House of Care Evaluation: Final Report

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Executive summary

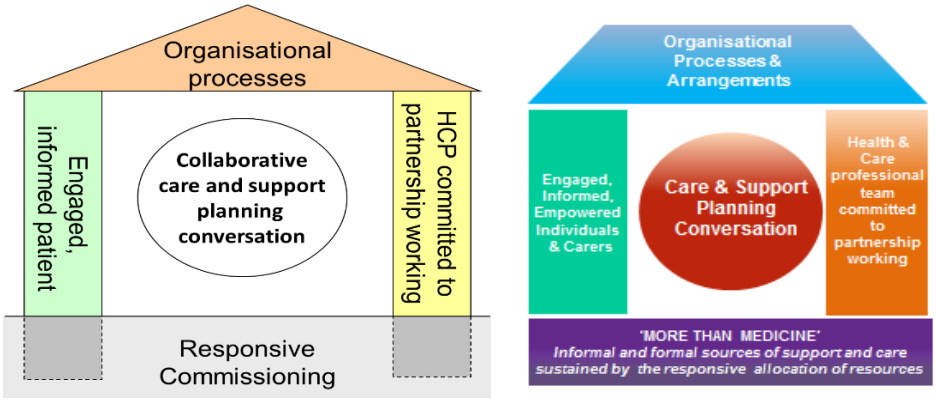
This is the final report for the evaluation of the British Heart Foundation's (BHF) House of Care (HoC) programme. The programme provided funding to support the implementation of a new approach to care for people living with cardiovascular disease (CVD). The new approach was based on the Year of Care model of collaborative care and support planning (CSP) using the HoC framework. BHF provided funding to five sites in total, two in England: Hardwick CCG and Newcastle Gateshead CCG[1] and three in Scotland: NHS Greater Glasgow and Clyde (GGC), NHS Lothian working with the Thistle Foundation and NHS Tayside. Partners to the programme include the Year of Care Partnerships (YoCP) which was funded by BHF to support implementation of the programme, and the Health and Social Care Alliance Scotland, which has been supporting the programme and wider work around CSP in Scotland. The main aim of the programme was to ensure that individuals with CVD engage in a collaborative CSP consultation, focused on what is important to them and that they are supported to access a wide variety of community and voluntary sector activities and services.

Introduction to the programme and evaluation

In 2015, ICF was appointed to evaluate the HoC programme for BHF. The evaluation took both a formative and summative approach, which included: support for project monitoring and the sharing of lessons learned between sites; qualitative fieldwork to capture the implementation journey and outcomes achieved; supporting individual sites to self-evaluate and produce outcome reports; and undertaking a programme-level impact evaluation, including a resource analysis. A number of interviews were also undertaken with key programme level stakeholders including from BHF, YoCP and the Health and Social Care Alliance Scotland. The programme (and its evaluation) was originally due to run for two years from 2015-2017, but was subsequently extended for another year, concluding in March 2018. Each site received additional funding to support this one year extension, to allow focus on embedding and sustaining CSP, as well as providing the opportunity to further enhance the evaluation and the insights it captured.

The HoC approach to CSP was developed by the YoC programme (Year of Care, 2011). It is a framework which brings together the following elements which enable the CSP conversation: engaged and informed people with LTCs working with HCPs committed to working in partnership, and supported by robust organisational processes and wider services. The Houses used in England and Scotland for the HoC programme are presented in the figure below.

Figure ES1.1 English and Scottish HoC



English HoC **Scottish HoC**

[1] Gateshead and Newcastle CCGs merged on the 1st April 2015. This report uses the official title of the newly merged CCG, however the BHF evaluation focuses on work in Gateshead only - as was the case at the time of funding.

Policy context

The landscape in which the HoC programme was first introduced has changed considerably over the last few years, this has impacted on the setting in which CSP was implemented. The health and social care context is in some respects, much more challenging than it was at the programme's inception, particularly in terms of financial and operational pressures. In such a demanding climate, there is the potential for a focus on change such as that required by the HoC approach to CSP, to take a back seat to efforts to maintain and sustain core (existing) services. However, improvements to the prevention, treatment and long-term management of people with long term conditions (LTCs) remains a priority for the NHS. Policy in both England and, particularly in Scotland, has increasingly emphasised the importance of person-centred, integrated care to support this (for example, NHS Five Year Forward View 2014; Scottish Government 2016a-b and Gaun Yersel - The Self-Management Strategy for Long Term Conditions in Scotland, Scottish Government and Long Term conditions Alliance Scotland 2008).

CSP, with a focus on engaged and informed people with LTCs who are supported to self-manage, is well-aligned to the current health and social care context in both countries. In England, the NHS Five Year Forward View encouraged a focus on empowered patients, personalised care and supported self-management as well as improvements in the delivery of care for people with LTCs. The priorities within this were to be driven through the development of new care models and more recently, Sustainability and Transformation Partnerships (STPs). The move towards a more place-based system of care also promotes an environment, which is likely to be favourable for CSP.

In Scotland, following on from the discontinuation of QOF in April 2016, there have been further changes in the health and social care landscape, which have created both opportunities and challenges for implementing CSP across primary care. A new GP contract signalled reform in GP services in Scotland, specifically rebranding the role of the GP in general practice to an "expert medical generalist", providing oversight and clinical leadership (The Scottish Government, 2017a). The ethos of the contract largely aligns with CSP and may help drive and embed the approach; the HoC framework provides an outline for how practices may wish to think about making changes to pathways for the delivery of LTC care, utilising a wider primary care team. More widely, the programme of work being undertaken in Scotland supports the spread and scale of CSP. The three BHF funded sites link in with the two other Scottish HoC sites funded and supported by the Scottish Government and the Health and Social Care Alliance Scotland. These sites sit within a broader suite of person-centred care work in Scotland, led by the Health and Social Care Alliance Scotland, with HoC joining with Self-Management and Third Sector Integration Team programmes to form their 'Self-Management and Co-production Hub'. This will support scale and spread of CSP and self-management across Scotland, alongside the current building of capacity and a case for change.

The case study sites

The five case study sites in the programme differed in terms of their local context, implementation, patient groups with whom CSP was implemented, outcomes and planned/achieved sustainability. We summarise below overall progress, outcomes to date and sustainability plans in each site, with more detail available in the main body of the report:

- In Hardwick CCG, CSP is live in eleven practices with target populations that have at least one CVD condition. Interviewees reflected that the national context of place-based care and STPs has become stronger, providing a favourable environment for CSP to operate within. In the last year of the programme the main emphasis was on the CCG monitoring practices and providing support in the face of resource challenges. A supportive project manager and clinical leads were reported as effective for implementing and embedding CSP. Challenges have included the loss of key staff at practices, and identification of suitable staff to attend train the trainer training. A number of outcomes were reported by stakeholders, these included: increases in patient satisfaction, changes towards a more person-centred approach, and expanded roles and increased confidence for HCPs. Most interviewees were confident that CSP would be sustained beyond the BHF funded programme, particularly given the supportive local context. However, while interviewees agreed that CSP would continue, some reflected that this would not necessarily be through the HoC framework.

- In Gateshead, all seven BHF evaluation practices and most Gateshead practices are now delivering care in line with the full HoC approach to CSP, with patient involvement an important part of the change process. Outcomes reported by interviewees included increases in patient and staff satisfaction, improvement in staff skills and more streamlined care. Stakeholders were strongly in favour of sustaining the approach locally identifying continued CCG funding and in-kind time provided by senior staff to develop the partnership approach as key factors. Over the past year, the CCG has focussed on embedding existing work within Gateshead, linking with and standardising the approach across Newcastle, sharing best practice and building on evaluation findings.
- NHS Greater Glasgow and Clyde has implemented CSP with 14 practices, four of which have a target population including CHD, with the others covering this within diabetes reviews. The team in GGC has made progress in developing their patient engagement work over the last year; they have invested significant in-kind resource in supporting patients to become representatives on sub-groups and the HoC steering group. Stakeholders shared a number of outcomes including: an increased patient engagement and ownership of conditions for some patients, some increased patient satisfaction and improvements in HCP morale. Many were therefore in favour of sustaining the HoC approach to CSP and were confident that it would be sustained in practices already implementing. Sustainability plans were bolstered by the securing of funding for the continuation of the project manager role for one year, however some interviewees felt that the vast area covered by GGC presents a challenge to scaling and spreading CSP.
- In NHS Lothian/Thistle Foundation, the current BHF-funded project fits into a much wider programme of work being delivered to implement and embed the HoC approach to CSP – six practices have been included in the BHF evaluation. Patient engagement work and more than medicine initiatives have continued this year: both of which are intrinsically linked to Lothian's much broader model of self-management. Emerging outcomes reported by stakeholders included, increased patient engagement, better relationships between HCPs and patients, an increased role for nurses and HCAs and more frequent referrals to STRIVE counsellors and Wellbeing practitioners. Strategic leads felt that by itself, the BHF project has limited sustainability. However, given the broader investment and networks in place in Lothian, the work will be sustained after the end of the funding period. The Lothian HoC Collaboration is working to spread the approach across Lothian through rolling out wider training, using learning events to spread best practice and networking with other cluster leads.
- NHS Tayside is implementing CSP with seven practices, two of which have a specific target population that includes at least one cardiovascular (CVD) condition and a further three practices that are actively planning implementation of CSP for people with CVD. Good progress has been made locally with a minimum level of investment thanks to the hard work of the Project Manager, undertaking multiple roles, as well as the in-kind contributions of time and resource provided by clinicians and wider teams. A number of emerging outcomes were shared by stakeholders, and centred on four key areas: promotion of the person centred care agenda, better use of skill mix and increased knowledge for HCPs, a more collaborative approach to LTC care focusing on what matters to the person and increased support for self-management. Most interviewees thought that CSP would be sustained within the practices already implementing, once the BHF funding came to an end, but were less certain about whether it would be expanded and scaled up, particularly without further funding.

Data analysis

An analysis of final site reported project inputs, outputs and reported outcomes was undertaken. The analysis was based on two types of data submission: 1) Input and output information taken from the Quarterly Monitoring Return (QMR) data submitted to BHF, and 2) Outcomes data shared through site self-evaluation reports based on patient reported questionnaires, which were submitted to ICF.

Inputs and outputs

For both English sites, BHF funding was the largest single input with £200,000 initially provided to each of the two sites. In Scotland, £200,000 was initially received across the three Scottish sites. These sites are also part of a wider programme receiving additional cash funding (£70,000 per site) and support from the Scottish Government, and the Health and Social Care Alliance Scotland. Each of the five sites received an additional £65,000 each as part of the programme's extension.

Additional resource contributed to the programme, over and above BHF provision, amounts to just over £338,000 including the £70,000 additional funding for each Scottish site, while estimated in-kind resources amount to £91,442. In total, across the programme 23,889 people with CVD were eligible for CSP. Of this whole cohort, approximately 33% (7,840) attended an information gathering appointment, 13,942 people were prepared for the CSP conversation through receiving their results, an integral part of the approach. 13,061 people were reported as receiving a CSP review[2].

Self-evaluation reports

Quantitative data submitted in self-evaluation reports were aggregated and compared as appropriate to provide findings at a programme level. Some limitations of the data include:

- Sites have progressed at different rates, with practices within each site being at varying stages of implementation.
- The length of time over which baseline questionnaires were distributed varied depending on each site's progress with implementation. In addition, the point in the CSP process at which they were completed was different across each site.
- Sample sizes are relatively small – particularly for follow-up. Not all sites submitted follow-up data.
- The data was not paired between baseline and follow up.

Analysis of responses revealed the 'typical' respondent has stayed the same as reported in the previous interim evaluation: this tends to be a white man, aged 65 – 74 and retired, with hypertension, CHD and/or diabetes.

Outcomes were captured using standardised tools, including the LTC 6, CQI, CARE and PEI (combined to make CQI), and WEMWBS. Overall, at a high level, programme perspective, responses reflected that practices are showing good progress with implementation and embedding of CSP and patients are receptive to CSP processes.

Patients continue to report a good level of involvement in their own care, particularly in relation to discussing what is important for them to manage their own health. They feel that their care and support is more joined up at follow-up compared to baseline. Patients feel more positive (compared to baseline) about the way HCPs explain things, make them feel at ease and let them tell their own story (based on two sites). At follow-up patients feel more positive about the amount of information and support received to help them manage their health but feel less confident about doing so.

At this final reporting stage, an analysis of changes in data over time was undertaken, looking at trends in responses that describe the outcomes achieved. Key findings included:

- Between baseline and follow up, there was a slight increase from 55% (361/654) to 59% (109/184) of patients who felt they 'almost always' discussed what was important for them in managing their own health. There was also an increase in respondents feeling that the support and care they receive was 'almost always' joined-up and working for them; from 56% (364/649) to 60% (111/185) at the follow-up stage.
- Respondents were positive about the amount of information received to help them manage their health, with an improvement of five percentage points (63%, 413/653/ to 68%, 125/185) from baseline to follow up noted in the overall proportion of respondents who state they 'always received enough information'. Patients feel able to understand their condition(s) better or much better following their consultation with 75% (446/595) responding that this was the case.
- However, respondents remain unsure about managing their own health; only 49% (320/653) stated they felt 'very confident' at baseline, and this reduced to 41% (76/185) at follow up. This

[2] The figures for receiving results and attending a CSP review are higher than those reported for attendance at an information gathering appointment. This is due to coding issues at two sites (Gateshead and Hardwick) which resulted in an under-reporting of numbers attending for information gathering appointments. There were also no submissions made from Lothian, for the number of people attending the information gathering appointment.

suggests that patients currently feel that support is in place but confidence to self-manage with this support may be an area that needs further encouragement, including during the CSP process.

- Practices have made good progress with implementation. Positive changes were noted for all statements for all three sites that provided follow up data in relation to this (Gateshead, GGC and Tayside). Overall, sites were doing well in: attending training; organising patient registers to identify which and how many LTC and registers that person is on; and setting up appointment systems. There was still work to do around consultation skills, goal setting and action planning.

Qualitative feedback submitted by sites showed that CSP had been received well by patients and staff, specifically in terms of improved care, patient involvement, and readiness to self-manage. Patients said there was more time for discussing issues affecting them; that appointments did not feel as rushed, and there was more clarity following the consultation. Patients also liked receiving their results in advance of their CSP review. Staff and patients in some sites noted that patients like the fact they get more of a say, and can get involved in their own care. A number of patients across the sites felt the process helped them to gain the confidence, skills and perspective to better manage their condition. However, this feeling of confidence in self-management was not universal – reinforcing the findings from the quantitative analysis.

Resource analysis

Sites were asked to produce a resource analysis, to compare practice-level costs before and after the introduction of CSP. Three sites provided this analysis: Gateshead, Hardwick and Tayside, (the full versions are within the site-evaluation reports at Annex 3), while GGC and Lothian found it challenging to engage practices to undertake this work. Findings from the analyses overall show that the biggest savings can be made against pre-HOC pathways when undertaking reviews with patients with more than one LTC (i.e. multi-morbidity reviews)[3]. The changes in pre and post HoC pathway ranged from a difference of an increase of five minutes (equating to £3.05 more) in one practice in Tayside to a decrease of 20 minutes (equating to £21.18) in one practice in Hardwick.

Thematic analysis

A thematic analysis was undertaken of findings from the programme, drawing out consistent themes across the sites.

Programme support has been valued

- The programme was well resourced, with some sites using BHF funding as the main source of financial support for CSP, and others using it to supplement CSP service redesign, which was already being funded locally.

- Practices have been well supported by local project managers and the project managers and local steering groups have found support from BHF, YoCP, Health and Social Care Alliance Scotland, and the evaluation team useful. More specific elements of support which were identified as being useful for sites, included the sharing of YoCP resources such as change management tools and a practice checklist, which allowed operational support to be tailored for individual practices. Reflections on training in the HoC approach to CSP showed that a balance is required between a whole team approach and tailoring to specific groups.

Different models were implemented

- In general, the HoC framework was well received by sites. Most interviewees described a close alignment to the HoC framework. On the whole, the dominant model was a Healthcare Assistant (HCA) doing the first appointment and tests (where there was this post available), followed by the results going out, and then a nurse doing the second consultation where the collaborative conversation took place.

[3] It is important to note that this analysis was not intended to provide a holistic assessment of the outcomes – economic or non-economic – of implementing the HoC.

- However, some interviewees thought that the approach taken by the programme was overly rigid, and that this impacted on practice staff engagement and potentially the programme's reach. Practices adapted the approach in a variety of ways, either by 'flexing' core components of the HoC approach to CSP, or in some cases by removing the core component of 'preparation' – which is not in keeping with CSP as defined by the HoC approach. Sites described two main reasons for making these changes: competing resource pressures requiring pragmatism and feeling changes could better meet the needs of specific groups of patients. In the case of removing the preparation stage, some interviewees questioned the evidence base for this.

Multi morbidity approach

- There has been recognition across all sites that a multi-morbidity[4] approach is where the biggest potential lies for providing holistic, person-centred, (and efficient) care and support for those with LTCs. The biggest benefits were reported by practices which moved from a single-condition to a multi-morbidity approach, as discussed in the resource analysis section. The table below shows that most sites have moved to multi-morbidity approaches.

Table ES1.2 Site progress with multi-morbidity approaches

Sites	Multi-morbidity in majority of practices	Moved to Multi-morbidity during programme	Inclusion of CVD and one other condition	Inclusion of 2+ conditions	Multi-morbidity to be sustained and spread
Gateshead	✓	Practices were in the process of moving to a multi-morbidity approach prior to the programme	✓	✓	✓
Hardwick	✓	✓	✓	✓	✓
Greater Glasgow & Clyde		✓ CHD plus diabetes in some practices	✓ CHD plus diabetes		CHD in some practices plus diabetes in all practices
Lothian	✓	✓	✓	✓	✓
Tayside	2/7 practices implemented Diabetes & CVD from outset. Further 3 practices are implementing Diabetes including people who will also have CVD.	✓	✓	✓	Multimorbidity/or shift towards this will be sustained in existing practices and spread in some others.

Culture change

- Some interviewees commented that the programme was very process-driven and recognised that these models can only be effective when accompanied by culture change. Culture change was defined in terms of a long-term commitment to a holistic understanding of patient care and

[4] In the context of this evaluation, multi-morbidity refers to a single CSP cycle for the routine review of patients who have more than one LTC. CVD as one of these LTCs is included here, using the BHF accepted definition as set out in the DH (2013) CVD outcomes strategy, with CVD being a 'family of diseases' including: coronary heart disease, stroke, hypertension, hypercholesterolemia, chronic kidney disease, peripheral arterial disease, and vascular dementia. BHF requirements for this programme were that diabetes was not used as a sole condition to select a cohort of patients.

partnership working. Partnership working refers to understanding patients as equals in their own care, as well as whole teams and systems working more closely together to embed this shared understanding. In practice this requires engagement at all levels and parts of the system – from senior leaders to frontline staff in health, social care, community, and voluntary sectors.

- The picture is mixed for having achieved culture change through this programme. Some individual practices were said to have achieved it, however there is still a long way to go in achieving this across whole sites and local systems. This is reflected in progress with the more than medicine component of the HoC approach to CSP, where the case studies showed some limited examples of progress in individual practices. Stakeholders have reflected that in order for significant progress to be made in this area, there needs to be an expansion of knowledge of community support services.

Conclusions and recommendations

On the whole, findings are generally positive: advances have been made in implementing CSP across five sites; positive staff and patient outcomes have been reported; and ongoing learning has been generated to support how CSP will be sustained. Going forward, BHF and its partners can continue to build on these achievements through ongoing and future development work. The main conclusions and recommendations from the final evaluation, building on previous work, are that:

Conclusions

1. **BHF's involvement with CSP and person-centred care will continue to benefit from a largely supportive policy context**. Over the last three years, the push towards ensuring care delivery is more person-centred has grown in both England and Scotland. This is set to continue, with CSP being a favoured approach within this. This programme has illustrated – through CVD conditions as an exemplar – that CSP can be implemented at scale and at population level.
2. **It takes time to implement change and to embed this in supportive culture.** The successful implementation of any programme takes time; implementation was dependent on a number of factors including practice and strategic buy-in and a strong infrastructure to support the projects. For new sites, a period of at least 6 months should be allowed to put systems in place before CSP can start, and it will be 2 or 3 years before it is embedded. For local project managers and facilitators, around 6-9 months should be expected to be able to fully support this process.
3. **The programme has prioritised practical implementation of CSP.** Sites within the programme have largely focused on particular elements of the house; namely the roof and walls. There has been great progress made in introducing and embedding infrastructure to support CSP, training HCPs and preparing patients. A whole team approach to CSP with strong clinical leadership and wider buy-in have emerged as important ingredients for successful implementation.
4. **The programme has demonstrated impact at the patient level.** Data reporting varied across sites, with some submitting higher quality returns than others. Nonetheless, reported outcomes included patients feeling more able to cope with life and their condition and keep healthy; and patients feeling their care and support is more joined up. This was echoed in qualitative interviews.
5. **Impact at the HCP level has been in terms of improved confidence and knowledge and better use of skill mix.** Stakeholders identified a number of outcomes for staff resulting from the opportunity to be involved in the programme, including: increased knowledge and understanding of CSP; increased job satisfaction; improved team working; the opportunity to deliver more person-centred care; better use of skill mix and the development of roles.
6. **Striking a balance between fidelity and flexibility is key for sustainability and replicability.** The dominant 'model' was of a two-step model consisting of preparation followed by a CSP conversation. Some practices made flexes to the core components of the approach, however in a small number of cases more substantial adaptations saw the removal of the preparation stage, which is a key component of the CSP approach as defined by the HoC programme. Enabling practices to strike a balance between maintaining fidelity to the HoC framework, while having

flexibility to account for local variation and contextual factors is important for embedding and spreading CSP going forward.

7. **A multi-morbidity approach is where the biggest potential lies for providing holistic, person-centred, (and efficient) care and support for those with LTCs.** At a programme level, the biggest benefits were generally reported by practices that moved from a single-condition to a multi-morbidity CSP approach. The delivery of CSP for a wider range of LTCs is increasingly being considered by sites and so the potential for spread of multi-morbidity approaches both in and across practices is high.
8. **The programme has successfully led to sustainable change across all five sites.** Reflections from all five sites have suggested that the funding provided by BHF (and the Scottish Government) has been successful in supporting sustainability of CSP, providing the initial impetus to make change, which has now been embedded. All sites indicated that CSP is likely to be maintained in practices which participated in the programme. However this is likely to be in adapted forms of the original approach, taking into account local contexts and financial barriers.

Recommendations

1. **BHF has an important role to play in promoting person-centred care and new models of delivering care for CVD.** BHF should continue with its work in promoting and driving forward person centred care as it has much to contribute in terms of advancing knowledge and practice using CVD conditions as an exemplar.
2. **It is important that programmes are designed with clear aims from the outset.** A number of stakeholders reflected that there was some uncertainty around the conditions to be included under the umbrella of CVD, the requirements of the evaluation and the expectations of BHF. BHF should bear this in mind when commissioning future programmes and evaluations.
3. **Funding longer programmes may be of greater benefit for implementation and evidencing impact.** Implementing CSP and promoting a more collaborative and person centred culture requires substantial change in both process and culture, which takes time. BHF should therefore consider designing and funding future programmes with this in mind.
4. **Support for culture change should accompany process support.** Throughout the evaluation, stakeholders highlighted the importance of change at both a practical level as well as a cultural level, sometimes reflecting that sufficient focus was not given to both. A lack of early attention to culture change risks later sustainability. Alongside its programme portfolio, BHF should support 'person-centred friendly' culture change and the strengthening of the voice of lived experience.
5. **BHF and partners should continue to develop efforts around the more than medicine element of the approach.** BHF, alongside the Health and Social Care Alliance Scotland and YoCP are well placed to continue supporting this work, developing the wider case for change and further understanding around the role of wider determinants of health and supported self-management.
6. **Approaches to monitoring and evaluation could be further refined.** The HoC programme has generated important learning around the ways in which monitoring and evaluation processes could be refined, including: balancing the requirements of BHF with efforts to ensure the evaluation is locally owned; focusing on measuring fewer indicators 'well'; setting realistic expectations; ensuring all requirements are fully understood; and improving the output reporting templates to provide more clarity to sites.
7. **Learning from the programme should be shared widely.** The programme and its evaluation has shown impact and generated a vast degree of learning around CSP and person-centred care and has built on previous learning from YoCP. BHF should therefore seek to disseminate findings as widely as possible; there is much to contribute to an as yet narrow evidence base around implementing CSP for patients with CVD and other LTCs.

Glossary of terms

- BHF - British Heart Foundation
- CARE measure - Consultation and Relational Empathy measure
- CCG – Clinical Commissioning Group
- CHD – Coronary Heart Disease
- COPD - Chronic obstructive pulmonary disease
- CQI – Consultation Quality Index
- CSP – Care and support planning
- CVD - Cardiovascular Disease
- GGC – Greater Glasgow & Clyde
- GMS – General Medical Services
- HCP – Healthcare Professional
- HoC – House of Care
- HSCP – Health and Social Care Partnership
- ICS – Integrated Care System
- IG – Information Gathering
- IJB – Integrated Joint Board
- LTC(s) – Long Term Condition(s)
- PEI – Patient enablement instrument
- QOF - Quality and Outcomes Framework
- QMR – Quarterly monitoring returns
- STP – Sustainability and Transformation Plans
- VCS – Voluntary and Community sector
- YoC – Year of Care
- YoCP – Year of Care Partnerships

1 Introduction

This is the fourth and final report for the evaluation of the British Heart Foundation's (BHF) House of Care (HoC) programme. The report presents findings from the fieldwork undertaken with each of the five participating sites (Hardwick, Newcastle Gateshead, Greater Glasgow and Clyde, Lothian and Tayside) during November and December 2017. The purpose of the final stage of the evaluation was to build on knowledge gained through previous fieldwork, exploring with stakeholders what outcomes are being achieved, lessons learned and how care and support planning (CSP) can be sustained locally. It has also provided learning around local adaption and tailoring of the HoC approach to CSP during implementation, at a practice and site level.

Each site is presented as a brief case study structured around a number of key foci, which will inform the programme level evaluation. This is followed by a qualitative, thematic analysis that draws out the key themes in implementation learning, impact, and sustainability at a programme level. As well as participating in the external evaluation, all sites supported by ICF, carried out a self-evaluation. Each site took a different approach to evaluating their local data but all used standardised tools to capture and measure outcome data and conducted independent qualitative research. Each site produced a self-evaluation report; these are included in Annex 3. These self-evaluation reports build on those produced in early 2017 for the third interim report (ICF, 2017), analysing, where able, changes and trends in data over time points. A synthesis of the data, drawing out common themes, trends and findings, is presented in Section 8.

