletal health and what they want from their care

Supports effective care planning by enabling people to think, and ask the questions, about what matters most to them

Widely distributed and on-line

Feasibility study for care planning and musculoskeletal conditions

- Arthritis Research UK is supporting a feasibility study, starting in 2017
- Developed in collaboration with the Year of Care Partnership Programme (YOCP)
- It will bring together and coordinate expertise and resources already developed within the musculoskeletal, primary care and Year of Care communities
- The study will develop and test the practical processes, skills, systems and tools needed to embed collaborative care and support planning as normal care within general practice for people living with a musculoskeletal conditions or with musculoskeletal conditions as part of multi-morbidity
- It will also demonstrate how this approach links with specialist care and community support

Feasibility study phases and outputs

Phase 1 (9 months): Three general practices with different demographic and organisational characteristics will identify the specific issues and develop solutions required to introduce high quality care planning for musculoskeletal conditions.

Phase 2 (12 months): These solutions will be tested across practices in a wider health community to ensure they are applicable to whole geographical populations in real world situations.

Outputs: By the end of the project there will be detailed guidance for commissioners and primary care teams on the attitudes, knowledge, skills, infrastructure, resources and approaches to implementation to enable care planning for people living with musculoskeletal conditions to be introduced as normal care across the UK. This will support exemplars to be set up as ‘laboratories’ to address future research questions.

Questions

- What resources are needed to promote care and support planning in practice?
- What would stop you implementing the house of care in your practice/CCG?
- What has been your experience implementing care and support planning in your area?


ARTHRITIS
RESEARCH UK
Everyday freedom from
the limits of arthritis

Thank You