1.1 Description of the BHF HoC programme

BHF has a broad portfolio of implementation into practice work, focusing on improving care, and ultimately, outcomes for people with cardiovascular disease (CVD). The HoC programme sits within this - providing funding to support the implementation of a new approach to care for people living with CVD. While the programme is primarily focused on CVD, it recognises that in many cases, people may be living with multiple long term conditions (LTCs). The model of CSP used within this programme was the House of Care framework, which was developed over the last 10 years by the Year of Care Partnerships (YoCP) primarily aimed at people with diabetes[5]. This BHF programme was designed to test the transferability of this to people with cardiovascular disease. This programme was funded by BHF (with Scottish Government funding also provided to Scottish sites) and implemented in partnership with YoCP and the Health and Social Care Alliance Scotland.

The programme aims to support individuals with CVD to engage in a collaborative CSP consultation, which is focussed around what matters most to them. Through this consultation they will be supported by healthcare professionals (HCPs), through the process of information sharing, goal setting and action planning to manage their condition effectively[6]. BHF have provided funding to five sites in total, two in England: Hardwick Clinical Commissioning Group (CCG) and Newcastle Gateshead CCG[7] and three in Scotland: NHS Greater Glasgow and Clyde (GGC), NHS Lothian working with the Thistle Foundation and

[5] Please see annex 4 for further information about the role YoCP played in the programme

[6] House of Care evaluation – Invitation to Tender, BHF 2014

[7] Gateshead and Newcastle CCGs merged on the 1st April 2015. This report uses the official title of the newly merged CCG, however the BHF evaluation focuses on work in Gateshead only - as was the case at the time of funding.

NHS Tayside. The Year of Care Partnerships (YoCP) have also received funding from BHF to provide training, expertise and ongoing support to each site and the programme as a whole. Hardwick, Gateshead, and Scotland as a whole, received £200,000 of funding each initially for two years between 2015 and 2017. The £200,000 was split three ways across the Scottish sites and administered by The Health and Social Care Alliance Scotland; these sites also received joint funding of £70,000 each from the Scottish Government. In 2016, each of the five sites received an additional amount of £65,000 to support a one year extension of the programme and evaluation from 2017 to 2018. The extension was granted to support the embedding and sustainability of CSP as well as provide outcomes for the evaluation.

The three Scottish sites are part of a wider HoC adoption across Scotland (presently in six adopter sites), linking into a national steering group directed by the Health and Social Care Alliance Scotland. The BHF, Scottish Government, and Health and Social Care Alliance Scotland view the work in the three Scottish sites as sub-sets of larger, different programmes, which also includes sites that are not part of their respective programmes.

The HoC approach to CSP was developed by the YoC programme (Year of Care, 2011). It is a framework which brings together the following elements which enable the CSP conversation: engaged and informed people with LTCs working with HCPs committed to working in partnership, and supported by robust organisational processes and wider services.

A summary of the essential components of CSP for the BHF programme was provided by YoCP as part of the third interim report (ICF, 2017) and is presented again below:

Essentials of CSP used in the BHF HoC Programme

Core components of implementation

- Core CSP elements: All CSP stages are included in the process – preparation, conversation, recording and follow up – there is a patient focused ethos to the whole process
- HoC components: All four themes represented by the HoC are addressed - working together in the local community- CSP is at the centre of the house
- CSP is built into routine clinical pathways and replaces usual care
- Training: Key practitioners and team members receive core CSP training, provided by YoCP within this programme. As CSP becomes embedded, shortened training for new team members provided by quality assured trainers and additional skills training tailored to the local team may be required.

The CSP Process

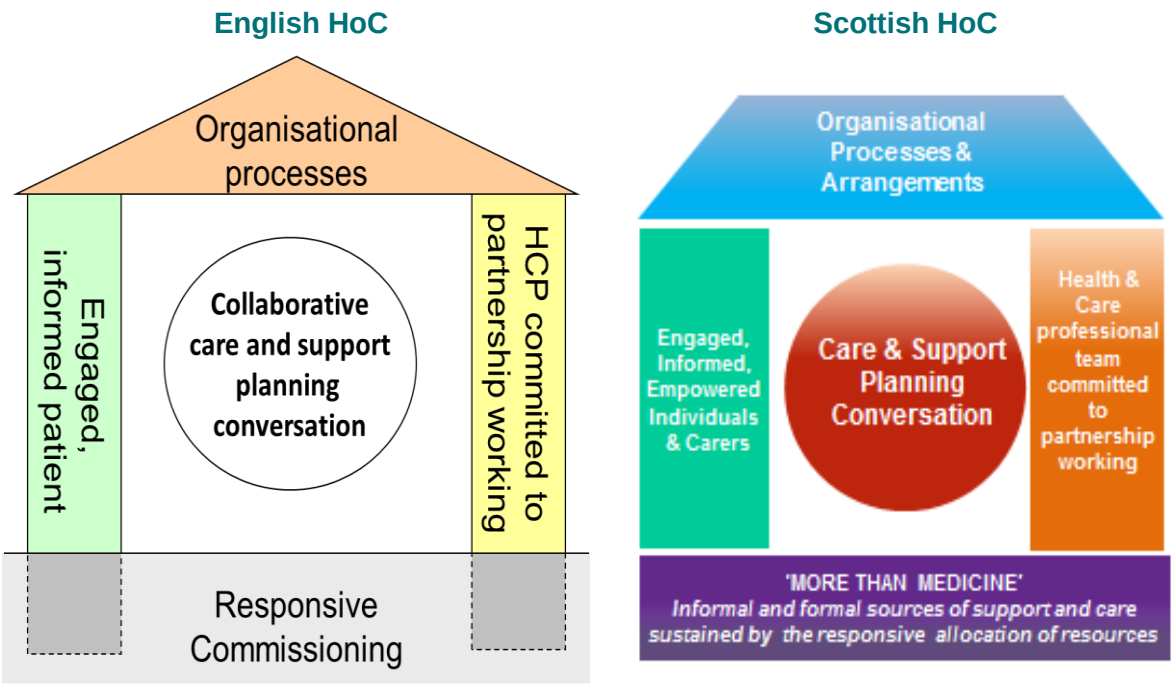
- Preparation for the person: separating disease surveillance, routine tests and health /social care assessments from the collaborative conversation. Must include explanation of the process, reflective prompts, sharing of information and time for reflection before the conversation
- Collaborative conversations: structured around what matters to the person, includes both the person's as well as the professional agenda, is forward looking and solution focused and production of a plan is not the entire focus of the conversation. The conversation is carried out by a suitably trained practitioner, and links to on-going support in the community, referrals to other health/social care agencies, and individualised review.

- Review: Individualised, discussed and agreed during conversation. Not all support is delivered in one to one sessions with the practitioner.

Local implementation and planning processes should take account of local context and settings, and create opportunities for flexibility whilst maintaining the essential elements and philosophy of CSP.

The Houses used in England and Scotland are depicted in Figure 1.1:

Figure 1.1 English and Scottish HoC



Situated in the centre of the HoC is the CSP conversation; a shared conversation, embedded in co-production and supported self-management, which results in a care plan driven by the patient. For CSP to be effective, it requires a shift in the relationship between a person and HCP and the way that this is viewed; the conversation is considered to be a meeting between experts: those with lived experience (patients/people) and those with technical expertise (clinicians).

The process should support the person to explore what is important to them, determine their own needs and priorities, develop actions, and drive the self-management of their own health. This should involve greater emphasis on collaboration and enablement of people with LTCs.

There are three main aims of the programme:

1. To introduce collaborative CSP as routine care, mainly within primary care, and develop a holistic review in place of the current tick box surveillance activities encouraged by the Quality Outcomes Framework (QOF);

2. To redesign local pathways for CVD services, driven by CSP; and

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

1.2 Description of the evaluation

In 2015, BHF appointed ICF to evaluate the HoC programme. The purpose of this evaluation is to:

> *"Evaluate and analyse how the Year of Care model has been adopted to develop innovative models of care and integrated pathways in the selected communities.[8]"*

The evaluation contributes to an evidence base on 'what works' in implementation, alongside the outcomes that the HoC approach to CSP can achieve for people with CVD. In addition, it presents an analysis of practice resources required for CSP providing quantitative insights. The evaluation looks at impact at a patient, HCP and the local health and social care system level as well as exploring the strategic added value of BHF's investment.

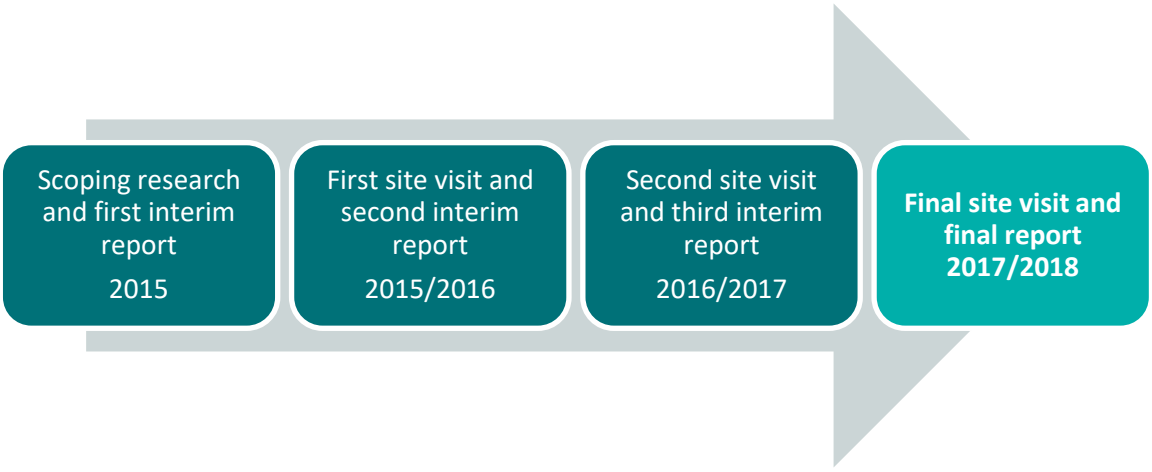
The evaluation of the BHF HoC programme was originally due to run for two years and conclude in March 2017. In 2016, both the HoC programme, and accompanying evaluation were extended by one year; this ended in March 2018. This extension allowed sites to concentrate their resource on embedding and sustaining CSP at a local level. It also provided the opportunity to enhance the evaluation and the range of insights captured. This has allowed for a more detailed examination of implementation and impact at the practice and site level, as well as the building of a richer picture of if and how the work may be sustained.

This report presents findings from the third and final round of local case study research, an analysis of quarterly monitoring information provided to BHF, and a second round of evaluative outcome data analysed and reported by each of the five sites (submitted to ICF in the form of self-evaluation reports). It also draws on a number of interviews with key programme level stakeholders including from BHF, YoCP and the Health and Social Care Alliance Scotland. Previous reports are available from BHF and included a review of programme documentation, programme logic model and overarching evaluation framework, site evaluation plans and findings from case study visits. These reports are listed below:

- BHF House of Care Evaluation: First Interim Report (ICF 2015)
- BHF House of Care Evaluation: Second Interim Report (ICF 2016)
- BHF House of Care Evaluation: Third Interim Report (ICF 2017)

[8] House of Care evaluation – Invitation to Tender, BHF 2014

Figure 1.2 Summary of evaluation timeline



ICF aimed to interview between 8-10 stakeholders at each site for the case study research. Table 1.1 below summarises the interviews undertaken:

Table 1.1 Number of interviews undertaken in the final phase of fieldwork

Site	Number of interviews conducted
Gateshead	7
Hardwick	9
Greater Glasgow & Clyde	11
Lothian	22[9]
Tayside	9
Programme level interviews	5
Total	**63**

Interviewees included the project managers at each site; GPs, practice nurses; practice managers; practice pharmacists; strategic stakeholders from CCGs or the wider NHS (including medical directors, health improvement policy leads/managers); representatives from the voluntary and community sector, and patient representatives.

In order to accurately reflect the local context and characteristics of each site, researchers have, wherever possible, presented findings in interviewees' own words. This means that across the five case study reports, terminology will sometimes differ, for example, with one site referring to the third sector and another, the voluntary and community sector.

The remainder of this report is structured in eight sections:

- Section 2 - This section situates the House of Care within the current, wider UK policy context for person-centred, coordinated care, drawing out the differences between England and Scotland and focusing on developments observed since the previous round of reporting.

[9] A number of focus groups with HCPs were undertaken in Lothian so this number is higher than for other sites

- Sections 3 to 7 – Case studies[10] of:
  - Hardwick CCG
  - Newcastle Gateshead CCG
  - NHS Greater Glasgow and Clyde
  - NHS Lothian working with the Thistle Foundation
  - NHS Tayside

- Section 8 – This section presents a synthesis of the outcomes data submitted by each of the sites, drawing out and presenting findings at a programme level.
- Section 9 – This section focuses on qualitative cross cutting themes across the five sites, providing insights at a programme level.
- Section 10 – This section presents conclusions, recommendations and learning for the programme overall.

In addition to the main body of the report there are three Annexes:

- Annex 1 contains a list of references used
- Annex 2 contains the research tools; and
- Annex 3 contains the self-evaluation reports submitted by sites.

[10] Each case study has been reviewed and signed off by site leads.

2 Policy and context

In total, around one third of the UK's population live with one or more LTCs. This proportion is expected to grow alongside an increasingly ageing population and advances in healthcare and treatment. The care and treatment of these individuals consumes a disproportionate amount of health and social care resources in England; accounting for around 55% of GP appointments and 77% of inpatient bed days. Approximately 70% of all money spent on health and social care is associated with the care and treatment of this group (one third of the population). Imison et al (2017) report an estimate from the Department of Health that as many as 80% of people with a LTC can be supported to self-manage. In Scotland, approximately 40% of the population have at least one LTC. The costs of LTCs in Scotland, both economically and at a human level, are also high; 60% of all deaths are attributable to LTCs and account for 80% of all GP consultations (Scottish Government 2015). Furthermore, people with LTCs are twice as likely to be admitted to hospital, remain there longer and account for over 60% of inpatient bed days (Ibid).

There is widespread recognition that the more traditional NHS models of care, with a reliance on hospital based services, no longer suit the needs of the population. Change is needed, to more effectively utilise services outside the hospital setting through improved integration of community support. This way of working would be particularly beneficial for people with LTCs who can be poorly served by services, often receiving uncoordinated and fragmented care from multiple providers (NHS England, Five Year Forward View 2014a; Nesta 2013). People with LTCs and co-morbidities require on-going management of symptoms and risks, rather than acute interactions with healthcare services and individual episodes of care. In light of this, the need to improve the management and treatment of people with LTCs has been a long term priority for the NHS in both England and Scotland. This is reflected in policy in both nations, which has increasingly emphasised the importance of integrated, person-centred care to encourage this (for example, NHS England, Five Year Forward View 2014a; Scottish Government 2016a-b; Gaun Yersel - The Self-Management Strategy for Long Term Conditions in Scotland, Scottish Government and Long Term conditions Alliance Scotland 2008).

However, whilst both countries move towards more integrated and person-centred policies, the mechanisms for achieving this look very different. Scotland has a longer, more coherent history of integration; the development of Health and Social Care partnerships (HSCPs) drives the integration of health and social care beyond anything seen in England. Reform is also driven differently in the two nations; in England, change is led by the commissioner-provider split and market-based mechanisms. In Scotland, Integrated Joint Boards (IJBs) have been created, which are ultimately responsible for and govern the planning, resourcing and delivery of integrated services.

2.1 Recent developments

The landscape in which the HoC programme was first introduced has changed considerably over the last few years. This has impacted on the setting in which CSP is being implemented across the five sites in England and Scotland.

The health and social care context is much more challenging than it was at the programme's inception, particularly in terms of financial and operational pressures. The current financial climate is tough, with a deterioration in NHS finances observed since the publication of the Five Year Forward View in England. Funding per person is projected to fall by 0.3% in 2018/2019 and funding growth is one of the lowest since the inception of the NHS, equating

to a real terms cut (Ham et al., 2017). Health services are under pressure to reduce costs and achieve savings to close the gap between patient needs and resources (National Audit Office, 2016). As a result, funding intended to develop new ways of working and promote innovation is increasingly being used to plug gaps and reduce deficits. The NHS faces a projected £20 billion funding gap by 2022/23 based on the government's projected current spending plans (, 2017) and NHS Improvement (2017) figures showed an increase in deficit from £461 million in quarter one of 2016 compared with a year-to-date deficit of £1,281 million as at quarter 3 of 2017/2018.

In Scotland, planned savings of £445 million are being put in place by Health Boards to bridge the gap between the cost of service delivery and funding from the Scottish Government, which fell in real terms (Audit Scotland, 2017).

In such a demanding climate, there is the potential for a focus on change such as that required by the HoC approach to CSP, to take a back seat to the importance of maintaining and sustaining services. Furthermore, such pressures can preoccupy system leaders limiting the emphasis that is placed on wider transformational change (Ham et al., 2017); as Ham et al. say, "*The urgent will drive out the important*" (Ibid, pg. 30).

Operationally, staff shortages across the NHS and inadequate workforce planning continue to limit the extent to which demands can be reduced or changes made. Figures from NHS Improvement (2017) show that one in eleven posts in NHS England are unfilled (equivalent to 100,000 vacancies) and Health Education England (2017) report that the number of GPs is lower than in 2012 with a 1.6% increase in the number of nurses leaving the NHS between 2011/12 and 16/17:

"Our ten year forward look shows that if no action is taken to reduce demand through prevention or through better productivity and service transformation, the NHS will need to grow by 190,000 clinical posts by 2027 to meet demand." (Health Education England, 2017, pg 9)

In Scotland, the National Primary Care Workforce Survey (Information Services Division, 2018) shows a consistent decline in the number of whole time equivalent GPs across Scotland since 2013. In addition, the survey found a slight increase in the rate of GP vacancies since 2015 although the survey reports an increase in WTE health care support workers and nurses. Over one third of GPs and half of nurses are also over 50 years of age with Audit Scotland reporting a lack of longer term workforce planning more generally (Audit Scotland 2017).

As General Practitioners Committee Scotland deputy chair Dr Andrew Buist said: "*General practice in Scotland has faced significant difficulties in recruitment and retention, with around one in four practices reporting vacancies"* (Cook, 2018).

These challenges when coupled with an increasing, ageing population, place a greater demand on healthcare services than ever before, demand that is increasing at a faster rate than resource (Ham et al., 2017). In light of this, there has been a recognition that services need to work differently with more focus on providing integrated care in the community and supporting people to manage their own conditions. Both of which align with the principles of CSP. Managing demand pressures in the longer term means prioritising prevention and the wider determinants of health; to do so will require a greater focus on working across local systems much more effectively. CSP approaches can help meet these needs through their holistic recognition of patients which involves working with wider partners and the promotion of better self-management of health.

Funding and operational pressures co-exist in England and Scotland yet there have been different developments in each. These developments are considered below, building on those examined in previous reports (ICF 2015, 2016, 2017).

2.1.1 Developments in England

The NHS Five Year Forward View encouraged a focus on empowered patients, personalised care and supported self-management as well as improvements in the delivery of care for people with LTCs. The priorities within this were to be driven through the development of new care models and more recently, Sustainability and Transformation Partnerships (STPs).

Sustainability and Transformation Partnerships "*are a way of bringing together GPs, hospitals, mental health services and social care to keep people healthier for longer and integrate services around the patients who need it most"* (NHS England, 2017, pg. 32). They represent a new way of working focused on place-based systems of care, promoting more collective action to address the health of specific populations. STPs provide an opportunity for areas to promote CSP more widely; supporting spread and scale across wider geographies.

The move towards a more place-based system of care promotes an environment, which is likely to be favourable for CSP. STPs will drive an increase in partnership working over a larger footprint than CCG areas, which provides the opportunity to tackle some of the more significant, shared health issues collectively. This includes the prevention, treatment and management of LTCs through increased integration of health and social care. Close working across multiple agencies speaks to a CSP approach, in particular making effective use of the resources of local communities to support a model of care, which is wider than 'medicine' alone. The appetite to look for new ways of working is also ripe, particularly in light of resource constraints and so system leaders and staff are receptive to transformational ways of delivering effective care, such as that promoted through the HoC approach to CSP.

Looking towards the future, place-based models of care are set to have greater power to innovate. Integrated Care Systems (ICS') are "*an 'evolved' version of an STP that is working as a locally integrated health system."* (NHS England 2017, pg. 35). An ICS will have increased control over commissioning, planning, funding and performance of their local area. It is expected that as ICS' develop, they will create collective governance and decision making structures and manage funding for a defined population (The King's Fund, 2017). An ICS will also have the ability to manage the health of the population to "*improve prevention, enhance patient activation and supported self- management for long term conditions"* (Ibid, pg. 36), thereby providing fertile ground for embedding CSP.

The emergence of new models of care (Vanguards) therefore set the scene for innovation, and there is strong potential for CSP approaches such as the HoC framework to be a feature of these. One such example is enhanced primary care models in which GPs lead a small team of HCPs who share the responsibility of caring for a defined population of patients. Enhanced Primary Care is centred around the patient and considers their holistic needs in order to deliver the most appropriate support, with the aim of empowering patients to self-manage and develop care plans to help with this. This model also encourages the creation of new non-clinical roles to provide non-clinical support and an increased role for receptionists and HCAs who can act as care navigators, providing information and signposting to other services. Many aspects of this enhanced primary care model align with a 'whole team' approach to CSP, it may therefore be one mechanism for providing further impetus to spread this way of working.

The role of technology and digital health more widely is also becoming increasingly prominent. This provides both opportunities and barriers for the spread and scale of CSP. Digital healthcare focuses on "*harnessing the potential of digital channels to enable patients and healthcare professionals to interact in different ways*" (NHS England, 2014b). In primary care, this includes reducing unnecessary face-to-face consultations between GPs and patients and providing appropriate, convenient access to services. The General Practice Forward View (NHS England, 2016) recognised that digital technology could be used to meet increases in demand, improve access and standards of care and better manage workloads. These developments in technology could provide a range of more flexible options for CSP including using video technology for consultations and digital self-management programmes. However if CSP approaches are reliant on providing two-step face-to-face appointments, then changes in the way care is delivered and accessed may hinder the uptake of CSP more widely.

Many of the changes described support the implementation of CSP, however workforce and financial challenges may limit the extent to which change is embraced, pushing a focus on stabilising and cost saving. Furthermore, new models of care include the testing of approaches that encourage more person-centred care but are delivered in a different way to CSP, for example, care planning without patient preparation. Perceived gaps in how to implement the approach at a more practical, practice level may also present a challenge in a pressured environment.

2.1.2 Developments in Scotland

Following on from the discontinuation of QOF in April 2016, there have been further changes in the health and social care landscape in Scotland. These changes have created both opportunities and challenges for implementing CSP across primary care. The key change in landscape since the time of the last evaluation is around the General Medical Services (GMS) contract. At the time of writing the interim report, negotiations around the new primary care GMS contract in Scotland were ongoing. The draft contract has since been released and put out for consultation, before being accepted in early 2018. It came into practice from 1 April 2018.

The new contract signals reform in GP services in Scotland, specifically rebranding the role of the GP in general practice to an "expert medical generalist", providing oversight and clinical leadership (The Scottish Government, 2017a). This will involve more multidisciplinary team working wherein some tasks currently undertaken by GPs will be carried out by the wider primary care team (including nurses, healthcare assistants and pharmacists), where appropriate. Practice nurses will continue to play a key role in the management of LTCs with support from others as part of an extended team approach leaving GPs more time to deal with more complex conditions. In addition, the development of Community Treatment and Care Services will take some of the burden around LTC monitoring e.g. routine checks, and related data collection away from general practice and in particular, nurses and healthcare assistants.

The ethos of the contract largely aligns with CSP and may help drive and embed the approach; the HoC framework provides an outline for how practices may wish to think about making changes to pathways for the delivery of LTC care, utilising a wider primary care team. Additionally, freeing up GP time to have more oversight of LTC management and the use of an extended team may give GPs and practice nurses more time in consultations to focus on aspects such as care planning. Care planning is specifically referenced and the

HoC framework could provide practices with a way to realise this. The draft Memorandum of Understanding for the GMS contract implementation between Scottish Government, British Medical Association, Integration Authorities and NHS Board also makes explicit reference to person-centred care as one of the key principles for the redesign of services, which again aligns directly with CSP.

The contract references a number of other changes, which could help to drive the CSP agenda. The role of nurses in supporting GPs to deliver care planning is made clear. A £2 million investment in additional training for nurses has been made in 2017/18 to enhance their skills around supporting people with complex conditions and play an even greater role in the delivery of primary care. This could be a key enabler for embedding CSP, given that one of the barriers cited to providing more holistic, person-centred care using the HoC framework is nursing skill level and confidence. As part of the move towards more multidisciplinary team working, there are new opportunities for receptionists to play an enhanced role. In particular, the contract details how receptionists could play a part in supporting patients with information on services that are available and makes explicit reference to the role of Links practitioners, which directly support the floor of the house in the HOC approach to CSP, and signposting to wider services.

More widely, the programme of work being undertaken in Scotland supports the spread and scale of CSP. The three BHF funded sites link in with the two other Scottish HoC sites funded and supported by the Scottish Government and the Health and Social Care Alliance Scotland. These sites sit within a broader suite of person-centred care work in Scotland, led by the Health and Social Care Alliance Scotland, with HoC joining with Self-Management and Third Sector Integration Team programmes to form their 'Self-Management and Co-production Hub'. This builds on recent work by the Health and Social Care Alliance, such as the National Links Worker programme delivered in GGC, which aimed to support practice teams to build their capacity for helping people to address social issues that may affect their health. This included embedding the new role of Community Links Practitioners in practices. This suite of work will support scale and spread of CSP and self-management across Scotland, alongside the current building of capacity and a case for change.

The Health and Social Care Alliance Scotland has received a further one year of funding (until late 2018) from the Scottish Government to support the overall House of Care programme work in Scotland, *"which gives additional support to sustainability, spread, scaling and legacy from the BHF programme".* One of the key tasks for the Health and Social Care Alliance Scotland will be *"to further support sites in building self-management networks and linking with other self-management funded projects".*

At a local level, the HoC approach features in strategic documents such as 'Moving Forward Together' in GGC. Nationally, the HoC has been referred to as a way of supporting system level change, and is included in the primary care transformation evidence collaborative, with work currently underway to build an evaluation framework. While stakeholders noted that this did not guarantee longer term embedding and success, it was also stated that *"these hooks are important to build from."*

The policy drivers above sit in a landscape in which cluster working is developing, offering the opportunity for areas to innovate and try new approaches at scale. The engagement of Cluster Quality Leads with CSP can also support the wider drive and implementation of the approach. Additionally, this innovation is underpinned by an investment in primary care services made by the Scottish Government, which specifically included funding to test new ways of delivering primary care services.

However while many of the changes are favourable for CSP, a reform in contract may create a barrier to uptake in new ways of working while general practice stabilises and figures out how best to deliver the contract's aims. The contract does not make explicit reference to CSP nor the HoC approach to CSP and so this could encourage a focus on other ways of delivering person-centred care. Furthermore, future changes in the workforce model could impact on the ability of practices to deliver CSP with a significant number of nursing staff due to retire in the next ten years. Overall, while these changes may support the approach, it is not yet clear how this will ensure a change in culture to become more person-centred.

2.1.3 Conclusion

Overall the landscape for CSP is favourable and a move towards more place-based care in England and further integration in Scotland paves the way for CSP to be meaningfully sustained beyond the programme. However, there are likely to be a number of challenges to this, not least the absence of more practical 'how to' guidance for implementation at a local system level.

The wider financial and operational challenges within the NHS has driven a focus on new ways of working to alleviate some of the pressure on primary and secondary care. CSP provides several mechanisms through which this can begin to happen, including encouraging a more effective use of practice skill mix, increased supported self-management and stronger integration with wider services outside of the 'traditional' health landscape.

Additionally, the financial climate may reduce the appeal of making practical changes to the delivery of LTC care, even if the changes could ultimately alleviate the pressure on primary care resources. Focus may continue to centre on sustaining and maintaining rather than transforming services.

The health and social care context has changed considerably since the outset of the programme; this has had various implications for both implementation and sustainability across sites. These implications will be discussed in more detail in the following case studies.

3 Hardwick CCG

At the time of writing, there were 11 practices (out of 18) participating in the programme.

Over the course of the programme the national context has become stronger, providing a favourable environment for CSP to operate within. Coupled with a local history of working towards a person-centred culture, this context has made CSP a strategic priority for Hardwick, and Derbyshire more broadly. Going forward, local policy is also supportive of meeting holistic needs, with 'demedicalisation of care' being a key objective under the place-based systems of care workstream.

In this last year of the programme the main emphasis has been on the CCG monitoring practices and providing support in the face of resource challenges. The majority of practices in the CCG are now participating, with some practices from outside the CCG (but within the same place-based system) also becoming involved. Interest from practices has remained strong throughout, even when in the second year a financial incentive was not provided. Reflecting on the programme as a whole, interviewees identified a number of strengths. Including: a supportive project manager who gave intensive support to change systems, and was responsive to emerging needs and the support of two clinical leads supporting practice buy-in. Interviewees talked of two main challenges; finding clinicians to attend the train the trainer training, and the loss of key practice staff, which has meant that some practices have had to cut back on the number of patients they have seen.

There were a number of outcomes reported by stakeholders, these include: increases in patient satisfaction, changes towards a more person-centred approach, expanded roles and increased confidence for HCPs, and potential future clinical outcomes such as better management of medicine. Sustainability plans are strong under the favourable local context described above; CSP is contained within the STP, and the likelihood of spread across the Derbyshire footprint is high. Practices which are more likely to sustain, are those which have had good resource for organic growth, with engaged GPs, experienced nursing staff, and proactive admin support. The consensus amongst interviewees was that whilst CSP would continue, this would not necessarily be through the HoC framework. The absence of a well-funded programme coupled with the desire for greater flexibility will mean that an adapted approach will prevail.

A number of lessons have emerged over the course of the programme, including: the impact that contextual challenges facing primary care nationally can have on willingness to change, the importance of taking a whole practice approach to support the embedding of changed practice and culture, the benefit of having stable practice teams and the value of practices beginning to think about how they might use their systems to capture clinical outcomes in future.

3.1 Introduction

In the final phase of the evaluation we have spoken to 9 interviewees, including the project manager; a CCG lead; two GPs; a practice manager; a nurse practitioner; a practice nurse; a healthcare assistant; and an administrator. There are currently 11 practices (out of 18), which are participating in the programme. Hardwick has had a phased approach to roll-out: 3 practices went live as the programme began, 6 practices went live in the last 12 months, and a further 2 practices have been with the programme for under 6 months.

Over the course of the programme the national context has become stronger, providing a favourable environment for CSP to operate within. The development of place-based systems of care under the Sustainability and Transformation Plans (STPs) will see closer working

between the four CCGs in Derbyshire. The big issues are similar across the county, and speak to a CSP approach, e.g. high prevalence of LTCs, and a greater focus on prevention. Coupled with a local history of working towards a person-centred culture, this context has made CSP a strategic priority for Hardwick, and Derbyshire more broadly.

The rationale for the programme is understood locally in these terms: CSP has been implemented using the HoC framework, and it contributes to ensuring greater patient empowerment, which is 1) the 'right thing to do', and 2) a way of managing demand in a context of increasing financial and service pressures. Since the last evaluation visit, there have been no substantial changes to design, although there have been resource challenges for primary care, which for small practices have impacted greatly on delivery. In particular some nurses, health care assistants and administrators have left (through retirement/moving out of area), resulting in a loss of expertise. This has resulted in a practice having to 'drop out' of the programme and has prevented others from getting involved.

3.2 Implementation

In this last year of the programme the main emphasis has been on the CCG monitoring practices and providing support in the face of resource challenges. There have been attempts to roll out learning and sharing events, but this has not been entirely successful; although there have been some action learning sets in practices, the CCG has found it difficult to find the appetite for anything beyond this: *"They see the value of it but just don't have the time to take out of their clinical practice, it's not seen as an essential thing to do."*

Reflecting on the programme as a whole, interviewees identified a number of strengths. They described a supportive project manager who gave intensive support to change systems, and was responsive to emerging needs (e.g. by providing additional hypertension training). The support of two clinical leads – who have been involved since the programme began – has also been a key facilitator for ensuring practice buy-in. Practice staff in particular described how the practical support from the CCG informatics team was also valued: *"What was wonderful was having the support with IT and the structure which we could then make fit our patients – for example that template to start with, and having that expertise come in to support you."*

Implementation was also aided by good uptake for involvement in the programme, right from the onset. This has continued, with two more practices coming on board this year. The majority of practices in the CCG are now participating, with some practices from outside the CCG (but within the same place-based system) also becoming involved. Interest from practices has remained strong throughout, even when in the second year a financial incentive was not provided.

Interviewees talked of two main challenges; the train the trainer training, and the loss of key practice staff. The CCG struggled to find a clinician to attend the training, and felt the criteria too rigid when they were not supported with their wishes to train a very passionate and engaged administrator. The inflexibility of eligibility criteria was described as impractical and obstructive to implementation. In addition, a number of key (trained) practice staff leaving this year has meant that some practices have had to cut back on the number of patients they have seen. Practices have struggled to replace these staff, with one interviewee saying that they were now advertising for the role of a practice nurse for the fourth time; the role requires a unique set of skills, combining both CVD and primary care expertise.

More than medicine

The CCG benefits from a Derbyshire-wide healthy lifestyles service *'Live Life Better Derbyshire'* funded by the county council, and providing access to a health trainer. There has been some work to link the HoC programme to this service, although most interviewees thought that the use of the health trainers would have happened regardless. It is also difficult to assess the impact the programme has had on use of the service, since patients in receipt of health trainer support have not been tracked for involvement in the programme.

Going forward, local policy is supportive of meeting holistic needs, with 'demedicalisation of care' being a key objective under the place-based systems of care workstream. This will enable closer working across the NHS and LA, although there is some way to go before this way of working is embedded in primary care: *"It still feels a little bit outside of the core business of primary care."* Public health moving to the LA presents a particular challenge; the CCG does not directly commission these services, and has no access to data on referrals and outcomes.

Health inequalities

Practices were asked to identify their own hard-to-reach groups at the start of the programme. For some this was the working population, which was accommodated by reserving early morning and evening appointments for working people. A couple of practices also identified the housebound; in these the HCAs and nurses provide home visits to run the tests and consultations. Another couple of practices have catered for those with low literacy skills by including a picture format and colour coding in the results letters. One of our interviewees also described how the Polish community was a significant minority group for their practice; they worked with a community cohesion officer who would contact patients and accompany them to appointments – although this service has now been lost the practice have recently employed a Polish receptionist who could help support this group in the future.

A more systematic analysis of reach is not possible as the CCG does not receive data on patient demographics for those going through the programme. Data on the respondents to the evaluation questionnaire do however show an under-representation of the BME community – with only one response out of 415 questionnaires coming from a respondent who did not describe themselves as 'White British'.

3.3 Outcomes

There were a number of outcomes reported, here we focus on those which are qualitative:

- Patient feedback has been very positive – Interviewees talked about very positive feedback from patients who returned questionnaires (see Section 8). Practice staff also talked about informal feedback from patients, which has shown that the change in process and style has been largely welcome – although not all patients have preferred being more involved in the consultation: *"It's given them an opportunity to think about what their condition for them actually means, and not just the results, but the sorts of things that they can take back to the next consultation, things that might not be directly related but that they really want to talk about, that may be non-clinical...it just says to them you know this is your half an hour, what really matters to you?"*
- Some progress in relation to culture change – Most interviewees thought that substantial in-roads have been made in terms of changes towards a more person-centred approach. Culture change was described in terms of better awareness of non-clinical needs and a consultative style which allows for greater patient involvement:

"This whole conversation about asking what matters most, has been the difference between the old style and this new way of working – taking it out of the purely clinical conversation and using this as the catalyst to take that management forward."

"The whole idea of person-centred approaches has suddenly become more prominent, that it's not acceptable to see someone, talk about their bloods and send them out the door, without exploring other things that are going on, so I think there is a general culture shift in managing LTCs".

"There will still be individuals that aren't doing the 'partnership approach' but the difference is that this has flipped, there's now more doing it than not. That's the most tangible change… that's how I see culture change, some of the ones that were most against it are now doing it."

The success in culture change was partially explained by a receptive primary care sector, which was already moving in this direction; the programme has therefore acted as a catalyst in achieving change faster: "*We've always been innovative so that old 'we've always done it this way' doesn't wash here."* A couple of interviewees also reflected that the culture change is not yet embedded in routine practice, and that more is required to spread change across whole teams and for all patients: *"I would have liked this to be the main way of doing things...quite a small percentage of patients have gone through the process."*

- <u>The programme has provided opportunities for staff development</u> – Some interviewees also reflected on the expanded – and transferable – skillset of staff, particularly HCAs who were described as having a more interesting job, where their confidence has grown.
- <u>Resource impact favours a multi-morbidity model</u> – The anonymised resource analysis was shared with all practices across the CCG – including those not in the programme. In this last year the CCG has extended the analysis to two further practices, and the previous findings have remained consistent: the biggest gains have been from moving to a multi-morbidity model, which makes use of a skillmix across the team, (see Section 8).
- <u>There is potential for future impact on clinical outcomes</u> – Interviewees were unanimous in saying that it is too soon to see clinical change, which is attributable to the programme. There were some anecdotal reflections however; one respondent said that they thought some patients had better control of their conditions, which in the longer term could lead to a reduction in medication and care utilisation.

3.4 Sustainability

Sustainability plans are strong under the favourable local context described above; CSP is contained within the STP, and the likelihood of spread across the Derbyshire footprint is high. Practices which are more likely to sustain, are those which have had good resource for organic growth, with engaged GPs, experienced nursing staff, and proactive admin support. A few practices will be extending their cohorts going forward, but a couple have not gotten to a sustainable point – mainly due to the staffing challenges mentioned above.

The consensus amongst interviewees was that whilst CSP would continue, this would not necessarily be through the HoC framework. The absence of a well-funded programme coupled with the desire for greater flexibility will mean that an adapted approach will continue: *"Can we tweak the process so that we can make it more practical…I like the principles and we have qualitative data that shows patients definitely benefit from this." A* particular element which was described as not continuing, was the 'rigid' training and QA.

Practice staff discussed how they would sustain the combined appointment but would not continue with the results letter, as this was considered the most resource intensive element of the process.

3.5 Key lessons

A major lesson which has continued throughout the programme, relates to the contextual challenges facing primary care nationally. As well as the well-versed constraints on resource, the sector is constantly in flux, with required changes coming through a multitude of processes (e.g. CQC visits, changes in QOF). This means that there is an unwillingness to change anything that is not considered essential: *"They are caught up in the day-to-day of seeing patients, and anything that doesn't add value to that they don't see as important because they can't afford it."*

Another key lesson has been in relation to involvement of whole practice teams. Some interviewees reflected that the changes adopted were restricted to small teams within the practice, and that in retrospect it would have been more beneficial to adopt a whole-practice approach; this would have allowed for greater embedding of changed practice and culture. Staff retention would also have had less of a destabilising impact; one interviewee said that the approach of selecting particular cohorts was not conducive to a whole-team approach, as it meant that it became part of individuals' roles rather than something that was embedded in wider practice.

Finally, some interviewees reflected on the future in terms of those outcomes which have not been observable in the lifetime of the programme. Clinical outcomes in particular will be of interest to clinicians, and it was thought that these will not be seen for at least another five years. In terms of the practicalities of capturing these outcomes, this can only be done on a practice-by-practice level as the CCG does not have access to this type of personal data. Practices will need to use their systems to identify patients having gone through CSP approaches, before tracking individual and population level trends. These outcomes can then be used to assess impact on care utilisation across the system.

4 Newcastle Gateshead CCG

All Gateshead practices have now received initial YoCP training and most process changes in practices are now complete. All evaluation practices and most Gateshead practices are now delivering care in line with the full HoC approach to CSP. Practices have been implementing the HoC approach to CSP slightly differently depending on resource pressures, the perceived needs of their patient cohort, skills/capacity of HCPs and existing practice set-ups. Key differences include the length of CSP appointments and administrative processes for booking appointments.

Social prescribing work has continued to develop over the past year and is well aligned with CSP. In general this work has been slower to emerge as it has required building trust in the approach among HCPs. Patient involvement has been an important part of the CCG's change process: Gateshead's patient reference group has continued to champion the CSP approach.

A number of emerging outcomes from implementation of CSP were shared by stakeholders including, increased patient satisfaction and preparation, more constructive, person-centred CSP consultations – which in many cases have revealed previously unknown support needs, better relationships between patients and HCPs, increased HCP enjoyment of their roles, and signs of change in culture where more focus is put on the patient as an agent in their own care. More widely, stakeholders feel that patient care is now more streamlined and practice nurses are referring patients on to care navigators and VCS services more frequently, with an increased awareness of social prescribing among HCPs reported. Furthermore, HCPs felt that the social prescribing work has helped to reduce social isolation, better support psychological needs and the needs of harder-to-reach groups. However one patient representative and one strategic stakeholder felt that not all patients were aware of the follow-up services available to them and more work could be done to raise awareness.

Stakeholders were strongly in favour of sustaining the approach given extensive inputs and buy-in over the last few years. It is viewed as a forward-thinking way to reduce primary care pressures and all stakeholders feel it has had substantial positive outcomes. Over the past year, the CCG has focussed on embedding existing work within Gateshead, linking with and standardising the approach across Newcastle, sharing best practice and building on evaluation findings. Stakeholders identified a number of factors that were essential for ensuring sustainability, including: in-kind time provided by senior staff to develop the partnership approach and continued CCG funding for training and the Local Incentives Scheme.

Over the course of the programme, a number of key lessons emerged, which support the implementation and future direction of CSP locally. These include: the success of using train the trainers and internal facilitators to support practices in Gateshead, the importance of strong clinical leadership to drive whole practice buy-in and supportive and engaged administrative staff, the need to ensure patients are well informed and the need to allow practices flexibility to tailor administrative systems and recognising what is feasible for them to achieve.

4.1 Introduction

The third and final visit to Newcastle Gateshead CCG was undertaken in November 2017. Seven interviews were conducted with: four strategic stakeholders including the project manager; two practice-based strategic/delivery stakeholders and one nurse practitioner from a practice that is implementing CSP. A meeting with CCG representatives and two patient reps was also observed.

Over the past year, a number of CCG-level changes have occurred that, as discussed below, have or may affect the project in the future. These include the decommissioning of "Livewell Gateshead" in April 2017, a Local Authority service supporting social prescribing ; and introduction of the STP contract (at present the CCG are unclear whether the CSP mentioned in the STP contract aligns with the HoC approach to CSP and what staff changes the STP will involve). This year the CCG also tightened their Local Incentives Scheme funding requirements to make preparation and results-sharing with patients compulsory across all practices and have merged their Steering Group and Operational Group.

4.2 Implementation

All Gateshead practices have now received initial YoCP training and most process changes in practices are now complete. All evaluation practices and most Gateshead practices are now delivering care in line with the full HoC approach to CSP, and buy-in has been excellent. However, a few non-evaluation practices in Gateshead and Newcastle are still not fully engaged with results-sharing and patient preparation.

All stakeholders interviewed are strong advocates of the importance of results-sharing to maximise patient outcomes, however they reported a lack of buy-in among staff in some practices. Patient representatives have been working closely with practices to encourage them to implement results-sharing and prepare patients for their CSP consultation. The CCG has also focussed on decreasing practice variation through altering Local Incentives Scheme funding requirements (as above) and aligning funding schemes across Gateshead and Newcastle.

A key part of implementation this year has focussed on delivering quarterly "top-up" training and providing bespoke support to practices from the six Gateshead trained trainers. The aim of this is to further embed culture change in practices by continuing to reinforce the rationale for why process changes have been made as well as addressing specific training needs identified by HCPs. The hope is that this will also support more systematic results-sharing.

"Particularly with understanding the purpose of it, I think there's a risk that people focus on the process, because at the beginning you do need to do a lot of process changing but [you need] to keep at the centre what you're actually trying to make the difference for."

Practices have been implementing the HoC approach to CSP slightly differently depending on resource pressures, the perceived needs of their patient cohort, skills/capacity of HCPs and existing practice set-ups. Key differences include:

- Administrative processes: smaller practices typically call patients to book appointments while others may use a triage process or require patients to call in themselves; one practice nurse reported having protected time to send care plans and appointment letters while others use separate administrative staff; and some practices have changed to birth month recall while other have combined CSP appointments with GP medication reviews;
- Patient cohorts: one practice reported using a CSP style consultation for all patients attending any GP appointment, while others have a fixed cohort and still focus on LTC annual review patients. and
- Length of CSP appointments: some practices have fixed appointment times while others allow flexibility depending on the LTC/combination of LTCs.

Social prescribing work has continued to develop over the past year and is well aligned with CSP:

"We have found that practices that are on-board with social prescribing are often aligned with care and support planning – I think there's a real shared philosophy."

In general this work has been slower to emerge as it has required building trust in the approach among HCPs. The CCG has three main approaches to implementing social prescribing: patient signposting (using posters or reception staff); longer HCP appointments/care navigator referral; and longer-term, more intensive support, usually from Voluntary and Community services (VCS) (for example, support with anxiety). Despite the loss of the 'Livewell' service which stakeholders felt has left a gap in provision, they feel there is sufficient coverage of VCS and follow-up services. However, almost all services are under-funded (this is part of a wider, national problem).

Patient involvement has been an important part of the CCG's change process: Gateshead's patient reference group has continued to champion the CSP approach, particularly the results-sharing aspect; developed and promoted "Our Gateshead" to connect patients with follow-up services; supported the development of last November's LTC strategy; and designed leaflets and engaged with receptionist groups to better inform patients of CSP and signposting to follow-up services.

4.3 Outcomes

Despite some initial reservations among patients, those who have now received their second or third annual review are generally very happy with the service as reflected in patient interview findings from the CCG's internal evaluation. In particular, patients and staff highlighted the benefit of sending out results prior to the consultation: in some cases this has led to patients making considerable lifestyle changes even before their second appointment while in others it has calmed and reassured patients in advance of their appointment.

Patients feel reassured that they can look at their results again whenever they like, compare them with previous years and think about what they would like to discuss. HCPs report that this has led to more constructive, person-centred CSP consultations and in many cases has flagged previously unknown support needs. Longer consultations have also allowed patients to build better relationships with HCPs and have made them feel more comfortable and relaxed.

"There's something about the information clicking because it's yours, and taking the responsibility for it."

"The results actually give the patient the time to think about it in their own way and to share it with their family if they wish."

Furthermore, HCPs felt that the social prescribing work has helped to reduce social isolation, better support psychological needs and the needs of harder-to-reach groups. However one patient representative and one strategic stakeholder felt that not all patients were aware of the follow-up services available to them and more work could be done to raise awareness.

In line with internal evaluation findings, HCPs are, in general, very positive about the approach and a culture change emphasising the patient as an agent of their own care is evident among stakeholders (strategic and delivery) and patients. Most nurses find the approach empowering, rewarding and enjoyable and have seen the positive impacts on patients' first-hand. Strategic stakeholders feel that the flexibility given to practices for early systems-change and implementation has been a key driver of HCP buy-in. However, outside of the evaluation practices, particularly where whole practice buy-in has been poor or where

individuals are used to treating single conditions, some nurses and GPs have struggled to engage with the approach.

"In the evaluation practices I feel like it's a set-up, different way of working and the staff who've led that are really on-board with the philosophy behind it and why they're doing things differently."

"I think people [nurses] have grown in confidence but I think there is probably still variation that takes a long time to work through."

More widely, stakeholders feel that patient care is now more streamlined and practice nurses are referring patients on to care navigators and VCS services more frequently. Internal audit results also reported evidence of culture change among HCPs relating to a greater awareness of social prescribing. While resource analysis work has shown that conducting combined multi-morbidity reviews is more cost-effective, the cost implications of CSP are still unclear. The CCG are also currently trying to identify the number of non-elective services accessed by patients who have attended a CSP appointment to look at longer-term impacts on the wider health system.

4.4 Sustainability

All stakeholders interviewed are strongly in favour of sustaining the approach given their extensive inputs and buy-in over the last few years. It is viewed as a forward-thinking way to reduce primary care pressures and all stakeholders feel it has had substantial positive outcomes. Over the past year, the CCG has focussed on embedding existing work within Gateshead, linking with and standardising the approach across Newcastle, sharing best practice and building on evaluation findings:

"From a project perspective it's been about how to embed, how to make it sustainable, and the evaluation."

Stakeholders identified the in-kind time provided by senior staff to develop the partnership approach, and continued CCG funding for training and the Local Incentives Scheme as essential for ensuring sustainability. Continued funding for the Local Incentives Scheme over the next three years has now been agreed by the CCG. However, while national funding for social prescribing work should support local sustainability and the emergent culture change should be self-sustaining, funding for more navigator posts, training for nurses and GPs to better identify referral pathways would be useful.

Finally, the team are working hard to sustain the patient reference group after the end of the LTC involvement officer funding in March 2018 and are producing a film about the CSP approach to share with stakeholders. The CCG is also working to improve patient involvement in the social prescribing workstream. Other plans focus on delivering mental health training to meet HCP skills needs, extending the CCG's funding requirements in 2018/19 to include frailty, and supporting staff to extend the approach to COPD conditions by expanding spirometry skills.

4.5 Key lessons

Stakeholders felt that extensive in-kind support at strategic level has been essential for project success. This includes the CCGs work to develop a LTC multi-morbidity template for practices, which has been well received. The HoC approach to CSP was also identified as a useful framework for project planning at both CCG and practice level and the support of the

patient reference group, including providing patient stories at steering group meetings has helped to drive HCP engagement.

Interviewees reported that using train the trainers and internal facilitators to support practices in Gateshead has been particularly successful. Having trained clinicians delivering tailored training has helped to support practice buy-in as trainers are well respected and have experience delivering the HoC approach to CSP in their own practice. Short, tailored "top-up" trainings have also helped to maintain momentum, particularly after staff changes. In hindsight, strategic stakeholders mentioned that using this approach right from the start would have been beneficial.

At practice level, delivery was identified as being particularly successful in practices that had a stable staff group/low staff turnover, strong clinical leadership to drive whole practice buy-in and supportive and engaged administrative staff. Ensuring patients were well informed about the new approach via leaflets, posters, information on the practice website and having the next stages clearly explained during the data gathering appointment was also identified as vital to ensuring patient buy-in and positive outcomes.

Finally, allowing practices flexibility to tailor administrative systems and recognising what is feasible for them to achieve has been important. Several stakeholders highlighted the success of using a triage process to allocate patients to clinicians for their CSP appointment. Having a flexible appointment time depending on patient need rather than generic timeslots for CSP consultations was also identified as leading to better patient outcomes.

"It is quite a complicated administration process and I think it does need to be different depending on the skills-set of the practices and how things work".

5 NHS Greater Glasgow and Clyde

CSP is live in fourteen practices as part of the BHF programme, four of which have a specific target population that includes coronary heart disease (CHD). Other practices cover patients with CHD within diabetes reviews, and one practice is delivering CSP for a range of conditions. All practices opted to introduce CSP focused on people with Diabetes initially, many of whom also have CHD. The HoC Project Manager has encouraged practices to expand their LTC focus and provided support where needed, however some practices continue to raise concerns about the "*requirement*" for a two-step appointment process.

Stakeholders reported that practices are *"largely following the approach set out by Year of Care Partnerships*". However a number described some flexes in approach (while remaining faithful to the underlying principles) that had helped with the practical implementation of CSP. The team in GGC has made progress in developing their patient engagement work over the last year; they have invested significant in-kind resource in supporting patients to become representatives on sub groups and the HoC steering group. Progress with more than medicine has been slower than hoped (despite ongoing national support from the Health and Social Care Alliance Scotland) but GGC, on the whole, benefits from a wide range of local services. Stakeholders shared examples of ways in which practices had started to further the 'More than medicine' element of the house themselves.

Many interviewees reflected that it was a little soon to begin to explore outcomes from the implementation of CSP, particularly when considering clinical impacts. A number of emerging outcomes were nonetheless shared by stakeholders, including: an increased patient engagement and ownership of conditions for some patients, some increased patient satisfaction and improvements in HCP morale. Plans are underway to support sustainability locally, which have been bolstered recently by securing funding for the continuation of the project manager role for one year. All stakeholders interviewed agreed that a more person-centred and collaborative approach to LTC care is the "*right way to go"* and many felt that the HoC approach to CSP presented an opportunity to put this ethos into practice. Many were therefore in favour of sustaining the HoC approach to CSP and interviewees were confident that it would be sustained in practices already implementing. However some interviewees felt that the vast area covered by GGC presents a challenge to scaling and spreading CSP. Stakeholders suggested that repackaging the support offered to practices would be crucial to ensure that this could happen within the envelope of available resources.

Over the course of the programme, a number of key lessons emerged, which support the implementation and future direction of CSP locally. These include: taking a whole practice approach to training and implementation, having a role in place (such as a project manager) to co-ordinate and support practices, the importance of tailoring the approach to fit with practice and patient needs, and promoting a focus on culture not process.

5.1 Introduction

The third and final site visit in Greater Glasgow and Clyde (GGC) was carried out in November 2017. Eleven interviews have been carried out, four of which were conducted with staff implementing (CSP). Other stakeholders who were interviewed included the HoC Project Manager and a patient representative.

A number of national level changes have occurred over the last two years that have had an impact on the context in which CSP has been implemented in GGC; predominately, the discontinuation of the Quality and Outcomes Framework (QOF) and new, draft Scottish GMS contract. Both of these represent significant changes for primary care, in terms of culture and

delivery. *'It's been a huge rollercoaster, not House of Care, but contractually, which has totally changed the landscape and its continually changing."*

These changes are explored in more detail in chapter two of the report and are highlighted, where relevant, below.

5.2 Implementation

CSP is live in fourteen practices as part of the BHF programme, four of which have a specific target population that includes coronary heart disease (CHD). Other practices cover patients with CHD within diabetes reviews and one practice is delivering CSP for a range of conditions. GGC has three trainers in place able to deliver CSP training (one of whom is also a trainer in Tayside) and have recently delivered sessions to another 23 HCPs. Interviewees reflected that this training would offer new opportunities to identify new local clinical champions and trainers and support a self-sustaining model. The project has also been supported by their HoC Steering Group and significant in-kind resource from wider teams including Primary Care and GMS.

All practices opted to introduce CSP focused on people with Diabetes initially, many of whom also have CHD. The HoC Project Manager has encouraged practices to expand their LTC focus and provided support where needed, however some practices continue to raise concerns about the "*requirement*" for a two-step appointment process. Interviewees reflected that a perceived increase in resource to deliver two-step appointments as well as uncertainty around the focus of the new GMS contract had contributed to a reluctance amongst some practices to include a wider range of conditions. An analysis of indicative costs for CSP undertaken locally reflected a slight increase in both time and costs to deliver CSP for patients with diabetes but a reduction in costs for those with CHD. It is hoped that taking a more holistic approach to LTC management would encourage further cost savings going forward.

Overall, stakeholders reported that practices are *"largely following the approach set out by Year of Care Partnerships*". However a number described some flexes in approach (while remaining faithful to the underlying principles) that had helped with the practical implementation of CSP. These adaptations included: using an online resource to upload diabetes test results and conducting CSP consultations by telephone for a small number of patients who struggle to attend two appointments e.g. some patients with carers.

"Do you need to have a set of results when there are other ways you can prepare the patient e.g. you can sent out in an information letter in advance, what matters to you leaflets, what you want to talk about, goals, you can still do that in advance you don't need two appointments for it."

Most interviewees were in agreement that a degree of flexibility in the CSP approach was beneficial for engaging new practices as well as in aiding implementation. All stakeholders reflected that ensuring patients are prepared is a critical part of CSP but many felt that finding alternative ways to do this would allow for a more tailored response to a patient's needs. *"We can't be stuck in parameters, we need to explore with patients how they want to be prepared and find out what they want"*

There is an appetite for understanding how else might you prepare a patient that is different from physically coming in."

The team in GGC has made progress in developing their patient engagement work over the last year; they have invested significant in-kind resource in supporting patients to become

representatives on sub groups and the HoC steering group. The patient representatives play an important role in supporting the implementation of CSP locally, e.g. they have recently shared feedback on the results letter and leaflets patients receive as part of CSP and offered suggestions on how these could be tweaked going forward. It is also hoped they will begin to help support local work around 'More than Medicine' building on the already strong foundations in GGC.

More general progress in relation to 'More than Medicine' continues to be slower than hoped at the outset (despite ongoing national support from the Health and Social Care Alliance Scotland), however stakeholders reflected that GGC, on the whole, benefits from a wide range of local services and so focus of work should be to ensure this information is captured and widely known. Stakeholders also shared examples of ways in which practices had started to further the 'More than medicine' element of the house themselves. Staff at one practice involved in the House of Care programme were concerned about patients with hypertension, diabetes and who were overweight and felt there was not appropriate wider provision in the local community to support these patients to manage and meet their own goals. As a result of the practice's new way of thinking "*driven by the HoC programme*", the practice started a weekly walking group, which has been very successful. Patients enjoy the social aspect of meeting up, have created friendships and there have also been improvements in bio-medical indicators as a result, for example a number of patients have lost weight and improved their blood pressure. The team at the practice has recently won the 'Chairman's Improving Health Category Gold Award' in GGC for this work.

"It's something that we traditionally wouldn't have looked at because obviously the medical model is very different from the social model, I think you need to encompass both."

5.3 Outcomes

Many interviewees reflected that it was a little soon to begin to explore outcomes from the implementation of CSP, particularly when considering clinical impacts. A number of emerging outcomes were nonetheless shared by stakeholders, strengthening those reported previously:

- A number of interviewees shared that implementation of CSP had "*renewed*" a focus on person-centred care and furthered this agenda both locally and nationally. Stakeholders highlighted that the project had provided a greater understanding and clarity of what person-centred care looks like in practice. As one interviewee noted, *"I guess what it gave us was more of a framework and showed us the bits that need to be in place."* The funding from BHF had also provided impetus to focus on implementing CSP for conditions beyond diabetes, "*without this we'd still be doing just diabetes, we wouldn't have even thought about doing one more condition never mind multiple conditions, we'd be thinking how can you do that and figure it out."*
- HCPs reported that patient engagement with CSP has improved over time and that some patients are taking more ownership of their conditions, this was also reflected in local evaluation work undertaken with patients. In particular, some patients feel they have a greater understanding of their condition and receiving their results enables them to monitor their progress over time as well as think about what they would like to discuss at their second appointment. HCPs provided multiple examples of patients who had arrived at their CSP appointment with a list of goals and felt able to talk through previously unknown needs. The completion of care plans was also thought to be beneficial for providing patients with a wider record of their general health and goals over time, providing further incentive to make changes.

Local work undertaken with patients revealed that many were very happy with the new style of review, feeling that their nurses supported and worked in collaboration with them as well as listened to their concerns. Most felt they had the skills and information to support them to self-manage and found it helpful to have everything recorded in a care plan (Traci Leven, House of Care Patient Experience Evaluation, 2017).

A number of interviewees however reported that patient engagement was variable and some groups of patients did not read their results letters or want to make goals. A number of stakeholders felt that this was likely a result of differences in patient preference but some suggested that it could be difficult for non-English speakers and those with low levels of literacy to engage with the current approach.

- A number of HCPs described improvements in their morale and increased enjoyment of delivering LTC care for patients. For some staff, CSP has led to a larger role for them within their practice and this has been rewarding, *"it's much more enjoyable to do [reviews] now compared to what it was like previously."* Two interviewees also felt that CSP had encouraged the practice to work more as a team, as *"we're better at managing it, I feel we work much more as a team because of House of Care, everyone has their own roles that work together but everyone knows what those roles are so there's not the stepping on each other's toes things which is quite important."* One practice has recently won an award in Glasgow for starting up a practice based walking group, which was driven by an aim to strengthen the 'bottom of the house' locally.

5.4 Sustainability

All stakeholders interviewed agreed that a more person-centred and collaborative approach to LTC care is the "*right way to go"* and many felt that the HoC approach to CSP presented an opportunity to put this ethos into practice: *"The house is a very good framework, it's simple and visual, it helps clinicians unpick what needs to be in place… I see it really clearly as a tool that can help support system change and more person-centred approach"*

Many were therefore in favour of sustaining the HoC approach to CSP and interviewees were confident that it would be sustained in practices already implementing, "*I think if practices carry on and get support and can see the benefits then it's pretty much self-sustaining*". Plans are underway to support sustainability locally, which have been bolstered recently by securing funding for the continuation of the project manager role for one year. Interviewees identified this as key for embedding and sustaining the progress achieved so far. A small number of stakeholders did however suggest that there may need to be further considerations around whether HoC was the best framework around which to implement, particularly as there was a perception among some that planning and implementation had resource implications on an already overstretched workforce.

"Everyone believes in the ethos, the person-centred care, the self-management and the way GPs are bursting at the seams. So even if it was in the absence of anything else we should go out and test. It might be that the model isn't right, the CSP approach, I don't know."

"[We want to extend it more] but we're going to look at the impact in terms of time and things and see how that'll impact on resources."

Interviewees felt that the vast area covered by GGC presents a challenge to scaling and spreading CSP. Stakeholders suggested that repackaging the support offered to practices would be crucial to ensure that this could happen within the envelope of available resources. Interviewees disclosed that supporting practices to implement CSP had been resource

intensive to date and had required a lot of project manager time. Extending this support to an increased number of practices was considered to be unfeasible and so the additional funding for the project manager was welcomed to allow time for implementation support to be reframed, for example, creating a suite of resources and tools for implementation. The three quality assured trainers would also support with this going forward.

A number of interviewees also thought that GP clusters should play a key role in driving the spread of CSP, "*There are so many practices and so far it has been quite resource intensive, I think we will start to roll it out within clusters which is more sustainable and is easier."* We heard that securing the buy in of cluster leads would be an effective way of spreading the message "*as once the cluster lead does it maybe others will follow suit*".

Finally, several stakeholders reflected on the importance of strengthening the links between primary and secondary care if CSP is to be sustained and spread. We heard that this would be key for encouraging a true change in culture to a more person-centred approach to patient care as well as help to improve consistency between services. A number of interviewees felt that linking in with Health and Social Care Partnerships and wider stakeholders in Integrated Joint Boards (IJBs) would drive this, as well support the more general understanding of CSP across GGC.

5.5 Key lessons

Over the course of the BHF HoC programme, a number of key lessons have emerged, which support the implementation and future direction of CSP locally:

- Taking a whole practice approach to training and implementation. The majority of stakeholders reflected that over the course of the programme, there had been an important shift in the way in which practices approached training and implementation, with a much greater focus on involving the whole team rather than one or two clinicians per practice. Interviewees felt that this whole team approach was crucial to success, both to ensure that the practice team as a whole understands and 'buys into' CSP but also to aid implementation and overcome challenges together. A number of stakeholders reflected that the practices that had been particularly 'successful' in implementing CSP were those with strong clinical leadership supported by whole practice buy-in. Local work undertaken with practices to understand the 'acceptability' of CSP using the HoC framework echoes this.
- Having a role in place to co-ordinate and support practices. As described in previous sections, the role of the Project Manager in guiding and assisting practices, particularly with process changes, was highlighted by many stakeholders as a key factor for success. Prior to the appointment of the project manager, interviewees described implementation progress as slow. Interviewees reported that this role had been important in providing practical support to practices and ensuring that implementation was in line with the HoC approach to CSP. This was further boosted by in-kind resource from wider teams including primary care team, GMS team, public health and clinicians on steering group.
- The importance of tailoring the approach to fit practice and patient needs. Feedback from interviewees suggested that making adaptations and flexing the approach would be key to securing wider buy in and longer term sustainability. A number of stakeholders emphasised the importance of practices 'owning' CSP and tailoring approaches to fit their structures and resources, while staying true to the underlying principles. This is particularly important in light of recent practice exits from the programme due to the HoC

two appointment process being "*labour intensive*". *"Making flexes would definitely, definitely make it easier for practices to implement… the way forward is to flex things."*

- Promoting a focus on culture rather than process. The majority of interviewees reported that implementing process changes to support CSP had been time consuming. Some stakeholders felt that this had contributed to practices overly focusing on changing systems and tools rather than developing more person-centred, collaborative conversations and equipping patients and staff with the skills to do this. Ensuring that the workforce are provided with the time and training to focus on the 'bigger picture' rather than immediate changes in process will help to facilitate and drive this change in culture. *"We've been so distracted by the tools, paperwork, the things you fill in, I think we've lost sight of the wider things a bit."*

6 NHS Lothian[11]

The current BHF-funded project fits into a much wider programme of work being delivered across Lothian to implement and embed the HoC approach to CSP – six of these practices have been included in the BHF evaluation. It has therefore benefitted from a significant amount of in-kind resource in the form of senior staff time, existing networks and groups, in-kind 'top-up' funding for the project manager post, and support from Headroom and Wellbeing workstreams.

Initial training and process changes are now complete in the six evaluation practices and more widely, approximately 20% of Lothian practices have received information and training about the HoC approach to CSP. Some differences in administrative processes and appointment structures exist between practices as a result of different practice set-ups, resources and patient cohorts. Patient engagement work and more than medicine initiatives detailed in the last case study have continued this year: both these elements are intrinsically linked to Lothian's much broader model of self-management.

A number of emerging outcomes from implementation of CSP were shared by stakeholders including: increased patient engagement with some patients writing their care plans prior to appointments and coming ready with questions, better relationships between HCPs and patients, an increased role for nurses and HCAs and more frequent referrals to STRIVE counsellors and Wellbeing practitioners.

Strategic leads felt that by itself, the BHF project has limited sustainability. However, given the broader investment and networks in place in Lothian, the work will be sustained after the end of the funding period. At practice level, practices are continuing to move towards a multi-morbidity approach and embed their existing CSP work across their practice, supported by ongoing training and learning sets. The Lothian HoC Collaboration is working to spread the approach across Lothian through rolling out wider training, using learning events to spread best practice and networking with other cluster leads. Work is also ongoing to deliver the approach in secondary care. Stakeholders identified a number of factors that may affect sustainability and the spread of the approach, these included: the introduction of the new GMS contract, the limited time and capacity of some of the wider practices to engage with the approach, and the heavy workload of HCAs, which some practices felt may become unsustainable. Training to broaden the skills of HCAs and nurses to cover respiratory conditions was also highlighted as important for facilitating the spread of the CSP approach across all LTCs.

Key lessons for Lothian that have emerged over the course of the BHF HoC programme include: the need to allow sufficient time and guidance to implement and embed the approach, the importance of learning sets to ensure practice engagement and whole practice buy in to the approach to support process and cultural change.

6.1 Introduction

The third and final visit to NHS Lothian took place in November 2017. Interviews and focus groups were undertaken with 22 stakeholders including: three strategic leads including the project manager, one trainer, three patients and 15 staff from two practices delivering the HoC approach to CSP.

Over the past year, a number of contextual changes have impacted on, or may impact on, project delivery, as discussed below. These include the discontinuation of the Quality

[11] NHS Lothian have been working with the Thistle Foundation to deliver this project

Outcomes Framework (QOF), recruitment of a new, full-time project lead, significant staff changes at practice level and loss of funding for some Wellbeing practitioners.

6.2 Implementation

The current BHF-funded project fits into a much wider programme of work being delivered across Lothian to implement and embed the HoC approach to CSP. It has therefore benefitted from a significant amount of in-kind resource in the form of senior staff time, existing networks and groups, in-kind 'top-up' funding for the project manager post, and support from Headroom and Wellbeing workstreams. Stakeholders feel that while BHF funding has been a catalyst for their work and has provided a solid framework for implementation, progress and outcomes should be considered in the context of the wider HoC workstream.

Initial training and process changes are now complete in the six evaluation practices and more widely, approximately 20% of Lothian practices have received information and training about the HoC approach to CSP. A key focus of work over the last year has been to solidify the culture change occurring in practices through the delivery of tailored, bitesize trainings (20 minutes to one hour) by the three locally trained trainers. These trainings take an "asset-based" approach and focus on health literacy and conversation skills.

In general, practices and strategic leads feel the work is largely embedded across practices and practices are feeling more comfortable with the approach in its second year. Stakeholder buy-in has generally been good, although practice-level stakeholders felt that engagement of GPs and administrative staff could be improved in some instances: lack of engagement was seen to be due to limited understanding/training among these groups rather than an aversion to the approach.

Practices mentioned that the new, full-time project lead has worked hard to reinforce the importance of results-sharing and standardising the approach across practices. As a result, with the exception of one evaluation practice , all practices that have signed up to the approach are now sending out results prior to consultations and all stakeholders interviewed now identify results-sharing as a key component of the approach.

Some differences in administrative processes and appointment structures exist between practices as a result of different practice set-ups, resources and patient cohorts. In some cases patients are required to make their own CSP appointments while in others they are arranged by the practice; one practice is sending out results for separate conditions; one practice uploads their diabetes test results onto an online resource for patients; some use a triage process; some have fixed appointment times while others are patient-specific; depending on the skills of healthcare assistants (HCAs), some nurses do foot checks during the CSP appointment; and in one practice a GP conducts the appointment as the practice is focussing on vulnerable patients.

Patient engagement work and more than medicine initiatives detailed in the last case study have continued this year (alongside ongoing national support from the Health and Social Care Alliance Scotland): both these elements are intrinsically linked to Lothian's much broader model of self-management.

6.3 Outcomes

Patient engagement in year two has greatly improved and interviewees reported that the large majority of patients like the new approach. Most practices appear to be providing clear

information to patients about the format of the new process which has helped to support patient buy-in. Practice staff reported that preparation has improved CSP engagement: some patients are writing their care plans prior to appointments and many come ready with questions.

Longer appointments have also allowed patients more time to raise issues important to them, with patients reporting that they feel well supported and cared for during the appointment:

"The nurses are very good and they do seem to treat you as an individual, as a person."

"I feel that the nurses…they've always got time for you and I think they do their duty over and above being a nurse."

HCPs have enjoyed building a stronger rapport with patients and getting to know them better and nurses enjoy having a bigger role within the practice. They also reported preferring the less "tick-box" approach to the consultation: this has also been aided by the discontinuation of QOF. HCAs have also increased their role and skillsets, although some have felt that they have a very high workload and the information gathering appointment is tightly timed. Some GPs also reported that they are changing their consultation style as a result of the training and think that in the longer-term, the approach will lead to cost savings. Additionally, HCPs reported referring to STRIVE counsellors and Wellbeing practitioners more frequently than before, although some practice staff reported that they would like the project team to provide them with more concrete evidence of project impact.

6.4 Sustainability

Strategic leads felt that by itself, the BHF project has limited sustainability. However, given the broader investment and networks in place in Lothian, the work will be sustained after the end of the funding period. At practice level, practices are continuing to move towards a multi-morbidity approach and embed their existing CSP work across their practice, supported by ongoing training and learning sets. The Lothian HoC Collaboration is working to spread the approach across Lothian through rolling out wider training, using learning events to spread best practice, networking with other cluster leads (e.g. NE Edinburgh cluster lead) and wider stakeholder groups, for example recent meetings with the Lothian lead for practice nursing and the Lothian Quality Academy. Work is also ongoing to deliver the approach in secondary care (their second wave of work with cardiac rehab is underway) and the approach is now being used for diabetes patients and pharmacists as part of the Collaboration's broader aim to ensure whole healthcare teams and systems are working in a person-centred way.

Stakeholders identified a number of factors that may affect sustainability and the spread of the approach, these included; the introduction of the new GMS contract, the limited time and capacity of some of the wider practices to engage with the approach, and the heavy workload of HCAs, which some practices felt may become unsustainable. Training to broaden the skills of HCAs and nurses to cover respiratory conditions was also highlighted as important for facilitating the spread of the CSP approach across all LTCs.

6.5 Key lessons

Stakeholders stressed the usefulness of the whole house as an approach for implementation, not just the CSP aspect. However, they did feel that there has at times been some tension between the broader Lothian-wide approach and the narrower BHF-focussed approach and differences in interpretation of the approach by the YoCP, BHF and the Collaboration took some time to iron out.

In hindsight, practices and strategic stakeholders felt that the very flexible approach to early implementation was difficult: practices felt most of the onus was on them and were a little overwhelmed by choice. All stakeholders highlighted how difficult and time-consuming early process changes were, particularly given early delays with the IT system, with strategic leads reporting that to some extent, these process changes limited the extent to which early culture change occurred. They identified the project extension as having been crucial in allowing sites sufficient time to implement and embed the approach. Stakeholders also felt overwhelmed by the evaluation requirements, with some HCPs reporting confusing with the evaluation process.

Learning sets were seen as key to ensuring practice buy-in. However, while useful in supporting a broad understanding of the HoC, a number of stakeholders felt that the original training sessions were not particularly relevant to managers, were not always well understood by HCAs and nurses, did not provide enough support for translating theory into practice, and in some cases, were delivered too late. Introduction of shorter training sessions has made it easier for HCPs to attend training and having internal, trusted trainers who are aware of the local context and been important for buy-in. Stakeholders feel that delivering these shorter training sessions from the start would have been beneficial.

Whole practice buy-in was identified as critical to project success, however significant staff changes over the lifetime of the project has diluted buy-in and culture change in some practices: the shorter training and bespoke support to practices is therefore important in ensuring “continued reflection and learning all the way through”.

Learnings from the BHF project have supported successful implementation of the new HoC diabetes work.

7 NHS Tayside

As part of the BHF programme, CSP is live in seven practices, two of which have a specific target population that includes at least one cardiovascular (CVD) condition and a further three practices are actively planning implementation of CSP for people with CVD. The majority of practices opted to introduce CSP focused on people with Diabetes initially, many of whom also have CVD. Interviewees suggested that ongoing uncertainty about the content of the new GMS contract had led practices to be more cautious about making "*more significant changes*"; as many stated that it was more straightforward to implement the approach for Diabetes with the two-step appointment process (key step within CSP) already in place. Interviewees reflected that flexibility in the approach to implementing CSP was welcomed and highlighted a number of ways in which they had tweaked or planned to tweak processes, while remaining faithful to the underlying principles.

The majority of interviewees suggested that it was still "*a little early*" to begin to explore concrete outcomes from the implementation of CSP locally, particularly in terms of clinical measures of success. Nonetheless, a number of observations and emerging outcomes were shared by stakeholders, building on those reported in the previous case study. These centred on four key areas: promotion of the person centred care agenda, better use of skill mix and increased knowledge for HCPs, a more collaborative approach to LTC care focusing on what matters to the person and increased support for self-management. Most interviewees thought that CSP would be sustained within the practices already implementing, once the BHF funding came to an end. There were a number of reasons for this, including the extent to which changes had already been embedded and the emergence of positive feedback e.g. in terms of perceived improvements in quality of care. Interviewees were less certain however about whether CSP would be expanded and scaled, particularly without further funding. Tayside has taken the approach of concentrating on ensuring practices implementing CSP do this effectively, rather than trying to scale and spread at pace.

It has been consistently clear that CSP is a long term goal for Tayside and there are multiple resources in place to support this, for example, a cohort of trainers and legacy materials. Stakeholders noted that the aim for CSP is to make this way of working "business as usual" and this is reflected in work to involve specialist services beyond general practice from an early stage. There was agreement among all interviewees that funding would be a crucial factor underpinning longer term sustainability and spread. Tayside are currently looking into alternative sources of funding once the BHF project ends, including the Scottish Primary Care Transformation Fund and ways in which local enhancement schemes could be structured differently.

Key lessons for Tayside that have emerged over the course of the BHF HoC programme include: the importance of the role of the project manager in coordinating and supporting practices to attend training and make changes, the need to ensure that process and infrastructural changes such as IT systems are successfully in place prior to scaling and spreading, and the benefit of having strong clinical leadership and champions with the drive and vision to see how CSP and HoC fits with their values and priorities to support buy-in and spread.

7.1 Introduction

The third and final site visit in Tayside was carried out in November 2017. Nine interviews have been carried out with a variety of stakeholders, including the HoC Project Manager and the Associate Medical Director of Primary Care. Five interviews were conducted with staff from practices which had gone live with CSP; these interviews included GPs and a Practice Manager.

CSP using the HoC approach is considered locally as the "*right way of doing things"* providing an effective framework for delivering a more person-centred, collaborative way of supporting people with LTCs. Over the course of the last few years, there have been a number of national level changes which have changed the local climate in which CSP has been implemented; the most notable of which is the discontinuation of the Quality and Outcomes Framework (QOF) and new, proposed Scottish GMS contract. The proposed contract focuses on new ways of working across extended multidisciplinary teams to alleviate some of the workload pressures general practices are facing. The changes highlighted in the contract are explored in detail in chapter two of the report and are highlighted, where relevant, below.

7.1 Implementation

At present, as part of the BHF programme, CSP is live in seven practices, two of which have a specific target population that includes at least one cardiovascular (CVD) condition[12] and a further three practices are actively planning implementation of CSP for people with CVD. A further 14 practices having received training for their staff, with four actively planning their implementation. Dundee's Keep Well Community Team (now part of Dundee's Community Health Team, which includes Links Workers) are also implementing the principles of CSP through opportunistic, CVD focused health checks for more vulnerable groups, where appropriate.

The majority of practices opted to introduce CSP focused on people with Diabetes initially, many of whom also have CVD. Interviewees suggested that ongoing uncertainty about the content of the new GMS contract had led practices to be more cautious about making "*more significant changes*"; as many stated that it was more straightforward to implement the approach for Diabetes with the two-step appointment process (key step within CSP) already in place. Flexibility around the LTC(s) to focus on at the outset when planning implementation was highlighted as important for buy in. However, all practices have been encouraged and supported by the HoC Project Manager to increase their LTC focus. This is an ongoing aspiration in many practices, however the HoC Project Manager reports a significant shift is beginning to emerge in relation to adopting CSP for one, or more LTCs.

A practical, phased and systematic approach to planning implementation has been taken based on the YoCP process mapping approach used during training. Process mapping is also proving of merit when facilitating implementation reviews, some of which have also been supported by YoCP, in agreement by BHF. Interviewees reflected that these methods have been useful in fostering a measured approach to implementation and ensuring that practices have all they need to effectively facilitate and deliver CSP, particularly those wishing to move towards an approach mindful of people with one, or more LTCs.

Implementation has been largely successful at a local level, although interviewees highlighted a number of remaining challenges – predominately related to the IT systems available to support the implementation of CSP at scale. This included expanding CSP to other conditions. "*From the start there has been a big problem with IT and for me this has been the stumbling block…it only works for Diabetes."* Critical in-kind resource has, and continues to be, provided by the local GMS (IT) team and Project Manager to overcome

[12] It should be noted that this number has reduced from nine practices in 2017 as one practice withdrew from the programme and another is implementing CSP outwith fidelity to the principles and process of the HoC approach.

these difficulties, including offering in-house support and guidance. Progress in relation to 'More than Medicine' continues to be slower than hoped (although there has been ongoing national support from the Health and Social Care Alliance Scotland); the local Dundee pilot to support this aspect received few referrals. It is hoped that the introduction of Links Workers (in Dundee) will help to evolve this aspect of the house.

Interviewees reflected that flexibility in the approach to implementing CSP was welcomed and highlighted a number of ways in which they had tweaked or planned to tweak processes, while remaining faithful to the underlying principles. Examples of adaptations included conducting the CSP consultation by phone for patients with hypertension only, flexing the length of appointment times and asking patients to collect their results from the practice directly. A number of interviewees emphasised that this flexibility was important in aiding implementation at a practice level and encouraging uptake, as practices tweak processes to align with their ways of working. *"You need flexibility and adaptability and understanding of that from those trying to introduce this into practices"*

"I'm sure people will be taking the principles and interpreting them slightly differently, there may be a little variation but we're trying to be true to the processes of CSP"

7.2 Outcomes

The majority of interviewees suggested that it was still "*a little early*" to begin to explore concrete outcomes from the implementation of CSP locally, particularly in terms of clinical measures of success. Nonetheless, a number of observations and emerging outcomes were shared by stakeholders, building on those reported in the previous case study. These centred on four key areas:

1) Promotion of the person-centred care agenda – many interviewees reflected that the HoC programme had advanced local thinking about person-centred care and supported self-management, which sits at the heart of CSP. Stakeholders thought that local work had encouraged swifter moves in this direction, "*It might not have achieved all the outcomes we wanted it to, but in terms of moving people's thinking on it's been really helpful."* Some interviewees noted that the new GMS contract would further accelerate this shift.
2) Better use of skill mix and increased knowledge for HCPs – interviewees highlighted changes in skill mix at a number of practices, with an increased role for healthcare assistants (HCAs) and Practice Nurses. A number of interviewees felt this aligned well with the new GMS contract, particularly the focus on the role of an extended multidisciplinary team in delivering LTC care. Expanded roles for HCA[13]s and Practice Nurses has led to up-skilling for many, with a pool of training to support this widening of roles. For example, training provided in partnership with BHF enhanced clinical knowledge of aspects of CVD care, health behaviour change training and Sage and Thyme sessions focused on building effective communication skills.
3) A more collaborative approach to LTC care – several interviewees noted that implementing CSP within their practices had led to people with LTCs receiving a more person-centred, collaborative consultation for their LTC review. Interviewees highlighted that the tools and training for CSP had enabled them to begin to focus conversations more

[13] It should be noted that not every practice has the HCA role and for some, there is reluctance to expand it, for a number of reasons

around what matters to the patient and had encouraged a more two-way and meaningful CSP conversation. A number of clinicians reported that CSP helps to look at a person holistically, rather than focus on individual conditions. For those practices moving towards a wider LTC approach, it was suggested that this would also lead to efficiencies for the practice as a whole. *"It undoubtedly is improving the productivity and quality of the interaction we are having with our patients."*

"*It's a genuine attempt to do better for a patient by looking at them more widely and dealing with the patient and not the condition"*

4) Supporting self-management – the impact of CSP on people with LTCs was an important area of focus for the interviews and a number of stakeholders shared anecdotal feedback of positive outcomes observed for this group. Interviewees reflected that while engagement with CSP was mixed, for people who were engaging, there were signs of people taking more responsibility for their LTCs. In addition, a number of examples of people having an increased understanding of their LTCs, feeling more empowered and motivated to set their own goals were shared. *"[for some patients] it works very well on helping them focus their mind on what they want to discuss with you that day, it allows them to feel they have control and can take some responsibility over their condition."*

"Patients are taking to it warmly, they are spending time formulating their own action plans and really thinking about goals beforehand, for example, one man is working on lowering his blood pressure"

7.3 Sustainability

All interviewees were asked to consider the sustainability of CSP within Tayside and the potential for rolling it out to other LTCs and practices. Most thought that CSP would be sustained within the practices already implementing, once the BHF funding came to an end. There were a number of reasons for this, including the extent to which changes had already been embedded and the emergence of positive feedback e.g. in terms of perceived improvements in quality of care.

Interviewees were less certain however about whether CSP would be expanded and scaled, particularly without further funding. Tayside has taken the approach of concentrating on ensuring practices implementing CSP do this effectively, rather than trying to scale and spread at pace.

We heard that there was a great deal of willingness and enthusiasm to spread and scale the approach, but that uncertainty over the GMS contract, as well as the national steer from Scottish Government, had hindered progress and made planning for sustainability more difficult. Interviewees felt that plans could begin to accelerate now details of the contract were emerging, yet were less certain about how this would look practically. Many reflected that buy in from Health and Social Care Partnerships (HSCPs) and Integrated Joint Boards (IJBs) and alignment with local, as well as national, strategies would be crucial if CSP is to be sustained; "*HSCPs will have to see this as something they want to work on, it will have to be in their local primary care improvement plan, if it's not it really won't happen and will perpetuate the old way of working. The key is to understand how we get an understanding of CSP to HSCPs, argue the case to them so they put it in their plans."* Despite this uncertainty, it has been consistently clear that CSP is a long term goal for Tayside; "[*We're working to get to] the vision around this being the way we work for everyone all of the time but we've got a long way to go".*

There are multiple resources in place to support this, for example, a cohort of trainers and legacy materials. Stakeholders noted that the aim for CSP is to make this way of working "business as usual" and this is reflected in work to involve specialist services beyond general practice from an early stage. Interviewees noted that developing links and planning services with secondary care will be important, not only to support the scale and spread of CSP, but to improve the consistency of care for people; *"I think it's a little confusing for patients that they are receiving one method of care in one place and another in another, if it was going to happen it would be better across the board."*

Effectively articulating a coherent explanation of CSP and how it is different to current ways of working was also emphasised by a number of stakeholders as an important factor in supporting spread and building a case for change; "*If the differences aren't articulated, it will just perpetuate the current model and it won't materially be any different from what we've had".* This would also support gaining buy in from local clinicians and practice clusters who could act as 'champions' to drive the agenda further forward.

Great progress has been made locally with a minimum level of investment thanks to the hard work of the Project Manager, undertaking multiple roles, as well as the in-kind contributions of time and resource provided by clinicians and wider teams. Despite this, there was agreement among all interviewees that funding would be a crucial factor underpinning longer term sustainability and spread. Tayside are currently looking into alternative sources of funding once the BHF project ends, including the Scottish Primary Care Transformation Fund and ways in which local enhancement schemes could be structured differently.

7.4 Key lessons

Important findings have emerged for Tayside over the course of the BHF HoC programme. Key lessons from these findings are summarised below:

The role of the Project Manager in coordinating and supporting practices to make changes has been crucial. Prior to the appointment of the Project Manager, seven practices received training in cohort 1 to support the introduction of CSP. Only one of practice initially implemented. A further 2 subsequently went live, however 1 withdrew after approximately 6 months. The 5 subsequent training cohorts delivered have achieved better implementation rates, yet some attend training and do not implement for a variety of reasons. The increased implementation rate does highlight the importance of the Project Manager in driving, coordinating and guiding implementation. Additionally, this role has been key in ensuring that expectations are managed locally and that those stakeholders attending training have the suitable skills and experience to support the delivery and embedding of CSP at a practice level. Most interviewees identified this role as a critical success factor and so securing funding to ensure that this coordination role remains in place will be key for future progress. This is particularly important for monitoring that delivery continues and remains faithful to the principles of CSP, particularly as several interviewees noted that changes in culture and language, e.g. having truly collaborative conservations take longer to embed than changes in process.

Ensuring that process and infrastructural changes are successfully in place prior to scaling and spreading is key. Local progress has been hindered by challenges with IT systems and administrative processes (e.g. making changes to call/recall and sending out results). This has led some practices to focus primarily on the process of CSP, rather than perhaps changes in culture and evolving more person-centred conversations, which includes goal setting and action planning. Putting more support in place for administration teams to

support with changes in process and IT will be important for the project to be sustained, *"There has been an underestimation of what was needed, there have been significant changes in process and it's not being supported enough."*

Strong clinical leadership and champions with the drive and vision to see how CSP and HoC fits with their values and priorities has been imperative for supporting implementation. Ensuring central stakeholders are involved and engaged from the outset and know what is expected of them is crucial to support buy-in and spread.

8 Analysis of data returns

This section provides a synthesis of the data gathered, analysed and reported by sites to BHF and ICF. This covers quarterly and annual data returns reported in the following ways:

1. **Information submitted to BHF as part of projects' quarterly monitoring returns (QMR).**

This is data gathered as part of projects' monitoring and self-evaluation. All BHF-funded projects are contracted to supply monitoring data. Within this, each site is required to report project outputs, (e.g. number of patients having a CSP consultation), as well as provide a general progress update including inputs and analysis of the potential risks to their local projects.

BHF administer and coordinate these returns, and ICF receive this information every quarter, in order for analysis to be included in formal evaluation reporting. The last QMRs received were Q3 2017/2018 covering the period up until December 2017.

2. **Outcomes data submitted to ICF in the form of self-evaluation reports.**

Each site selected a number of standardised, evaluation tools to administer locally, at a practice level, to capture information about project implementation and impact. These tools included Long Term Conditions 6 (LTC-6), Consultation Quality Index ((CQI) CARE (Consultation and Relational Empathy measure) and Patient Enablement Instrument (PEI) for Lothian) and the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS). Bespoke excel spreadsheets were provided by ICF for inputting the data gathered using these tools, to support projects with data management and analysis. Sites were then responsible for analysing and reporting this information in a self-evaluation report following a suggested format, as documented in reporting outcomes guidance shared with project managers. The content and style of each self-evaluation report invariably differed to account for local variance in tools used, sample size and pace of implementation. Sites submitted draft versions of these reports in February 2018 with final versions received between February and April 2018.

Each site also conducted qualitative work with their staff and patients; this was locally designed to reflect their project's focus.

All of the data submitted have been aggregated by ICF in order for comparisons to be made at a programme level. The remainder of this section presents this analysis.

8.1 QMR data: programme inputs

Overall, the additional resource contributed to the programme, over and above BHF provision, amounts to just over £338,277. Data submitted by the projects shows that the total non-BHF cash funding contributions made to the programme was £246,834 including the £70,000 additional funding for each Scottish site (Table 8.1).

Measurement of in-kind inputs is a less exact undertaking as it requires estimation of the value of equipment / venues as well as inputs from members of staff. The total estimated in-kind resources across the programme's lifespan amounts to £91,442 with the largest in-kind contribution made in GGC where there was a high level of support provided from the Practice Nurse Support and Development team. Since the interim evaluation, all five sites have continued to describe in-kind resources that had been used but did not quantify these,

including inputs from IT staff, the provision of venues and clinical leadership time. As a result, the table below presents in-kind resources as quantified by the time of the interim evaluation.

There is significant variation in additional inputs across the sites. In relation to non-BHF cash funding, the largest single input comes from GGC (£100,000), £70,000 of which is from the Scottish Government. Hardwick reported no other cash inputs.

Table 8.1 Non-BHF costs and in-kind resources (from QMR data)

Project site	Non-BHF Cash Funding	In-kind resources
Gateshead	£6834	£34,732
Hardwick	£0	£0 (not quantified)
Greater Glasgow & Clyde	£100,000	£51,000
Lothian	£70,000	£0 (not quantified)
Tayside	£70,000	£5,711
Total	**£246,834**	**£91,443**

There is a degree of variation in the ways in which sites have reported non-BHF cash funding and in-kind resources. Sites were provided with a template and guidance for sharing this information but it was not followed consistently. As a result, we aimed to explore the use and value of in-kind resources in our fieldwork but sites reported similar findings to those above. Sites described using in-kind resource to support with IT, to provide venues for steering group meetings and to build a narrative for change through the engagement of clinical leadership and wider stakeholders who shared their time freely. Stakeholders shared the difficulty in quantifying the value of the in-kind resource used but felt that it had been important in driving the projects on.

8.2 QMR data: cohort description

Table 8.2 below gives a breakdown of people with CVD eligible for, and attending, CSP appointments. In total, across the programme 23,889 people with CVD were eligible for CSP. Of this cohort, 7,840 (33%) people attended an information gathering appointment. 13,942 people were prepared for the CSP conversation through receiving their results, an integral part of the approach. 13,061 people were reported as receiving a CSP review[14].

[14] The figures for receiving results and attending a CSP review are higher than those reported for attendance at an information gathering appointment. This is due to coding issues at two sites (Gateshead and Hardwick) which resulted in an under-reporting of numbers attending for information gathering appointments. There were also no submissions made from Lothian, for the number of people attending the information gathering appointment.

Table 8.2 Programme outputs (from QMR data) (% = percentage of eligible population)

	No. with CVD eligible for CSP	No. invited for an information gathering appointment	No. attending information gathering appointment	No. prepared for appt. through receiving results	No. receiving CSP review
Gateshead	11,831	Not collected/ submitted by site	5558 (47%)	11320[15] (96%)	9740 (82%)
Hardwick	1839	1718 (93%)	1412 (77%)	1494[16] (81%)	1483 (81%)
GGC	3461	Not collected/ submitted by site	596 (17%)	Not collected/ submitted by site	500 (14%)
Lothian	5141	2168 (42%)	Not collected/ submitted by site	892 (17%)	1054 (21%)
Tayside[17]	1617	549 (34%)	274 (17%)	236 (15%)	284 (18%)
Total	**23,889**	**4,435 (19%)**	**7,840 (33%)**	**13,942 (58%)**	**13,061 (55%)**

Some stakeholders reflected that more additional resource may have aided progress at a site level, both in terms of initial implementation and the degree to which CSP has been embedded. A number of sites commented on the importance of IT support in the early stages of the project and so dedicated IT time may have sped up the introduction of CSP in practices. In addition, capacity to deliver CSP at a practice level had hindered the ability of some to continue or expand their work. This may have impacted on the numbers of patients that received CSP as a proportion of those eligible to do so.

A further reflection shared by some was on the degree of 'drop off' of patients between the information gathering appointment and the CSP review. Interviewees generally reported that this had not been a significant issue but suggested a number of reasons why this could be the case, if observed, including patients not feeling that a second appointment was necessary for them, or being unable to attend.

8.3 Self-evaluation report data

All sites were given a final deadline in early 2018 for submitting their self-evaluation reports with a cut off for data inclusion requested as the end of December 2017. All sites submitted

[15] This figure is higher than those reported as attending information gathering appointments as coding to capture data around the information gathering appointment was added at a later stage.

[16] The number of patients receiving their results is higher than those receiving an information gathering appointment due to challenges around coding information in a number of practices.

[17] Information reported from Q4 2016/17 onwards

at least a draft version to meet the deadline. The data presented in the rest of this section is taken from these reports.

8.3.1 Limitations

The following aims to give an in-depth overview of findings at baseline compared to follow up time-points, looking at trends in responses which describe the outcomes achieved. However, as each site has progressed at different rates and took a flexible approach to distributing the surveys, there is some inconsistency in the number of questionnaires distributed and collected (i.e. the sample size). This has also impacted on the ability of sites to collect good quality follow-up data, with one sites (Tayside) not collecting any data at all.

There are a number of details that should be borne in mind when considering the analysis within this section:

- Each site has progressed at different rates and furthermore, practices within each site are at varying stages of implementation. This impacted on the ability of some practices to engage with the evaluation to date and so for some sites this has meant a lower return rate for questionnaires.
- The sample size for analysis, especially for follow-up, is relatively small and so the findings presented in this section should be interpreted with this in mind. Furthermore, across each of the five sites, the number of responses to each questionnaire provided by practices is variable.
- The responses included in this report are meant to focus on patients with CVD, excluding those from patients with diabetes only. However, not all sites provided data with this filter in place. Only those sites which have provided a filtered subset sample could be included within this evaluation.
- LTC-6 is a validated tool however it was not developed specifically for use with CSP and so has not been validated for use in this area. Findings should be interpreted with this in mind.
- The length of time over which baseline questionnaires were distributed varied depending on each site's progress with implementation. In addition, the point in the CSP process at which they were completed was different across each site. Follow up timeframes were similarly mixed with variation in the length of time and duration after baseline over which they were distributed.
- There is no guarantee that every eligible patient was given a form or given it at the suggested time. Practices also did not keep a count of the actual number of forms given out to patients so the response rate cannot be determined.
- There are a number of challenges with self-reported patient data. The process requires a degree of self-selection and so returns may not be fully representative of all HoC patients seen during the timeframe. In addition, there is a potential for underreporting of LTCs meaning that patients who have CVD, but have not identified as such, have been excluded from the analysis.
- The data was not paired between baseline and follow up, which means the same people may not be completing both surveys and direct comparison is not possible. As a result, it is not possible to accurately determine whether those that completed questionnaires at follow up also completed the initial baseline questionnaire, or whether questionnaires received at follow up are from patients who had previously received

CSP. In such cases, larger sample sizes are useful to allow more accurate snapshots of a period in time.

Sites have also reported specific limitations in relation to their own data collection practices:

- **Gateshead:** Two practices were unable to participate in the baseline and follow up LTC-6 survey. Three practices had to stop collecting CQI data early as there were no eligible patients and one practice was not in a position to participate.
- **Hardwick:** Only one practice achieved at least 50 responses to the LTC-6 questionnaire and had two full datasets for both years, and only three practices managed to gather data from at least 20 patients for the CQI – this was a result of the phased approach to implementing HoC, which also means some practices submitting data had only been implementing for less than a year.
- **GGC:** Few returns were available from those with CHD in the second year (only 19, though this is proportionally more than in the first period). Adherence to the guidelines set out for data collection was difficult for the project manager to monitor, however subsequent contact was made with the practices where the questionnaire return numbers were low or non-existent. Nevertheless, completed forms were received from patients from all of the 11 practices to varying degrees – practices with low returns were keen to point out that this did not necessarily equate with low numbers of questionnaires issued, reporting that they had given out many more forms than completed. For the purposes of comparison, the data from GGC was divided into two periods of similar duration. This is not a direct baseline and follow up analysis but reflects two consecutive time points between 2016 and 2017. The data was not paired and so we are unable to track whether patients in the first period also completed a questionnaire in the second period.
- **Lothian:** Four practices submitted baseline data only, one practice submitted date at the follow up time point but had not submitted any previous data. One practice submitted both baseline and follow up data but the practice did not target patients with CVD only and one practice did not submit any data.
- **Tayside:** Results are only available at one time period. The site reports that they had intended to compare and contrast feedback at two time points (baseline and follow up). however thisThis has not been feasible due to difficulties engaging practices that were further on in the CSP implementation process, in the evaluation; practices felt unable to meet the requirements of the evaluation with regards sharing and collecting questionnaires. Additionally, in Tayside, people being offered outreach Keep Well health checks were included in the evaluation cohort initially, due to the team applying some CSP principles. The number that were included is small and it is unlikely that they appear in the CVD subset analysis (which is the data reported in Tayside's figures in this section). However, although unlikely, any questionnaires received from this cohort would not be representative of the full CSP intervention and so this should be borne in mind when interpreting the data below.
- Table 8.3 below provides a site by site breakdown of questionnaire numbers included in the programme level analysis. Unless noted, sample sizes of LTC-6 and CQI are for patients with CVD who completed the questionnaire.

Table 8.3 Evaluation sample sizes and details on tools

Site	Cohort size[18]	Questionnaires used	Time periods	Notes on sample	Sample size – LTC-6 Baseline	Sample size – LTC-6 Follow up	Sample size – CQI Baseline	Sample size – CQI Follow up
Gateshead	5558[19]	LTC-6 and CQI	LTC-6 Baseline: March-Sept 2016 LTC-6 Follow Up: Jul 2017-Jan 2018 CQI-2 Survey: Oct 2016 - Jul 2017	CVD patients	190 - prior to the IG appointment	49 – after CSP appointment	189 – after CSP appointment	No follow up data collected
Hardwick	1718	LTC-6 and CQI	Not provided	CVD patients	298 - prior to IG appointment	117- prior to IG appointment	192 – after CSP appointment	51
Greater Glasgow & Clyde	596	LTC-6	Period 1: 1st July 2016 - 31st March 2017 (9 months). Period 2: 1st Apr 2017 - 30th Nov 2017 (8 months)	CHD only/with other LTCs	40[20] - at the IG appointment	19[21] - at the IG appointment	Not being used	Not being used
Lothian	2168	CARE, PEI and WEMWBS	Not provided	CVD patients	Not being used	Not being used	233[22]	197
Tayside	549	LTC-6 and CQI	August 2016 to December 2017	CVD patients	128 – after the IG appointment	No follow up data collected	66- after CSP appointment	No follow up data collected
Total	**10,589**	**N/A**	**N/A**	**N/A**	**656**	**185**	**680**	**248**

[18] Number of people invited for an information gathering appointment

[19] Represents the number of people with CVD who attended an information gathering appointment

[20] 241 people completed a follow up questionnaire however questionnaire data has been reported for the CVD specific sample only

[21] 111 people completed a follow up questionnaire however questionnaire data has been reported for the CVD specific sample only

[22] 234 filled in CARE and 233 respondents filled in PEI and which together make CQI at the baseline. 205 filled in CARE and 197 respondents filled in PEI and which together make CQI at the baseline. This figure includes responses from CVD patients or those who participated in CSP. Practice 1, Practice 3, Practice 4 and Practice 6 submitted baseline data only. No data was received from Practice 2. Practice 5 submitted both baseline and follow up data but as the practice did not target patients with CVD only, data are not included. Practice 7 submitted data at follow up but not at baseline. Surveys where more than two questions are answered 'Does not apply' or are left blank are considered invalid. Lothian also reported results of the WEMWBS survey (which was filled out by 272 people at baseline, and 73 people at follow up).

The findings in the rest of this section are largely based on the analysis of baseline and follow up data, however are not necessarily indicative of the final conclusions that can be drawn as a result of implementing CSP across the five sites due to the limitations explored above. Overall, at a high level, programme perspective, responses reflect that:

- Respondents to questionnaires participating in CSP are predominantly of a white ethnicity and retired.
- Patients continue to report a good level of involvement in their own care, particularly in relation to discussing what is important for them to manage their own health.
- Patients feel their care and support is more joined up than at baseline.
- Patients were more positive (compared to baseline) about the amount of information and support received to help them manage their health but feel less confident about doing so and so would benefit from continued focus at a practice and site level.
- Patients feel more positive about the way HCPs explain things, make them feel at ease and let them tell their own story (based on two sites).
- Practices are showing good progress with implementation and embedding of CSP and patients are receptive to CSP processes.

8.3.2 A 'typical' respondent profile has emerged for most sites

Sites included a patient demographic section in questionnaires to gain some insight into characteristics of the people participating in CSP. However, it should be noted that due to the sample sizes used, and the degree of self-selection in responding to questionnaires, the profile is not entirely representative of the cohort of patients seen for CSP or the diversity of the population within each site. Aggregating responses to the baseline and follow-up LTC-6 questionnaires[23] (available for all sites apart from Lothian) and the CQI questionnaires (available for all sites apart from GGC), reveals the 'typical' respondent has stayed the same as reported in the last interim evaluation: this tends to be a white man, aged 65 – 74 and retired, with hypertension, CHD and/or diabetes[24].

In more detail, the LTC-6 questionnaire revealed that the majority (73%, 597/816) of respondents are retired, 39% (314/807) are within the 65-74 age category, and 96% (798/834) identified as white. This is confirmed by available CQI results (for Tayside, Hardwick and Gateshead)[25]. The only difference noted between questionnaires relates to gender. According to results of the LTC-6 questionnaire, 58% (487/833) were male compared to 37% of respondents who were female (300/833). In contrast, slightly more respondents to the CQI were female (50%, 657/1313) than male (46%, 60/1313). However, this difference can be attributed to a single site (Lothian) where 58% of respondents were female (252/436 and 247/427 for the CARE and PEI surveys respectively) compared to 42% who were male (184/436 and 180/427 for the CARE and PEI surveys respectively.

[23] Due to the inconsistencies in the way sites recorded baseline and follow-up data, it is unclear whether this was taken into account when baseline and follow-up demographic information was provided. As such, this information has been aggregated for the purpose of ICF's analysis.

[24] Information on employment status and ethnicity was not provided by Lothian.

[25] The majority of respondents were white (87%, 391/441) and Retired (63%, 247/390). In addition, and also taking into account demographic results provided by the CARE and PEI questionnaires submitted by Lothian respondents, most respondents were also likely to be aged 65-74 (33%, 425/1288).

Across both surveys, hypertension, diabetes and CHD are the most commonly reported LTCs respectively. Multi-morbidity conditions also appear prevalent as indicated by people selecting multiple LTCs – for example, 501 respondents chose hypertension, 464 chose diabetes, and 255 chose CHD when responding to the LTC-6 questionnaire. It was noted by one site (Tayside) that there is a high likelihood of under-reporting CHD due to the nature of self-reporting.

8.3.3 Patients generally feel involved in their care

At a programme level, patients continue to report a good level of involvement in their own care across all sites, though there are no large changes between baseline and follow-up[26].

LTC-6 was issued by practices around the time of the information gathering appointment and asks patients to reflect on their care over the last 12 months. As such, the findings should offer more of a reflection on CSP as a whole compared with the baseline as CSP has had longer to embed across practices.

The majority of respondents stated they 'almost always' discussed what was important for them in managing their own health at both stages, with a slight increase in the proportion who agreed in the 'follow-up' stage (59% or 109/184 compared to 55% or 361/654 at baseline). This was largely a result of an improvement of 12 percentage points in Gateshead (61%, 114/188 to 73%, 35/48) as results in Hardwick and GGC fell slightly (4 and 1 percentage points respectively). Slightly more respondents also felt that they only 'rarely' discussed what was most important during the follow-up stage (6% or 40/654 at baseline compared to 8% or 15/184 at follow-up), which could suggest that a small number of respondents may feel less involved in their healthcare at the follow-up stage. Whilst this difference (two percentage points) is small given the difference in sample sizes at both stages, it is still important to note that there was little change in percentage points in the proportion of respondents recorded 'not at all' in at both stages (6% or 38/654 and 5% or 10/184) – though no respondents recorded 'not at all' at follow-up in Gateshead or at either stage in GGC.

Over half of all respondents (56%, 368/654) felt that they were 'almost always' involved as much as they wanted to be in decisions about their care or treatment at baseline[27]. A slightly smaller proportion of respondents (53%, 98/185) felt the same at follow-up, with decreases observed across Gateshead, Hardwick and GGC. A slightly higher number of respondents felt they were only involved in their care 'more often than not' (27% or 50/185 at follow-up compared to 20% or 133/654 at baseline). A similar proportion of people (4-5%) reported 'not at all' to this question at baseline and follow-up (33/654 and 8/185 respectively), with no respondents recording 'not at all' at follow-up in Gateshead and GGC.

Overall, a good standard and quality of care was reported at both the baseline and follow up (after patients have been receiving care in a practice environment which has introduced CSP in the last 12 months). However we cannot determine that CSP has impacted on this, as no large changes at follow-up were observed.

[26] This is based on results to the LTC-6 questionnaire, which Lothian did not collect data for. Follow up data is not available for Tayside.

[27] Other options included: 'More often than not', 'To some extent' and 'Not at all'

Table 8.4 Respondents answering almost always to questions on involvement in care[28]

Site	Did you discuss what was most important for you in managing your own health?		Were you involved as much as you wanted to be in decisions about your care or treatment?	
	Baseline	Follow-up	Baseline	Follow-up
Gateshead	61% (114/188)	73% (35/48)	68% (127/188)	65% (32/49)
Hardwick	54% (162/298)	50% (59/117)	51% (153/298)	44% (51/117)
Greater Glasgow & Clyde	64% (26/40)	63% (15/19)	64% (26/40)	63% (15/19)
Tayside	39% (59/128)	Not available	48% (62/128)	Not available
Programme total	55% (361/654)	59% (109/184)	56% (368/654)	53% (98/185)

Source: LTC-6 questionnaire (issued before/at IG appointment)

8.3.4 Patients mainly report that their care and support is joined up

Patient experiences of joined up care (based on LTC-6 questionnaires[26]) remain largely positive. Over half of respondents across the four sites (56%, 364/649) felt that the support and care they receive was 'almost always' joined-up and working for them at baseline. This increased to 60% (111/185) at the follow-up stage at a programme level, although in Hardwick the number actually fell by two percentage points). A similar proportion of respondents (2-3%) felt that the support and care was 'not at all' joined-up or working at both stages (14/649 at baseline and 5/185 at follow-up).

The information reported here shows baseline and follow up when most patients should have participated in the full CSP process. At a site and programme level, this suggests that, on the whole, improvements in scores have been observed over the last year and patients feel their care and support is more joined up than previously.

Table 8.5 Respondents answering that care and support is 'almost always' joined-up and working

Site	Do you think the care and support you receive is joined up and working for you?	
	Baseline	Follow-up
Gateshead	63% (115/183)	67% (33/49)
Hardwick	56% (166/298)	54% (63/117)
Greater Glasgow & Clyde	63% (25/40)	79% (15/19)
Tayside	45% (58/128)	Not available
Programme total	56% (364/649)	60% (111/185)

Source: LTC-6 questionnaire (issued before/at IG appointment)

[28] Table key: green shading indicates an increase between baseline and follow up, red shading indicates a decrease and blue indicates no change between baseline and follow up

8.3.5 Patients receive information and support to self-manage but many still lack some confidence to do so

On the whole, questionnaire respondents were positive about the amount of information and support received to help them manage their health, with improvements of five and three percentage points respectively noted in the overall proportion of respondents who state they 'always received enough information' or 'always felt supported (Table 8.6). This indicates a positive effect of the HoC approach to CSP which prepares patients by providing results of disease surveillance/routine tests/assessments, followed by a (separate) collaborative conversation. Responses in GGC and Gateshead were particularly positive in relation to the amount of information received to help manage health, with a 5 and 18 percentage point change respectively observed between the baseline and follow-up stages.

Table 8.6 Respondents answering 'almost always' to questions about managing health

	How would you describe the amount of information you received to help you manage your health?		Have you had enough support from your health and social care team to help you manage your health?	
	Baseline	Follow-up	Baseline	Follow-up
Gateshead	64% (120/187)	82% (40/49)	73% (136/187)	84% (41/49)
Hardwick	62% (185/298)	60% (70/117)	67% (200/298)	63% (74/117)
Greater Glasgow & Clyde	68% (31/40)	73% (15/19)	68% (31/40)	73% (13/19)
Tayside	60% (77/128)	Not available	67% (86/128)	Not available
Programme total	63% (413/653)	68% (125/185)	66% (433/653)	69% (128/185)

Source: LTC-6 questionnaire (issued before/at IG appointment)

However, across all sites, respondents remain unsure about managing their own health; only 49% (320/653) stated they felt 'very confident' at baseline, and this reduced to 41% (76/185) at follow up. This suggests that patients currently feel that support is in place but confidence to self-manage with this support may be an area that needs further encouragement, including during the CSP process.

Table 8.7 Respondents' confidence in managing their own health (% answering: Very confident)

Site	How confident are you that you can manage your own health? (% answering: Very confident)	
	Baseline	Follow-up
Gateshead	58% (108/187)	41% (20/49)
Hardwick	44% (132/298)	38% (44/117)
Greater Glasgow & Clyde	41% (23/40)	42% (12/19)
Tayside	45% (57/128)	Not available
Programme total	49% (320/653)	41% (76/185)

Source: LTC-6 questionnaire (issued before/at IG appointment)

Baseline responses from CQI (PEI for Lothian) issued after the CSP consultation also revealed respondents were able to understand and cope with their condition. However, fewer respondents indicated being able to cope with life and being able to help themselves. Table 8.8 shows the baseline scores collected for four sites[29] and table 8.9 shows the follow up scores for Hardwick and Lothian only. Highest scores were mainly seen for Hardwick respondents, and the lowest were for Tayside.

Table 8.8 Respondents answering 'much better' (or much more) and 'better' (or more) to questions about the results of their consultation (baseline only)

As a result of your consultation today, do you feel you are…	Gateshead	Hardwick	Lothian	Tayside	Total
Able to cope with life	67% (94/140)	78% (150/192)	62% (123/199)	35% (23/66)	64% (390/597)
Able to cope with your condition(s)	73% (99/136)	78% (150/192)	65% (130/199)	45% (30/66)	70% (409/593)
Able to understand your condition(s)	81% (112/138)	83% (160/192)	67% (134/199)	48% (32/66)	75% (446/595)
Able to keep yourself healthy	Not collected	Not collected	67% (133/199)	45% (30/66)	62% (163/265)
Confident about your health	72% (102/141)	73% (140/192)	64% (128/199)	41% (27/66)	66% (393/598)
Able to help yourself	71% (99/139)	72% (139/192)	63% (126/199)	41% (27/66)	65% (387/596)

Source: CQI (Gateshead, Hardwick and Tayside) and PEI (Lothian)[30] questionnaires (issued after CSP consultation)

Table 8.9 Respondents answering 'much better' (or much more) and 'better' (or more) to questions about the results of their consultation (follow up only)

As a result of your consultation today, do you feel you are…	Hardwick	Lothian	Total
Able to cope with life	80% (41/51)	75% (118/158)	76% (159/209)
Able to cope with your condition(s)	76% (39/51)	72% (113/158)	73% (152/209)
Able to understand your condition(s)	75% (38/51)	80% (126/158)	78% (164/209)
Able to keep yourself healthy	Not collected	71% (112/158)	71% (112/158)
Confident about your health	73% (37/51)	70% (111/158)	71% (148/209)
Able to help yourself	75%	72%	72% (151/209)

[29] Follow-up scores for **all** of the statements displayed in Table 1.8 were only collected by Lothian. These show that there was either a small positive change for all statements – however, it is important to note that follow-up scores were only collected for one practice (and no baseline scores were collected for this practice).

[30] In Lothian, questionnaires were administered as PEI and CARE separately, which together make CQI

As a result of your consultation today, do you feel you are…	Hardwick	Lothian	Total
	(38/51)	(113/158)	

Source: CQI (Hardwick) and CARE (Lothian) questionnaires (issued after CSP consultation)

Responses received at the follow up time point for CQI (PEI for Lothian) revealed a between four and 13 percentage point increase in responses for all questions in Lothian, indicating respondents felt better able to understand and cope with their condition – however these scores were reported by one practice only (and this practice had not reported baseline data). In Hardwick, follow up responses revealed that respondents felt more able to cope with life (increase of two percentage points) and able to help themselves (increase of three percentage points) but less able to understand and cope with their condition (a decrease between baseline and follow up of eight and two percentage points respectively).

A separate survey distributed in Lothian (WEMWBS[31]) reflects improvements in the self-management of care at the follow-up stage. For example:

- Respondents were asked if they have been dealing with problems well, to which 28% of respondents said they were all of the time at baseline (74/269) compared to 35% at follow-up (25/72). In addition, only one respondent answered 'none of the time' at follow-up, compared to 12 at baseline.
- Respondents were also asked if they are able to make up their own mind about things. In response, a slightly larger proportion of respondents agreed this was the case 'all of the time' at follow-up (54%, 39/72) compared to at baseline (52%, 139/269).

8.3.6 Patients have positive perceptions of their HCPs

In general, respondents have a positive perception of HCPs based on information gathered after their CSP consultation.

Table 8.10 Percentage of respondents answering 'excellent' or 'very good' to the following questions about their HCP (baseline only)

How was the person you saw at…?	Gateshead	Hardwick	Lothian	Tayside	Total for four sites
Making you feel at ease	93% (128/138)	96% (184/192)	90% (199/220)	85% (56/66)	92% (566/616)
Letting you tell your story	92% (128/139)	94% (181/192)	89% (196/220)	76% (50/66)	90% (555/617)
Really listening	94% (130/139)	93% (179/192)	89% (195/220)	80% (53/66)	90% (557/617)

[31] The Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) reflects a patient's mental wellbeing which is known to be an important outcome for most people. Across 4 practices, a total of 272 individuals completed a WEMWBS survey at baseline and 73 also completed a follow up survey. WEMWBS surveys where less than 11 out of 14 answers have been completed are considered invalid. Three surveys completed at baseline and one at follow up were invalid, giving a total of 269 valid baseline surveys and 72 valid follow up surveys. Invalid surveys are excluded from the following analysis.

How was the person you saw at…?	Gateshead	Hardwick	Lothian	Tayside	Total for four sites
Being interested in you as a whole person	89% (123/138)	93% (178/192)	87% (192/220)	79% (52/66)	88% (545/616)
Fully understanding your concerns	86% (120/140)	93% (179/192)	83% (183/220)	68% (45/66)	85% (527/618)
Showing care and compassion	93% (128/138)	95% (182/192)	88% (193/220)	76% (50/66)	90% (544/616)
Being positive	94% (130/139)	94% (180/192)	89% (195/220)	79% (52/66)	90% (557/617)
Explaining things clearly	96% (133/139)	97% (186/192)	92% (202/220)	80% (53/66)	93% (574/617)
Helping you take control	81% (114/140)	93% (179/192)	83% (182/220)	64% (42/66)	84% (517/618)
Making a plan of action with you	84% (115/137)	94% (180/192)	83% (182/220)	59% (39/66)	84% (516/615)

Source: CQI (Gateshead, Hardwick and Tayside) and CARE (Lothian)[32] questionnaires (issued after CSP consultation)

At baseline, scores varied across sites with more positive perceptions reported by patients in Gateshead and Hardwick. This could be as a result of CSP having had longer to embed for CVD patients here; by comparison, in Tayside some practices focused on introducing CSP for diabetes initially and so delivering CSP for patients with CVD is less mature.

Overall, respondents felt most positive about the way their HCPs explained things clearly; had made them feel at ease; were being positive; and let patients tell their own story. Further improvements could be made, for example, in helping patients take control and fully understanding the concerns patients have.

Follow up responses are only available for Hardwick and Lothian. The proportion of respondents who answered excellent or very good to questions about HCPs are shown below. Respondents in Lothian answered more favourably at the follow-up stage to all questions concerning their HCP, with the greatest improvement noted for the statement ‘Fully understanding your concerns’ (an increase of 12 percentage points). In contrast, fewer respondents in Hardwick stated ‘excellent’ or ‘very good’ to the questions below during the follow-up stage than the baseline; in particular, there was a decline in the proportion of respondents who agreed the HCP was very good or excellent at making a plan of action with them (decrease of 10 percentage points).

[32] In Lothian, questionnaires were administered as PEI and CARE separately, which together make CQI

Table 8.11 Percentage of respondents answering excellent or very good to the following questions about their HCP (follow up only)

How was the person you saw at…?	Hardwick	Lothian	Total for two sites
Making you feel at ease	94% (48/51)	97% (186/191)	977% (234/242)
Letting you tell your story	90% (46/51)	98% (187/191)	97% (234/242)
Really listening	90% (46/51)	96% (184/191)	95% (230/242)
Being interested in you as a whole person	92% (47/51)	93% (178/191)	93% (224/242)
Fully understanding your concerns	90% (46/51)	95% (181/191)	94% (227/242)
Showing care and compassion	90% (46/51)	94% (180/191)	93% (226/242)
Being positive	94% (48/51)	95% (182/191)	95% (230/242)
Explaining things clearly	92% (47/51)	97% (185/191)	96% (232/242)
Helping you take control	94% (47/51)	85% (162/191)	86% (209/242)
Making a plan of action with you	84% (43/51)	92% (175/191)	90% (218/242)

Source: CQI (Hardwick) and CARE (Lothian) questionnaires (issued after CSP consultation)

8.3.7 The CSP process is still embedding

Additional questions centred on the information received to support people to make the most of their CSP conversations and to self-manage were asked by Hardwick, Gateshead and Tayside[33]

In Hardwick, there was a reduction from baseline to follow up observed in the percentage of people reporting they remembered getting a letter asking them to think about their health (89%, 171/192 compared to 69%, 35/51), who discussed services and supports in the local community during their appointment[34] (70%, 135/192 to 45%, 23/51) and who found their experience of care planning better than their previous annual review (55%, 105/192 to 43%, 22/51). In Tayside, there was a small reduction in the percentage of people who discussed wider services in their appointment from 16% to 14%. However, there was a slight increase in the percentage of people reporting they remembered getting a letter asking them to think about their health (from 74% to 76%).[35]

Responses were most positive in Gateshead where 95% (134/141) of respondents remembered getting a letter and 69% (95/137) found this very useful. Questionnaire respondents were also asked to rate their overall experience of the day's care planning appointment compared to the patient's last annual review. 47% (65/138) found their overall

[33] As Gateshead only collected CQI data at the time point of follow up, the results considered in this section only relate to this period of time.

[34] It should be noted that discussion of community services and support is not appropriate nor necessary for all patients and is dependent on personal circumstances.

[35] Based on an increase in the number of time point one responses

experience ‘excellent’, and a further 39% (54/138) found it very good. Only two respondents rated the services as ‘fair’, and none reported it as poor. However, a lower percentage of respondents discussed services and supports in the local community during their appointment compared with Hardwick (45%, 23/51 compared with 33%, 46/141 in Gateshead).

8.3.8 Practices continue to make good progress with most parts of implementation

The sites used the YoCP Quality Mark tool in order to support practices to reflect on their progress with implementing CSP using the HoC framework. Project managers across sites have used Quality Mark to monitor progress at a practice level and support the identification of issues. The Quality Mark is divided into 10 sections, which relate to different implementation themes and are summarised in the box below.

Table 8.12 below shows the average score in each Quality Mark category by site. The average score at a site level was calculated by adding together the scores from each practice within a site and dividing this total score by the number of practices in total. The number of practices per site is in brackets in the table below.

The overall average was calculated by adding together the total score (across all practices) from each site and dividing by the total number of practices that submitted QM data (31[36]). This gives an idea of performance at a programme level and an indication of areas of strength and weakness overall.

Table 8.12 Average quality mark scores by site (baseline)[37]

	Gateshead (7)	Hardwick (8)	GGC (6)	Lothian (4)	Tayside (9)	Average across sites (34)
Attending YoC Training	3.7	3.6	2.5	3.5	3.3	3.3
Register of patients with LTCs	3.9	3.1	3	2.5	2.3	3.0
People with LTCs are informed and aware of the care and support planning process	3.9	2.4	1.7	2.9	2.1	2.6
Language and literacy	3.9	2.5	1.5	2.8	2.4	2.6
Clinics appointment system	3.9	3.4	1.7	2.9	3.4	3.1
Preparation; sharing results/assessments and reflective prompts	3.9	2.4	1.0	2.5	2.9	2.5
Consultation skills	2.6	2.3	1.3	2.8	2.3	2.3
Goal setting and action planning	3.0	1.9	1.7	2.8	2.0	2.3
Sign posting, referral and review	4.0	2.4	1.5	2.7	2.0	2.5

[36] No data was provided by some practices.

[37] In GGC, Gateshead and Tayside, Quality Mark has been administered more than once. This table includes the first year.

	Gateshead (7)	Hardwick (8)	GGC (6)	Lothian (4)	Tayside (9)	Average across sites (34)
Reflective practice and ongoing review of team working	3.9	2.1	1.5	3.3	2.4	2.7

Key

(x) = number of practices

Quality Mark score	1	2	3	4
Description	Limited progress	Getting there	Doing well	Cracked it

The higher the score given, the more progress that has been felt to be made by the practice.

The table reflects that across all sites, there was some consistency in the areas in which practices felt they had made the most progress. Overall, sites were doing well in: attending training; organising patient registers to identify which and how many LTC and registers that person is on; and setting up appointment systems. The areas in which practices scored themselves lowest varied slightly more. The lowest average score calculated from practices across all sites was for consultation skills and goal setting and action planning, which suggests these are two areas that needs further support and time to embed. It is likely that these scores could increase over time as practices introduce processes to collect feedback around clinician consultation skills to support the identification of any training needs and as clinician confidence in delivering CSP continues to improve.

There was some variation between sites. Overall, practices in GGC provided a lower initial baseline score for almost all statements compared to other sites, whilst Gateshead posted the highest scores for most statements. As the scoring is a subjective process and scores were provided at different timepoints, comparisons between sites for scores should be limited. Nonetheless, Gateshead, GGC and Tayside repeated the Quality Mark again, to show the progress of ongoing implementation. Follow-up scores and the change between years are shown below for these sites.

8.3.9 Positive change was seen over time in three sites

Positive changes were noted for all statements for all three sites that provided follow up data. GGC showed the greatest change between baseline and follow-up, while practices in Gateshead awarded eight statements the highest possible score (four). The lowest average score observed at baseline (for consultation skills) remained consistently the lowest at follow up in Gateshead and GGC (3.4 and 2.4 for Gateshead and GGC respectively). However, practices in Tayside showed the greatest improvement in scores between baseline and follow up in these two areas (an increase in score of 0.83 for consultation skills and 1.00 for goal setting and action planning). People with LTCs being informed and aware of the CSP process was the lowest scoring area for Tayside.

Table 8.13 Average quality mark scores (follow up for Gateshead and GGC)

	Gateshead (7)		GGC[38] (6)		Tayside (6)	
Attending YoC Training	4.0	+0.3[39]	3.5	+1.0	3.7	+0.3
Register of patients with LTCs	4.0	+0.1	3.8	+0.8	2.5	+0.2
People with LTCs are informed and aware of the care and support planning process	4.0	+0.1	3.2	+1.5	2.2	+0.1
Language and literacy	4.0	+0.1	3.3	+1.8	2.7	+0.2
Clinics appointment system	4.0	+0.1	3.8	+2.1	3.7	+0.2
Preparation; sharing results/assessments and reflective prompts	4.0	+0.1	3.8	+2.8	3.0	+0.1
Consultation skills	3.4	+0.9	2.4	+1.1	3.2	+0.8
Goal setting and action planning	3.9	+0.9	3.3	+1.6	3.0	+1.0
Sign posting, referral and review	4.0	+0.0	3.3	+1.8	2.3	+0.3
Reflective practice and ongoing review of team working	4.0	+0.1	3.4	+1.9	2.8	+0.4

8.3.10 Qualitative themes

All sites carried out qualitative research with patients and/or staff:

- **Gateshead:** Ten one-to-one interviews were conducted with patients currently receiving CSP as part of their care, and one focus group was held with seven HCPs (including administration staff, HCAs, nurses and GPs) to generate staff feedback. Both sets of qualitative data were then analysed using the methodological approach of Grounded Theory and analytical method of Framework Analysis.
- **Hardwick:** Practices agreed to take part in discussions about the challenges and successes of the HoC in their practices. This happened in various ways, either in one to one discussions, 'in-practice' group discussions or large multi-practice groups. Feedback from patients was obtained using open boxes in the questionnaires distributed during and after appointments.
- **GGC:** The qualitative data used consisted of the following: GP Practice Acceptability (questions asked to practices); House of Care Patient Experience Evaluation (interviews conducted with 29 patients either face-to-face or over the phone); NHSGGC Summary evaluation paper produced in May 2017 (providing an overview of activities in 2016-17); and a Community Asset approach (case study of a walking group led by a GP practice for seven patients).
- **Lothian:** The qualitative evaluation of CSP involved 1:1 semi-structured interviews with: two GPs, three practice managers, two practice nurses and seven patients. Baseline interviews were held from mid-2016 with follow up interviews from mid-2017. One GP and one practice nurse were still to be interviewed at the time the follow up evaluative findings were generated.

[38] GGC had three practices which posted Year 2 and 3 scores (as they have been going on for one year longer than the other three practices). Average Year 2 (calculated as an average of six sites) and Year 3 scores (calculated as an average of three sites) were averaged to provide the follow-up scores for this site.

[39] Difference from year one

- **Tayside:** Staff feedback was provided as part of the Quality Mark assessments conducted by practices. Qualitative research with patients was obtained through interviewing patients (N = 16) in six practices of which four were implementing CSP/HoC with their focus being people with Diabetes solely (11 participants), and two practices (5 participants) were focusing on people with Diabetes +/- CVD. Interviews were conducted between March and December 2017.

In spite of differences in approach/method, some shared themes can be drawn from this work.

8.3.10.1 Improved delivery of care

Overall, feedback from staff suggested that those involved in HoC were positive about the content and the impact that training had on their roles. For example, practitioners in Hardwick stated that this had led to improved job satisfaction, whilst those in in Gateshead reported role development (an increased personal skill set and increased capability) as they now deal with all conditions rather than specialise in one. Similarly, staff in GGC noted professional satisfaction arising from the opportunity to utilise clinical and advanced consultation skills e.g. one GP described HoC as allowing nurses to work *"at the top of their licence"* whilst other participants highlighted enhanced role of healthcare support workers and assistants.

However, nearly all sites noted that one limitation of the HoC approach to CSP and its focus on staff training is that there is a loss of knowledge and skills when staff leave. It is particularly a problem when trained administrative staff leave as it was recognised their buy-in is important to help deliver a streamlined service. One suggestion made by practitioners in GGC was to extend the YoCP training to more practice staff to ensure a whole-practice approach, as there was little use of the 'cascading approach'. This would also help to ensure buy-in from all staff.

Feedback from staff suggests that the HoC approach to CSP has enabled improvements in efficiency and team-working (e.g. GPs in Hardwick noted increased confidence in test results checked by nurses as part of a structured process), however, comments from practitioners in GGC suggest that establishing the processes can still be a resource-intensive task. For example, practices in Tayside reported that IT systems were difficult to adapt to new ways of working, and there is often a reluctance to shift from specific LTC disease registers. Robust implementation planning helped ensure that people were aware of system and process changes in advance of those changes happening, and the potential positive impacts of these changes were communicated to all staff.

Other challenges have also been reported by practitioners. For example, some practice nurses in Hardwick reported the loss of the opportunity for rapport building with patients (as this would have happened when they carried out foot checks which are now carried out by HCAs). One challenge for practices in Tayside has been getting timely feedback relayed to clinicians within current resources and the poor engagement/return rate. Staff in Gateshead reflected on the need to have enough appointments and remain flexible about the way these are assigned to patients – there is also a need to ensure consistent surgery processes.

8.3.10.2 Improvements in care received by patients

Feedback from staff and patients suggests that most people were largely positive about the new care pathways in place for patients. Staff interviewed in Gateshead found the CSP approach enabled a patient-HCP relationship to develop which enabled discussions of issues the patient may not have disclosed otherwise, and patients had a feeling of receiving more bespoke and individualised care. Comments received by patients across all sites suggested:

There was more time for discussion for issues affecting patients; appointments did not feel as rushed and there was more clarity following the consultation. A few patients contrasted this with previous experiences of care, and highlighted differences in the way staff delivered the care.

Patients felt the staff were 'friendly', 'compassionate' and 'had time for them'. This enabled patients to talk about personal problems, as they felt the consultation was more empathetic and more reflexed. For example, one patient in Gateshead noted about her nurse practitioner: "she talks about the whole of you, not just your condition, which is great because then, you know, you're not a condition, you know what I mean? I lost mi mam last year and I was her main carer so she was asking us about how I was coping with um, not having mam".

Staff were very knowledgeable about the patients' condition and issues. For example, those interviewed in Hardwick felt the nurses could always answer any questions and put them at ease about specific issues, and it was useful to have continuity in care. Similarly, in Gateshead, patients described how the HCPs were good at assisting with the setting of personal goals.

Patients liked receiving their written test results in advance of the CSP conversation, and most thought this was a really well-timed service. For example, five of the seven patients interviewed in Lothian were happy to receive results in the post prior to the appointment with the practice nurse, citing increased knowledge, feedback and opportunity to prepare questions as reasons. Similarly, patients in Tayside stated that having their results earlier meant they could spend time thinking about them and arrive at their appointment prepared with results.

Nevertheless, improvements can be made in meeting the needs of complex patients and those currently not engaging in the CSP approach. Equity issues put forward by GP practice staff in GGC included: recognising the importance of socio-economic factors in non-engagement with CSP; improving the accessibility of printed information; and understanding that disability can be a barrier when there is a two-appointment system. Nearly all the sites reported instances of result letters not being received or being incorrectly or inappropriately formatted. For example, one patient in Hardwick noted: "The leaflet we received beforehand was difficult for me… because of the small print, lack of colour and difficult language, but it was no good at all for my husband who is partially sighted". This can contribute to a lack of understanding of the results that came out to them through the post or the preference that the results are discussed during their appointment. Finally, some patients felt the CSP system was a 'waste of time' or did not fit in with their busy schedule, and a minority also suggested the appointments could still be longer.

8.3.10.3 Improved patient involvement in care:

Staff and patients across all sites were aware that patient-centred care can help to create new ways of consulting which: treat patients as a whole person, let the patients set the agenda; and involve the patients more in their own care. Staff in certain sites noted that patients like the fact they get more of a say, or can get involved in their own care, and this was reiterated by the patients themselves:

> *"I see it as we're in this together, you know I'm listening to her [practice nurse] because she has that professional expertise but I also know what I'm about. And, er, also if she sees me as being responsible in managing the condition…then I think there's a kind of element of trust from her to me you know. So I see it as this partnership."*

In Lothian, practitioners noted that patients are speaking about the wider aspects of their health or what matters most for them, which is important as patient priorities can be very

different to that which is expected: “if a patient has issues more significant to them than their health condition, these can need resolving before the patient can focus on their health”. The care plan, completed by patients with their priorities in mind, also helped to structure the discussion and cover all bases.

Patients felt prepared to be involved in the care because of the ability to think about issues and problems in advance. For example, patients in Hardwick, Tayside and Gateshead expressed how useful it was to receive letters and test results before the appointments, and being kept informed throughout the process of expectations: “naturally when you go to see a doctor or nurse things slide right out of your head. This this was very handy. It meant I could talk about what problems I had”. Some patients also described how being prepared led them to do more research about other aspects of their health they hadn’t considered before e.g. healthy lifestyle changes. In GGC, practitioners also noted that relatives were sometimes motivated by discussing results to attend the consultation with patients; this support aided understanding and goal setting.

Though on the whole the experience of patients being more involved in their care was perceived as positive, it was noted by staff that literacy issues challenged this process – and in some cases were more of a problem than expected. In addition, some patients felt some anxiety or stress about being more involved in the conversation, which links to the following section (about the confidence to self-manage).

8.3.10.4 Confidence and knowledge to self-manage:

A final theme identified was linked to the confidence and knowledge of patients to self-manage. A number of patients across the sites felt the process helped them to gain the confidence, skills and perspective to better manage their condition – for example: "having results written down (with a description of their tests, results, normal Ranges and previous results) gave [patients] confidence and reduced anxiety when going into their appointments. Having results almost immediately in the posts was reassuring, especially when you can compare results to the previous year.

However, this feeling of confidence in self-management was not universal (reinforcing the findings from the LTC-6 survey). Sometimes, this linked to being unsure of what the results meant – one patient in Tayside said they did not get sufficient information about their LTC which meant they could not ask questions during their appointment.

Nonetheless, overall, sites were positive that the HoC is a supportive route towards self-management (especially for patients with multiple morbidities). Staff report that patients are taking more control of their own health or are being empowered to do so; e.g. in Gateshead it was stated that the process has become more proactive rather than reactive, and HCPs have multiple examples of how patients are now thinking about what they want to get from the consultation before they come in. Similar findings were also noted in Lothian, which have helped practitioners to develop in their role from ‘fixer’ to ‘facilitator’, and help maximise the patient’s own health and wellbeing through mutual conversation.

8.4 Resource analysis: pre- and post- HOC

Sites were asked to produce a resource analysis, to compare practice-level costs before and after the introduction of CSP. More specifically, the sites:

- Mapped ‘pre’ and ‘post’ pathways of care in order to illustrate how CVD/LTC care is organised and delivered at a practice level, which staff are involved, and how long different care processes take.

- Based on the above, assessed the cost impact of introducing CSP for a defined patient population. Costs were calculated on a per patient basis.

8.4.1 Limitations

Three sites provided resource analysis, but this varied in detail. For example: Hardwick analysed pathways across seven practices; Tayside focussed on two practices but provided post-pathway costs under four different options and Gateshead analysed one practice of medium size with approximately 9000 patients. Lothian and GGC found it challenging to engage practices to undertake this work and so these sites are not included.

Sites aimed to provide a snapshot of how pathways of care differ prior to and after the introduction of CSP. It is important to note that this analysis was not intended to provide a holistic assessment of the outcomes – economic or non-economic – of implementing the HoC. As such, it does not capture or assess any possible changes in the quality of care, the ability of patients to self-manage or improvements to the patient experience. The analysis is based on all contact-time patients receive as part of the annual review process, and so does not analyse the impact of CSP on patient's overall service utilisation or track longer-term changes in how CSP is offered.

It is assumed that all sites have taken a consistent approach to calculating pre and post costs, and to deciding which processes to include and exclude. Nevertheless, not accounting for interim reviews and/or other appointments, as well as incorrect staff salary estimates, may lead to an under- or over-estimation of savings/losses[40]. The findings below are analysed and summarised by site before high level insights comparing findings are presented. Please refer to site specific annexes for the detailed resource analysis for Hardwick, Gateshead and Tayside.

8.4.2 Findings by site

8.4.2.1 Hardwick

Table 8.14 summarises the savings and losses created by the introduction of HOC in seven GP practices in Hardwick. Each practice had a different pre-HOC pathway, characterised by differences in existing procedures and patient population conditions[41]. Three practices illustrated cost and time saving (up to 60 minutes and £75) after the introduction of the HOC model. Out of the four practices with higher costs following the introduction of HOC, the increase in costs per patient were relatively small (ranging from £3.63 to £16.41, and 10-25 minutes).

Table 8.14 Summary of changes to Hardwick pathways after introduction of HOC

	Pre-HOC Pathway	Post-HOC Pathway	Change
Practice 1	Option 1: 52 minutes, £28.19 Option 2: 67 minutes, £36.02	72 minutes, £44.60	Option 1: +25 minutes, +£16.41 Option 2: +10 minutes, +£8.57

[40] The information from Tayside has not been included in detail in this part of the report as it was requested that this information be presented solely in the site level reports.

[41] If separate pathways were offered for different medical checks, the length of time and costs for the pathways have been aggregated to enable comparison to the post-HOC pathway. In cases where there are different options present in the pre-HOC pathway, the change is presented as a range (minimum – maximum).

	Pre-HOC Pathway	Post-HOC Pathway	Change
Practice 2	CVD and Diabetes total: 88 minutes, £69.20	65.5 minutes, £44.02	-20 minutes, -£21.18
Practice 3	49.5 minutes, £44.21	64.5 minutes, £49.50	+15 minutes, +£4.00
Practice 4	Diabetes and Hypertension total: 93 minutes, £119.92	77 minutes, £26.68	-16 minutes, -£43
Practice 5	Diabetes Option 1: 38 minutes, £24.33 Diabetes Option 2: 45 minutes, £53.13 Atrial Fibrillation Option 1: 12 minutes, £29.04 Atrial Fibrillation Option 2: 36 minutes, £59.52 COPD: 57 minutes, £33.6	69 minutes – 84 minutes, £70.82 - £72.62	-40 to -60 minutes, -£15 to -£75
Practice 6	Diabetes Option 1: 43.5 minutes, £50.85 Diabetes Option 2: 43.5 minutes, £68.85	66 minutes, £65.22	+22.5 minutes, +£3.63 to +£14.70
Practice 7	Option 1: 41 minutes, £28.91 Option 2: 56 minutes, £59.33 Option 3: 42 minutes, £31.76	Option 1: 66 minutes, £39.59 Option 2: 81 minutes, £69.01 Option 3: 67 minutes, £41.44	+25 minutes, +£9.60

8.4.3 Tayside

Results from a diabetes only analysis in Tayside indicate that the introduction of CSP has increased time and costs (per patient) as a result of the additional stages required, such as posting out results and nursing time. The practice analysis is presented as four options, which therefore have different cost/time increases. Option 1 is the current post-CSP pathway used by this practice, and currently this pathway is £16.08 more expensive per patient per year, and takes 20 minutes longer. The Tayside analysis then presented a number of alternative delivery scenarios showing potential models, which explore how costs and time could reduce. These include shortening the length of the information gathering appointment with a practice nurse, using a HCA to undertake this appointment and using telephone follow up instead of a face-to-face.

Tayside also conducted an additional illustrative analysis for a second practice to explore ways in which post-HOC pathways could create more savings for patients with multi-morbidity conditions (compared to people with just one LTC).This illustrative analysis calculated that cost savings could be demonstrated for people with more than one LTC post HoC, compared with the previous single disease reviews with potential savings ranging from 25% for two LTCs (£2.99) to 70% (£21.10) for five LTCs. Please see annex 3 for more information.

8.4.4 Gateshead

Gateshead presents resource analysis for one practice of medium size with approximately 9000 patients. The analysis was based on the following consideration: what is the package/pathway of routine care that a practice is most likely to provide for patients with x condition(s)? Across each pathway, savings were illustrated for both time and costs after the

introduction of CSP, with the biggest savings for patients with more complex multi-morbidities.

Table 8.15 Summary of changes to Gateshead pathways after introduction of HOC

	Pre-HOC Pathway	Post-HOC Pathway	Change
CHD and Diabetes	56 minutes, £32.88	46.5 minutes, £17.49	-9.5 minutes, -£15.39
CHD, Diabetes and COPD	156 minutes, £75.99	71.5 minutes, £25.72	-84.5 minutes, -£50.27
CHD, Diabetes, COPD and Heart Failure	191 minutes, £110.29	96.5 minutes, £33.99	-94.5 minutes, -£76.30

8.4.5 Comparison and summary

Overall, it appears that the biggest savings can be made against pre-HOC pathways when undertaking reviews with patients with more than one LTC (i.e. multi-morbidity reviews).

Tayside and some practices in Hardwick both show increases in costs and time after the introduction of the HOC pathway, though the extent to which there are increases in cost/time varies. For example, only four practices in Hardwick marked increases in costs/time, and these were often as a result of the inclusion of additional stages for care planning in the healthcare pathway.

The table below shows a comparison of the pre- and post- pathways for CVD and Diabetic conditions for a number of practices. Gateshead shows cost and time savings whereas findings in Hardwick are variable. The table below shows an example of two practices; one in which time and costs increase and another in which there are cost and time savings. This links to the types of changes being made. Practice 3 in Hardwick was already offering integrated condition reviews whilst Practice 2 was offering separate condition reviews. There are small increases in time and cost in Tayside's example – much of the increase has been mitigated by savings and efficiencies in the new recall process.

	Description of target group	Description of change in pathway	Pre-HOC Pathway	Post-HOC Pathway	Change
Gateshead	People with CHD and Diabetes in one practice of medium size with approximately 9000 patients	Changes to the recall, invitation and appointment processes. Prior to HoC, patients would be offered an annual review consultation with nurse or GP which is replaced by CSP split between nurse and GPs.	56 minutes, £32.88	46.5 minutes, £17.49	-9.5 minutes, -£15.39
Hardwick[42]	Practice 2 and Practice 3 (people with CHD and Diabetes)	Was offering separate annual reviews for diabetes and CHD prior to the HoC being introduced	CVD and Diabetes total: 88 minutes, £69.20	65.5 minutes, £44.02	-20 minutes, -£21.18

[42] Example practices taken from full resource analysis to illustrate the reason for differences

	Description of target group	Description of change in pathway	Pre-HOC Pathway	Post-HOC Pathway	Change
		Was offering integrated LTC reviews prior to the HoC being introduced	49.5 minutes, £44.21	64.5 minutes, £49.50	+15 minutes, +£4.00
Tayside	People with CVD +/- Diabetes in one practice (365), live Oct 2016 ***Illustrative example.***	This practice was moving towards streamlining of LTC monitoring prior to implementing CSP/HoC. Moved to birthday recalls and changes to recall process.	10 minutes, £6.04	15 minutes, £9.09	+5 minutes, +£3.05

A comparison of the changes in practice delivery models across the three sites provides a number of high level insights:

- **The move to integrated, multi-morbidity reviews leads to cost and time savings for practices.** The Gateshead analysis reveals that following a move from individual, separate condition clinics to a single combined, integrated review, a saving in both time and costs was observed. This was the case for three combinations of between two and four CVD related conditions. Similarly, in Hardwick – four practices saw an increase in time and costs following the introduction of CSP, yet all four practices had previously been delivering some degree of integrated review. In the three practices in which a reduction in time and costs was observed, this was accompanied by a move from single condition to combined reviews. Furthermore, both the Gateshead analysis and illustrative example provided by Tayside show that the greater the number of multi-morbidities a patient has, the greater the time and cost savings that can be observed when moving to an integrated, holistic review process. For example, illustrative calculations in Tayside suggested a saving of 70% from previous single disease reviews for patients with five LTCs or more compared with a saving of 25% for people with two LTCs. In Gateshead, as the number of LTCs a patient has increases, the cost and time savings rise accordingly.

  Practices that have already moved towards a more holistic, integrated way of delivering LTC care have seen an increase in costs. This is largely due to the in administrative time required, however it is likely that these processes will become streamlined as changes embed, reducing the time and costs required going forward.

  This suggests that the savings in time and money are generated by the transition from single condition clinics to combined LTC clinics and that the greater the number of co-morbidities, the greater this saving could be.

- **The CSP approach has been accompanied by a wider use of skill mix and more flexibility in the team delivering LTC care.** Across the practices that have undertaken a resource analysis, there is a broad variation in the staff delivering LTC care, post the introduction of CSP. Examples include utilising HCAs, increasing the responsibilities of administrative staff, reducing the role of GPs and increasing the role of practice nurses in LTC care. Practices that have observed a reduction in their delivery costs per patient have also often lessened the role played by GPs in delivering this type of care. Five practices involved in this analysis have decreased GP input and five have seen an associated reduction in costs.

- **More flexibility in the approaches taken could lead to further efficiencies.** A key theme that emerged from the evaluation is that stakeholders considered that being able to have more flexibility in the approaches taken to deliver CSP would be valuable. A greater degree of flexibility could also lead to a higher degree of cost and time savings, for example, alternative ways of sharing information, undertaking CSP conversations by telephone or undertaking two appointments as appropriate to patient needs, rather than for every patient with a LTC. The analysis undertaken by Tayside shows the current time and costs required for a practice delivering diabetes care, however it also explores the ways in which the resource levels and costs of delivery may change if flexibilities in the approach could be introduced. One such example is undertaking the CSP appointment by telephone and when this example is costed, the increase in cost post HOC reduces to 43p (compared to a current increase in cost of £16.08).

It should be noted that these insights solely focus on efficiencies in terms of time and costs, not changes in patient experience or quality of care, which were the primary aims of the programme. From the outset, the efficiency aims were for better value for money rather than cost savings per se. Despite this, cost savings were still a key area of focus for clinicians and commissioners. Having a more flexible approach to delivering CSP may also be valued by patients who may not need or want two-step appointments for their conditions.

9 Programme level learning

The case studies presented in Sections 3-7 of this report have described site-specific qualitative findings from interviews undertaken by ICF. Section 8 presented a synthesis of quantitative findings submitted by sites in the QMR and self-evaluation reports, to give a programme-level analysis of impact. Qualitative themes from self-evaluation reports were also included here.

This section will present the key programme-level messages from the qualitative work conducted by ICF, with a special focus on how the HoC framework has been interpreted by sites, and the learning that this has generated.

9.1 Programme support

In this final year, programme support has continued to be valued. The programme has been well resourced, with some sites using BHF funding as the main source of financial support for CSP, and others using it to supplement CSP service redesign, which was already being funded locally – through CCGs – or through the Scottish Government.

Ongoing support from BHF, YoCP, Health and Social Care Alliance Scotland, and the evaluation team was described as helpful, although a degree of confusion over role clarity has continued. In particular, there has been a tension between BHF providing the funding and YoCP delivering the training, where some talked about mixed messages: *"From a site perspective it's like having two masters and that becomes difficult".* Issues resulting from this have been resolved by seeking clarity from BHF. The role of a dedicated programme manager has been regarded as a real strength throughout the programme. This year we again heard how this support has been vital for facilitating implementation and resolving issues. The programme manager was commended for being pragmatic and accessible:

"Support from the BHF programme manager has been fantastic, very pragmatic, it has been a partnership rather than top down."

More specific elements of support which were identified as being helpful, included the sharing of YoCP resources, such as change management tools and a practice checklist, which allowed operational support to be tailored for individual practices.

The project manager telephone calls have continued to strengthen relationships between the project managers, fostering a network for shared learning and peer-support, which was drawn on beyond the calls. Examples include the Hardwick project manager taking on the role of evaluation lead, and the Glasgow project manager sharing 'Wisdom reports' which show-cased a method for feeding back progress to practices. Some of the project managers commented that this informal contact will remain beyond the life of the programme. This will be made easier since all project managers are being sustained locally, albeit with amended job roles.

Reflections on training in the HoC approach to CSP showed that a balance is required between a whole team approach and tailoring to specific groups. Interviewees suggested that having clinicians, nursing staff, healthcare assistants, and administrators attend an overview together was useful in encouraging a whole team approach to implementation. However they felt that the bulk of training should be tailored to the different roles. Speaking to administrative staff directly revealed that they appreciated being included in the training as this gave them a greater understanding of processes and reasons for change. This in turn impacted on their motivation to implement new procedures: *"It's nice to know why we're doing something rather than being told to just do it."* Very detailed information on patient outcomes however was said to be confusing and irrelevant to administrative staff.

The 'Train the Trainer' (TtT) training prepared some sites (e.g. Lothian and Gateshead) to develop their own 'top-up' training to cover staff loss and to serve as a refresher. This training was shorter – between 20-60 minutes – and was delivered by trainers who attended the TtT training. The TtT training was therefore critical in giving trainers the knowledge and credibility to lead this work locally.

Reflections on evaluation have shown that adopting a co-produced approach to designing the method meant that for some, direction was lacking in the early part of the programme. One interviewee reflected that it took considerable time for the metrics to be decided, and that clarity over BHF requirements would have allowed for better comparisons across the programme. Similarly, some interviewees thought that the guidance on CVD conditions for inclusion (and a multi-morbidity approach) should have been given earlier in the programme.

9.2 Models implemented

In Section 1 of this report we presented the essential components of CSP for this programme, which were developed by the YoCP. In commissioning this programme, BHF aimed to test how the HoC framework would be adopted by local areas to provide evidence for 'what works' – both in terms of implementation and outcomes. In this section we describe how the HoC framework was interpreted by sites to provide CSP for people with CVD. Towards the end of the section, Table 9.1 maps the sites against the essential components provided by YoCP.

In general, the HoC framework was well received by sites; it was described as the 'right thing to do', supported by wider policy, and well suited to developing holistic care for people with CVD. Implementation support provided by YoCP aided with articulation of the theory of change, and feeding back progress to practices. Most interviewees described a close alignment to the HoC framework, which is evidenced in Table 9.1; on the whole the dominant model was of a two-step process with a Heathcare Assistant (HCA) doing the first appointment and tests (where there was this post available), followed by the results going out, and then a nurse doing the second consultation where the collaborative conversation took place. In these cases interviewees talked about the ways in which the approach allowed for flexibility – for example in selecting cohorts, adapting templates, and embedding recall processes.

There were however, some interviewees who thought that the approach taken by the programme was overly rigid, and that this impacted on practice staff engagement – and potentially on reach of the programme as a result:

"Rigidity of the model might be difficult to maintain going forward, because our perspective is there's not a lot of flexibility and it needs flex, the model doesn't really lend itself to that. So I am sure that the practices will be fixing it within certain parameters to make it work for them."

Practices sometimes made more substantial adaptations to the HoC framework, which in some cases meant that one of the core elements – preparation – was missed. The preparation stage is a core element of CSP as defined by the programme using the HoC approach; it ensures people can enter a CSP conversation as an equal expert having had a chance to consider relevant information and prompts about living with their condition. Whilst there were some examples of practices employing more creative methods with this component – such as electronic sharing of results (see below) – there were others where preparation was omitted in its entirety – for example the use of opportunistic health checks to implement CSP with no mechanisms in place for either sharing results or for follow-up (e.g. of goals) in primary care.

Two main reasons were given for more substantive changes: firstly practices faced with competing resource pressures wanted pragmatic approaches to achieving change – this

often included adapting the required administrative processes to align with existing processes and procedures, and secondly some practices felt that by making these adaptations they could better meet the needs of specific groups of patients. There were also some interviewees who thought that there was a weak evidence base for impact of the preparation stage in particular. For these reasons, alternative models which emerged from this programme included the following:

1. GP delivery of CSP

In some practices GPs were more involved in delivering CSP, varying from at least one practice where all of the second consultations and reviews were delivered by GPs, to some practices operating a triage system. The deciding factor for this variant of the approach was the complexity of patients being seen. In the practice where GPs routinely did the CSP consultation the cohort was considered to be 'sicker' patients – and the nurse in this practice did not have clinical CVD expertise. In the practices operating a triage system, results would be reviewed as they went out, and those considered more complex at this stage would be seen by a GP.

One practice in Glasgow approached the provision of GP input in a different way – albeit for diabetes. In this practice a weekly meeting is attended by all the GPs (who are diabetes specialists) and the practice nurse. Patient results and disease management are reviewed in the meeting, and the practice nurse then delivers the CSP appointment. This may be a model which makes use of specialist clinical expertise whilst still providing an efficient approach, although this cannot be verified since this site did not provide a resource analysis.

2. Alternative result-sharing and consultation modes

Some practices opted not to send results to patients via postal services. A few of these have made use of web-based platforms when the results are not problematic, or for certain conditions – such as using an online diabetes platform. Feedback from patients has been mixed on the use of web-based platforms to share results; notable concerns have been in relation to data-sharing and confidentiality.

Other practices have asked patients to come and collect their results, sometimes forgoing the preparation stage – and therefore omitting a core component of the CSP approach as defined by the HoC programme. There were also examples of practices in Lothian and Gateshead which combined disease surveillance and the collaborative conversation, with some tests being done in the second consultation, in cases where only the nurse had the skills to be able to do these (e.g. diabetic foot tests).

Telephone consultations have also been used in various cases across the sites, for example when patients are less complex, or have good results, or when they are housebound/have limited mobility:

"There wasn't a readiness to think differently about how to prepare a patient, I think you can do it in different ways e.g. telephone consultations, the blood results are important but they're not the most important part of it, it's more about helping that individual be prepared to come and talk about what they want, I felt there was too much emphasis on getting people physically in the practice."

3. CSP for the housebound

Some practices have tried to provide solutions for ensuring that those people who are housebound also received CSP. This was mainly around adapting the consultation mode, to either conduct it over the telephone (as above) or provide a home-visit. At least one practice combined the two-step process of disease surveillance and collaborative consultation into

one home-visit, thereby not including the preparation stage according to the CSP approach as defined by the HoC programme.

Home visits have provided a method for addressing some health inequalities, and ensuring one particular hard-to-reach group receives CSP. It is however less sustainable than telephone calls in the longer term due to the resource required.

4. Future models

A few interviewees reflected that further innovation could be tested in the future; one example given was the use of a hub model across local areas, where all eligible patients across the area could be taken as a single cohort in order to pool resources such as administrative support and nursing staff. This would circumvent some of the common implementation challenges faced by sites – such as administrative burden and staff retention.

Table 9.1 Delivery of the HoC framework against the core components for CSP implementation and process[43]

Sites	Implementation				CSP process		
	All CSP stages included within patient-focussed ethos: ***Preparation, conversation, recording and follow-up***	**All four HoC themes addressed with CSP at the centre:** ***Organisational processes, responsive commissioning/ more than medicine, engaged/informed patients and carers, committed HCPs***	**CSP built into routine clinical pathways, and replacing routine care**	**Key HCPs/team members received core CSP training provided by YoCP**	**Preparation:** ***Separating disease surveillance/ routine tests and assessments from collaborative conversation, and including explanation of process and time for reflection***	**Collaborative conversation:** ***Structured around what matters to person, linking to support in community/ referrals to other agencies, and individualised review***	**Individualised review:** ***Agreed during conversation, and not all support delivered in 1-1 sessions with HCP***
Gateshead[44]	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓	✓✓
Hardwick	✓✓✓	✓✓	✓✓	✓✓	✓✓✓	✓✓	✓✓
Greater Glasgow & Clyde	✓✓	✓✓	✓✓	✓✓✓	✓✓	✓✓	✓✓
Lothian	✓✓	✓✓✓	✓✓	✓✓	✓✓	✓✓✓	✓✓✓
Tayside	✓✓✓	✓✓	✓✓	✓✓✓	✓✓✓	✓✓	✓✓

✓ = Minimum evidence that component met (i.e. fully in place in a minority of practices/partially in place in some practices).

✓✓ = Some evidence that component met (i.e. fully in place in some practices/partially in place in majority of practices).

✓✓✓ = Substantial evidence that component met (i.e. fully in place in majority of practices).

[43] This table presents site lead assessments as based on the qualitative fieldwork. Site project managers have been involved in these assessments.

[44] Findings reported in this table refer only to the evaluation practices. Information about the progress of wider (non-evaluation) practices can be found in the case study report for Newcastle and Gateshead CCG.

9.3 Multi-morbidity approach

A key lesson which has emerged from this programme is the recognition across all sites that a multi-morbidity[45] approach is where the biggest potential lies for providing holistic, person-centred, (and efficient) care and support for those with LTCs. Three years on from the inception of this programme, LTCs are starting to be looked at in different ways, the profile of CVD as one of these LTCs has risen, and the potential for spread is high:

"This is not the magic wand that will make people better, but it has put CVD on the map, it's focussed primary care to re-look at how they manage their LTCs more generally, it will be a stepping stone to managing other LTCs in a similar way in the long term."

Looking across the programme, the biggest benefits were reported by practices which moved from a single-condition to a multi-morbidity approach. These benefits included savings in both cost and time, as reported in Section 7. There were also reported benefits in terms of patient experience, where for example patients benefit from holistic conversations in a single consultation. For Gateshead, which had started to implement multi-morbidity approaches before entering into the programme, being part of the programme facilitated a more structured and systematic method for extending the changes made. Moving to multi-morbidity approaches also has implications for sustainability, with those practices which have made the change already more likely to sustain. The table below shows the progress that sites have made with multi-morbidity approaches, where most sites have moved to multi-morbidity approaches, and will continue to do so after the programme has ended.

Table 9.2 Site progress with multi-morbidity approaches

Sites	Multi-morbidity in majority of practices	Moved to Multi-morbidity during programme	Inclusion of CVD and one other condition	Inclusion of 2+ conditions	Multi-morbidity to be sustained and spread
Gateshead	✓	Practices were in the process of moving to a multi-morbidity approach prior to the programme	✓	✓	✓
Hardwick	✓	✓	✓	✓	✓
Greater Glasgow & Clyde		✓ CHD plus diabetes in some practices	✓ CHD plus diabetes		CHD in some practices plus diabetes in all practices
Lothian	✓	✓	✓	✓	✓

[45] In the context of this evaluation, multi-morbidity refers to a single CSP cycle for the routine review of patients who have more than one LTC. CVD as one of these LTCs is included here, using the BHF accepted definition as set out in the DH (2013) CVD outcomes strategy, with CVD being a 'family of diseases' including: coronary heart disease, stroke, hypertension, hypercholesterolemia, chronic kidney disease, peripheral arterial disease, and vascular dementia. BHF requirements for this programme were that diabetes was not used as a sole condition to select a cohort of patients.

Sites	Multi-morbidity in majority of practices	Moved to Multi-morbidity during programme	Inclusion of CVD and one other condition	Inclusion of 2+ conditions	Multi-morbidity to be sustained and spread
Tayside	2/7 practices implemented Diabetes & CVD from outset. Further 3 practices are implementing Diabetes including people who will also have CVD.	✓	✓	✓	Multimorbidity/or shift towards this will be sustained in existing practices and spread in some others.

Moving to multi-morbidity approaches has not been without its challenges however. One issue has been in relation to ensuring a CVD focus as per the requirements of this programme. A couple of sites have struggled to do this, and still retain a stronger emphasis on diabetes. Some interviewees reflected on the HoC framework being better suited to diabetes in its current form, suggesting that greater flexibility to adapt the approach was required to make it more relevant to CVD. There was also the suggestion that a CVD focus detracted from testing a multi-morbidity approach, and that the HoC framework over-emphasised process rather than principle:

"I also think we need to stop thinking about a person's condition, they might have CVD but they might have other conditions. We talk about person-centred care but then there's still this emphasis on patients with CVD and/or diabetes, I think we are getting lost. When you're trying to have a person-centred conversation the diagnosis is almost secondary to that, I think that's prohibited things a bit, its diverted things a bit, our intention was to look at multi-morbidity, and use CVD as a bit of an exemplar of that, but quite quickly when we got involved with BHF there was such a focus on CVD, the pre-consultation is about results and getting a person ready but it's been too focused on results and I think that's where we've lost the way a bit and lost some of the principles. One of the clear messages from Tower Hamlets was that this could be too focussed on process and I think it's happened a bit again."

Although there are challenges, there is a general will to extend the multi-morbidity approach beyond the programme life. All sites have indicated that these approaches will be sustained and extended to include more LTCs, and/or to spread across larger geographies. As this work progresses there will be other models which will come to the fore – for example making use of skill mix in different ways according to the specific conditions included; and offering multiple appointments when combining a greater number of conditions, to avoid unfeasibly lengthy consultations. Ultimately, the consensus was that tailoring the process to specific cohorts was the way forward: *"Not shoe-horning people, but being flexible to individual needs."*

9.4 Culture change

The description of models thus far has focussed on process; this is characteristic of how the programme has been implemented, with some interviewees commenting that it has been very process-driven. Many interviewees recognised that these models can only be effective when accompanied by culture change. As well as understanding the extent to which culture change has happened, we sought to understand definitions of culture change, and what helped or hindered its achievement.

Culture change was defined in terms of a holistic understanding of patient care, which is characterised by partnership working. Partnership working refers to understanding patients as equals in their own care, as well as whole teams and systems working more closely together to embed this shared understanding. In practice this requires engagement in this new way of working at all levels and parts of the system – from senior leaders to frontline staff in health,

social care, community, and voluntary sectors. Culture change within the context of this programme was also described as an understanding of working towards longer-term change (rather than 'doing a project') in relationships between HCPs and patients, but also between different roles across the workforce:

"It's about good internal working relationships, a team approach with different roles coming together, with each role of equal value, whether this is admin, HCAs, nurses, or GPs, all are valued, and there are partners involved across the system."

Interviewees commonly appreciated the quality of training provision in this programme. Some reflected however that although this gave them the tools to implement CSP, the links between these tools and how the conversation was improved were not always clear. There was a suggestion that evidence of these tools 'working' – such as through sharing practice examples – would have been helpful to this end. To some extent this gap between training and practice was accommodated by the introduction of facilitator training. The core CSP programme has now been redesigned to include practice visits, which are sandwiched between the days of the core training. During these visits, trained facilitators meet with whole practice teams, support them to map pathways and roles, and role model the facilitation process for local project managers/facilitators. This is the approach now in place for further adoption across Scotland. Advanced clinical skills training for nurses has also now been developed to be introduced when staff have had a chance to practice basic skills within the new process.

The picture is mixed for having achieved culture change through this programme – something which is also reflected in the relatively slow progress of the adoption of a social model of health through embedding the 'more than medicine' element of the HoC approach. Some individual practices were said to have achieved culture change, however there is still a long way to go in achieving this across whole sites and local systems. The case studies have also shown some (limited) examples of practices where there has been evidence in relation to 'more than medicine' – e.g. in GGC where a new walking group was set up to fill a gap in community provision and has shown impact on improved biomedical outcomes.

Particular challenges to culture change have been staff changes – in Hardwick for example there have been changes in the whole nursing teams for some practices. There were also some reflections on culture change amongst patients, with many healthcare professionals saying that it was not an approach which was welcomed universally. Barriers for patients included literacy skills and confidence to self-manage. Nevertheless, where patients have been in favour of the new approach they are beginning to take more personal responsibility and build goal-setting and action-planning into their self-management. Many stakeholders form across the sites acknowledged that key to developing 'more than medicine' further was the need to expand knowledge of support services in the community. Another challenge mentioned in at least one site was that a lack of data-sharing across NHS and local authority run services means that progress is difficult to gauge as patient outcomes are not tracked once they are referred out.

TtT and top-up training has helped achieve momentum in some cases, with interviewees from at least two sites saying that this was central to driving culture change. Local trainers have been instrumental in achieving buy-in, they are credible and well-respected, and in Gateshead and Tayside provided practical implementation support in addition to training.

The fundamental characteristic of those practices which have shown a change in culture was the pre-existing ethos of the practice; those where a team approach was already favoured were more likely to make the shift, in spite of financial pressures:

"They're not awash with money, but some of them have been able to sort of appreciate that this is a longer term approach, and whilst they won't necessarily see the (financial) benefits immediately, they've been willing to work with that."

Facilitators of culture change included buy-in from practice managers and GPs, and clinical leadership. Incentivising practices was also discussed, where on the one hand it may catalyse change, but on the other hand it may act as a disincentive. In Gateshead practices receiving (local) incentivisation funding for moving to a multi-morbidity approach was described as effective. In Hardwick however, the opposite was found; when in phase 2 they didn't fund practices to be part of the programme they found that they had better engagement. Not funding practices may encourage those practices who are already culturally 'primed' to take part – i.e. those which already believe in the ethos, thereby making for more sustainable changes. Funding practices can also act as a disincentive in the longer term when this funding is withdrawn.

The programme has undoubtedly made contributions to laying the groundwork for a more holistic view of patients, with a number of sites reflecting that it had acted as a catalyst to this way of thinking locally. There is therefore much scope for continued work in this direction as sites move forward beyond the funded programme.

10 Conclusions and recommendations

The BHF House of Care programme has now ended. This final report has built upon previous evaluation reports and presented qualitative and quantitative findings on the progress and impact of the programme and individual projects within it. On the whole, findings are generally positive: advances have been made in implementing CSP across five sites; positive staff and patient outcomes have been reported; and ongoing learning has been generated to support how CSP will be sustained. Going forward, BHF and its partners can continue to build on these achievements through ongoing and future development work.

10.1 Conclusions

In consideration of the above, our main conclusions from the final evaluation, building on previous work, are that:

1. **BHF's involvement with CSP and person-centred care will continue to benefit from a largely supportive policy context**

Although there are well documented financial and workforce challenges across the NHS, over the lifespan of the programme the wider policy context has become increasingly favourable for CSP. Over the last three years, the push towards ensuring care delivery is more person-centred has grown in both England and Scotland. Similarly, there is now a greater emphasis on innovative efforts to deliver LTC care effectively and efficiently. This programme has illustrated – through CVD conditions as an exemplar – that CSP can be implemented at scale and at population level. The House of Care approach to CSP offers both practical tools and support for delivering LTC care, that puts the person at the centre as well as encouraging a broader shift in culture. The approach also allows for an increased use in skill mix, supported self-management and encourages working with wider services, all of which are important in a system beset by financial and workforce pressures. As a result, the scene is set for a continued focus on person-centred care (and CSP as a favoured approach within this) in policy and practice.

2. **It takes time to implement change and to embed this in supportive culture**

The successful implementation of any programme takes time and this has been reflected throughout the evaluation from project sites. Implementation was dependent on a number of factors including practice and strategic buy-in, and a strong infrastructure to support the projects, development of local project managers and facilitators, and the embedding of CSP processes. These elements all took time to develop and embed, and the progress of projects reflects this. Furthermore, the programme was fundamentally about a change in culture towards relationships that are genuinely enabling and collaborative, and care that is truly person-centred. In terms of achieving culture change, progress is still at an early stage, despite the programme extension: some individual practices were said to have achieved it, however there is still a long way to go in achieving this across whole sites and local systems. This is also reflected in progress with the more than medicine component of the approach – where some individual practices have made in-roads into adopting a social model of health, but this has not been evidenced at a site level.

The substantial amount of time invested in planning and implementing CSP as required at the outset has meant that projects were only starting to mature as the programme drew to a close, and longer term outcomes of this nature will be realised after completion. For new sites, this can mean that it will take new teams at least six months to put systems in place before CSP can start, and it will be two to three years before it is embedded. Of equal importance is the recognition that it takes six to nine months for local project managers and facilitators to be able to fully support this process.

3. The programme has prioritised practical implementation of CSP

Sites within the programme have largely focused on particular elements of the house; namely the roof and walls. There has been great progress made in introducing and embedding infrastructure to support CSP, training HCPs and preparing patients. Through the programme, a considerable number of practices across the five sites are now practically equipped to deliver CSP for patients with CVD, diabetes and for some, other LTCs. A whole team approach to CSP with strong clinical leadership and wider buy-in have emerged as important ingredients for successful implementation. However, the required focus on supporting practical implementation has been at the cost of some of the other aims of the programme; in particular, addressing health inequalities and developing more than medicine. Although these elements of the approach were understood to be important by sites (and there were examples of progress in a limited number of individual practices), they were not significant features of the implementation journey as described by interviewees during site visits, and also evidenced in the third interim report (ICF 2017). These elements are defined by the local context – 'hard to reach' groups vary according to site, as do community resources for holistic support. This meant that there were potentially missed opportunities for national support around the 'how to' of delivering equitable 'whole-system' care models. Future efforts of this nature would benefit from practical guidance, which allows for local interpretation – e.g. on how to map and work with community organisations to establish referral pathways and data sharing which enables follow-up and recording of referral outcomes.

4. The programme has demonstrated impact at the patient level

Data reporting varied across sites, with some submitting higher quality returns than others. Site visits and ongoing contact identified challenges with reporting for some projects, particularly in terms of capturing large sample sizes at baseline and follow up. Nonetheless, across the programme there has been impact at the patient level, including: an increase in the number of patients receiving CSP for their LTCs; patients feeling able to discuss what is important for them to manage their own health; patients receiving enough information to manage their own health; patients feeling they had enough support from their care team to manage their own health; patients feeling more able to cope with life and their condition and keeping healthy; and patients feeling their care and support is more joined up.

Qualitative interviews undertaken with patients have also shown outcomes in relation to their satisfaction with care received; improved knowledge and understanding of their conditions; feeling more prepared for appointments; and having more time to discuss what was important to them. Most people receiving CSP through this programme have only been doing so for one to two years; clinical outcomes will therefore be seen in the longer term, once patients have adopted changes (e.g. in self-management and accessing services) for a longer period of time.

5. Impact at the HCP level has been in terms of improved confidence and knowledge and better use of skill mix

The programme has also had an impact for HCPs. Stakeholders identified a number of outcomes for staff resulting from the opportunity to be involved in the programme. These included: increased knowledge and understanding of CSP from training and wider implementation; increased job satisfaction; improved team working; the opportunity to deliver more person-centred care and the development of roles. A number of interviewees considered that CSP has driven a change in skill mix across teams and the expansion of responsibilities for delivering LTC care, which had also included the upskilling of HCAs. The development of roles and increased responsibilities for HCPs was considered to be particularly important by stakeholders. Interviewees also reported learning gains on the job and project leads had access to programme and other BHF events.

6. **Striking a balance between fidelity and flexibility is key for sustainability and replicability**

In general, CSP using the HoC framework was well received, frequently described as the 'right thing to do', and well suited to developing holistic care for people with CVD. However there was a degree of variation in the approaches taken by practices and some flexibility was exercised. In a small number of cases, the preparation stage was omitted, and we have noted that this is a key component of the CSP approach as defined by the HoC programme. On the whole, the dominant 'model' was of a two-step model consisting of preparation followed by a CSP conversation. The preparation stage involved a HCA doing the first appointment and tests, followed by the results going out along with an agenda setting prompt. The second step involves a nurse doing the CSP consultation where the collaborative conversation took place. Interviewees described a range of adaptations they had made, including adapting templates and processes for recall. However many also reflected that the opportunity to make further flexes to the approach would allow them to better meet the needs of specific groups of patients. Adaptations made included telephone consultations and the sharing of results online. Enabling practices to strike a balance between maintaining fidelity to the HoC framework and its key principles, while having flexibility to account for local variation and contextual factors is important for embedding and spreading CSP going forward.

7. **A multi-morbidity approach is where the biggest potential lies for providing holistic, person-centred, (and efficient) care and support for those with LTCs**

At a programme level, the biggest benefits were generally reported by practices that moved from a single-condition to a multi-morbidity CSP approach. These benefits included both time and cost efficiencies, as reflected in the practice level resource analyses in section 8. In terms of patient experience, there were also benefits reported wherein patients receive more holistic care for their LTCs. Some sites had started to implement multi-morbidity approaches prior to the HoC programme and so the programme had facilitated a more structured method for extending the changes already made. The profile of CVD and the conditions included within the 'CVD umbrella' has expanded, and the delivery of CSP for a wider range of LTCs is increasingly being considered by sites. As a result, the potential for spread of multi-morbidity approaches both in and across practices is high.

8. **The programme has successfully led to sustainable change across all five sites**

Reflections from all five sites have suggested that the funding provided by BHF (and the Scottish Government) has been successful in supporting sustainability of CSP, providing the initial impetus to make change, which has now been embedded. All sites indicated that CSP is likely to be maintained in practices which participated in the programme where there is now significant 'buy in' to the underlying philosophy of CSP. The desire to scale and spread further, both in terms of the range of conditions included as well as practices involved, was also generally strong. However this is likely to be in adapted forms of the original approach, taking into account local contexts and financial barriers. Most sites had plans in place for mainstreaming and sustaining CSP post-programme. There were however cases where future direction was less clear, given recent contextual changes (e.g. in Scotland) and the availability of wider funding.

10.2 Recommendations

Building on these conclusions, our **main recommendations** from the evaluation are:

1. **BHF has an important role to play in promoting person-centred care and new models of delivering care for CVD**

The HoC programme has demonstrated that BHF has a key role to play in accelerating changed practice and testing new approaches to delivering person centred care for patients with CVD. BHF should continue with its work in promoting and driving forward person centred care as it has much to contribute in terms of advancing knowledge and practice. Importantly, BHF (and other third sector organisations) are perfectly placed to begin to build on the learning base generated here; particularly in relation to 'what works' in implementing change in this area and the different approaches to delivering person-centred care for people with CVD. This is significant, considering that stakeholders valued support with how to implement the approach at a more practical level i.e. a 'how to' guide. BHF should continue to fund innovation programmes, and should also consider the benefits of a more cohesive approach to sharing learning across – and beyond – programmes. Going forward, it is also important that in programmes where there are multiple support providers involved, BHF become stronger in asserting its role as a commissioner to ensure that uncertainty and confusion about requirements is avoided.

2. **It is important that programmes are designed with clear aims from the outset**

It is important that the intended aims and expectations of innovation programmes and their evaluations are clear. A number of stakeholders reflected that there was some uncertainty around the conditions to be included under the umbrella of CVD and whether including CVD as part of a multi-morbidity approach was appropriate. Additionally, some reported that the requirements of the accompanying evaluation were not always clear and that the expectations of BHF altered from the outset (for example, the drive for all sites to use the same suite of evaluation tools). As such, when designing future programmes and commissioning evaluations, BHF should use the learning from this programme and continue to ensure that all stakeholders are clear of the expectations and aims of both. This would also help to make sure that the expectations of all stakeholders are managed in relation to the potential impact that could be evidenced by the evaluation. In a dynamic programme such as this, it is reasonable that some changes to requirements may need to be made over the course of the programme. In these cases clear communication and support is required to minimise confusion and risks to implementation.

3. **Funding longer programmes may be of greater benefit for implementation and evidencing impact**

Implementing CSP and promoting a more collaborative and person centred culture requires substantial change at practice level and wider. This is a significant undertaking, which requires shifts in both process (for example, reorganising clinics, changing recall systems) and culture (promoting a more collaborative way of working focused around what matters to the patient). The programme has demonstrated that such an undertaking takes more time than was initially anticipated – to secure buy in, introduce new ways of working and develop relationships. This was reflected in BHF's decision to extend the programme and its evaluation. BHF should therefore consider whether future programmes of this kind should be designed and funded with this in mind. A longer term investment in a programme allows for a longer lead-in time and overall duration, which would provide the opportunity to give early focus to culture change, and more fully observe and evidence the outcomes achieved by mature projects. This would also benefit longer term sustainability, allowing projects a greater period over which to plan for post-BHF funding and gather evidence showing impact, which can be shared with commissioners and Health Boards.

Sites would benefit from exploring their findings in more detail as they progress beyond the programme. It would be interesting to observe how these findings hold as more adapted approaches are sustained and with larger sample sizes, and to explore the longer term – including clinical – impacts of CSP. The impact evaluation has also revealed particular areas for further research, for example an apparent drop in patient confidence to self-manage requires validation, and possibly more detailed exploration. Given the quality of data, the consistency of this finding with larger sample sizes should be noted over the next two to three years. Should this finding remain a consistent pattern, qualitative research with questionnaire respondents could shed light on possible explanations such as – is this a result of greater knowledge of their condition and lifestyle management following CSP (so a case of not knowing what one doesn't know) or a 'true' drop in confidence. Should it be the latter, then CSP processes may require adaptation to ensure confidence-building is a key feature.

4. Support for culture change should accompany process support

Throughout the evaluation, stakeholders highlighted the importance of change at both a practical level as well as a cultural level, sometimes reflecting that sufficient focus was not given to both. This ultimately impacted on the degree to which CSP has been embedded. There is a balance to be struck between the two: too much focus on process can limit the extent to which changes in culture develop, with attention primarily centred on the 'how' rather than the 'why'. Conversely, overly focusing on culture change risks achieving changes in hearts and minds without the tools to support work on the ground.

The very nature of 'programmes' which require sufficient progress to be made in discrete periods of time lend themselves to a process-focussed approach – implementers need tangible elements of practice to apply change to, against set milestones. However a lack of early attention to culture change risks later sustainability. Part of the challenge in supporting culture change is translating this abstract concept into key ingredients. Learning from this programme has highlighted that for embedding CSP – and person-centred care more generally – the key ingredient is relationships – and so requires prioritising winning 'hearts' rather than 'minds'. Vital to this will be strengthening the voice of lived experience. A philosophy of working in partnership across whole practices and local systems provides fertile ground for extending this ethos to interactions between HCPs and patients, with CSP being one mechanism of achieving this. BHF has an important role to play in supporting such culture change which underpins many of their innovation programmes: efforts should be made to support 'person-centred friendly' culture change in parallel to funding programmes – for example through the training portfolio already offered to HCPs; through written guidance and toolkits which are built around mechanisms for change; and through intensive implementation support around culture change specifically.

5. BHF and partners should continue to develop efforts around the more than medicine element of the approach

It is important that going forward work continues around local embedding, and building on the progress made, for example through Health Boards, CCGs and STPs. There is increasing policy focus on the wider determinants of health and more social, rather than medical, models of care, which aligns well with the floor of the house and emphasis on supporting people to live well. The Health and Social Care Alliance Scotland has provided strong support across the duration of the BHF programme, keeping the HoC approach in the policy consciousness and sharing learning at a national level in Scotland. Further to this, the programme has helped to catalyse a holistic view of patients. As such, BHF, alongside the Health and Social Care Alliance Scotland and YoCP are well placed to continue supporting this work, developing the wider case for change and providing support to develop the left wall of the house further – for example by working as part of the legacy work, to influence HSCP/IJP buy-in for CSP, ensuring that 'social' models of health are accepted and embedded. The organisations should work together to continue to align CSP and the programme outcomes with the wider policy rhetoric, using the expertise of the Health and Social Care Alliance Scotland, which works across a number of interlinked agendas

including integration, self-management support and person centred care. BHF should also capitalise and build on the existing work of the Health and Social Care Alliance Scotland e.g. using ALISS and the Links Workers programme, to understand the role of wider, supported self-management and develop a broader understanding of the wider determinants of health in relation to CSP.

6. Approaches to monitoring and evaluation could be further refined

The HoC programme has generated important learning around the role monitoring and evaluation has to play. Capacity and skills for data analysis, self-evaluation and reporting varied considerably across the five sites within the programme. Additionally, there were early challenges related to balancing the desire to have a more standardised approach to evaluation (sites using similar tools to capture change) alongside having a more site led, tailored approach. There are a number of ways in which these processes could be refined in future, including: further balancing the requirements of BHF with efforts to ensure the evaluation is co-produced with local professionals and service-users (i.e. ensuring a locally owned 'bottom-up' approach); focusing on measuring a smaller number of indicators but ensuring these are measured 'well'; setting realistic expectations of what can be achieved with data collection in light of resource, capacity and timescales for change; ensuring all monitoring and evaluation requirements are fully understood and agreed to from the outset; and improving the reporting templates to provide more clarity around how to capture and report outputs to give less room for site level interpretation and variance. Additionally administration of returns could benefit from some streamlining; in previous programmes both QMR and annual returns were administered from a central point, and this proved more effective in ensuring returns were submitted as required by BHF.

Opportunities to build site capacity for evaluation skills have also been missed. Across the programme, the task of self-evaluation has been taken on by project managers. Cascading evaluation training to practice staff would have ensured greater confidence and buy-in to the national evaluation, and would have helped improve the final sample sizes. BHF should consider methods for cascading evaluation learning in future primary care programmes such as this. Sites may want to consider improving their evaluation capacity – and will – so that they can improve on data capture – for example by making use of existing in-house analytics resource, and implementing evaluation engagement activities such as dissemination and skills-building events for practices.

7. Learning from the programme should be shared widely

As highlighted throughout the report, the programme and individual sites have achieved much in three years. While three years is a short time over which change can be embedded and observed, the programme and its evaluation has shown impact and generated a vast degree of learning around CSP and person-centred care, and has built on previous learning from YoCP. BHF should therefore seek to disseminate findings as widely as possible; there is much to contribute to an as yet narrow evidence base around implementing CSP for patients with CVD and other LTCs. There is valuable learning to be shared; for other BHF programmes, for other health charities and for other practices and sites interested in CSP and person-centred care. Given the favourable policy context in both England and Scotland, the demand for this type of learning will be high. BHF should consider up-scaling their dissemination activities – for example through publishing 'bite-sized' guides, or running conference and events programmes based on the findings. Opportunities to showcase success in this way will invariably support BHF's profile-raising efforts.

Part A: ANNEXES

Annex 1 References

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Annex 2 Topic Guides

A2.1 Introduction to the visits

This document is a guide for researchers undertaking final site visits as part of ICF's evaluation of BHF's House of Care (HoC) programme. The document includes a short introduction setting out the purpose of the visits, guidance on setting up and conducting the visits and topic guides to be used for interviews.

Alongside this document, researchers should familiarise themselves with the following supportive material, to ensure they have a thorough understanding of the HoC, the programme, and their particular site:

- Project logic models and evaluation plans;
- The three previous interim reports, including the in-depth case studies of each site;
- Site level self-evaluation reports (including resource analysis report where available) and ongoing site led evaluation work;
- Essentials of CSP (page 11 of ICF interim evaluation report); and
- A briefing for researchers produced by Year of Care Partnerships.

A2.2 Purpose of the visits

ICF is conducting a programme-level evaluation of the HoC approach to CSP and this is the third and final visit of the evaluation. The focus of the visits will be different to the previous two, as there will be much less focus on programme design and implementation, but more focus on outcomes, challenges and enablers, patient experience, lessons learned and sustainability.

To achieve this, ICF will conduct up to 12 interviews at each site with (as appropriate) with project leads, healthcare professionals (HCPs), key partners/ stakeholders and patients. ICF will also talk with national stakeholders including those from BHF, YoCP, the Scottish Government and the Health and Social Care Alliance Scotland.

The visits will each be written up as stand-alone case studies. These will be included in the final evaluation report, with projects' baseline and follow-up quantitative data. The final evaluation report will be submitted to BHF in April 2018.

A2.3 Setting up the final visits

Visits will take place between October and December 2017. Four days have been assigned to each of these visits. This includes setting up, undertaking the visits, follow-up phone interviews and writing the case studies.

Where interviewees are not available on the day of the visit, researchers should arrange to interview them over the phone.

General topic guide – for use with project manager

This topic guide is designed for use with the project manager(s). It is intended to be used as a broad, general topic guide. Researchers should tailor their questioning according to the knowledge and experience of their interviewee. To support this, researchers should ensure that they are familiar with the HoC, care and support planning (CSP) and the local context in to which this has been introduced. Interviewees should ensure they are able to prompt interviewees, as appropriate, on different aspects of the House.

The focus of these interviews will be less on design and implementation and much more on outcomes, challenges and enablers, lessons learned and sustainability.

These interviews should be undertaken face-to-face during a site visit and are likely to last for about an hour. If a particular interviewee is not available on the date that the site visit has been arranged for, then arrange to speak to them over the phone.

Interviewers should emphasise that interviewees can withdraw at any time, and that participation in the study does not affect the funding they receive from BHF. Interviewees are being interviewed on the basis that whilst individual organisations may be identified, no individuals will be and that all quotations used will be made anonymous. Please ask permission to record the interviews.

A2.4 Background

- Please describe your background, and role in this project (if changed since last visit)

A2.5 Context

Interviewers should familiarise themselves with the local context for projects outlined in the previous report. The purpose of this section is to ensure we are up to date with any **changes** in context – including policies, programmes, and local structure – that have occurred since the last visit.

- Has the local context for the HoC programme changed since our last site visit? If yes, how? [Probe for new policies, programmes and initiatives, any changes in the financial climate etc]. What implications do these new developments have for the HoC programme?
- What else is going on locally related to HoC? How are other local policies and initiatives that have links with CSP (e.g. around cardiovascular disease (CVD) care, person-centred care, social prescribing etc, care navigators, primary care development) progressing? What achievements have there been in the last year? What challenges?
- How has local partnership working developed over the last year? For example, local organisations working together to signpost patients to other services.

A2.6 Rationale, design and inputs

The purpose of this section is to refresh our understanding of their perspective on the rationale and design of the HoC approach to CSP, to gather reflections from

interviewees on the HoC's initial design, to track any changes to design that have been made in the last year, and to reflect on local translation of the HoC approach to CSP.

- Looking back, what are your overall reflections on the design of the BHF programme? Has it been fit for purpose locally? What limitations has it had, if any? How have these limitations affected local approaches for BHF practices?
  - Explore: each aspect of the HoC approach to CSP and the approach as a whole;
  - Explore if and how local adaptations to the approach have been made and ability to make these.
  - Why did you need to introduce these local adaptations? In response to what?
  - What would have happened if you were unable to do these local adaptations?
  - What learnings have you made (in terms of adaptations) that you could share with others e.g. how is it best approached?
- Do you think that your project has benefitted from being part of a larger programme; if so, how? If not, why not? Which elements have been most helpful?
- What in-kind resource has been used to implement and sustain the BHF practices involved in the project?
- Have there been any other sources of funding used to implement and sustain the project?
- What aspects of the programme management and support have been beneficial; are there any elements that have been detrimental?

  Probe for:
  - Role of BHF programme manager
  - CDC, HSE lead activity
  - Workshops and events
- What role has your steering group played throughout the programme?

A2.6.1 The role of BHF, YoCP, the Health and Social Care Alliance Scotland and ICF

Use this section to explore sites' views on the roles of BHF, YoCP, the Health and Social Care Alliance Scotland and ICF throughout the programme, including what has worked well and less well, and any additional support they might need.

- How do you find the on-going support from BHF/YoCP/ICF/Scottish Government and Health and Social Care Alliance? Explore:
  - What has worked well?
  - What has worked less well; any suggestions on how this could be improved?
  - Any additional support needs that haven't been addressed.
- How do you find the on-going support from the local project manager/steering group/local facilitators? Explore:
  - What has worked well/ less well?;
  - Any additional support needs that haven't been addressed.

A2.7 Implementation

The purpose of this section is to understand what sites have been doing since our last visit, and how they are doing it. Researchers should adapt their questioning according to the knowledge of their interviewee.

A2.7.1 Background to introducing CSP

- How have you raised awareness of CSP locally?
- What activities have been undertaken with people with CVD to:
  - Engage people in CSP as an approach;
  - Prepare people for changes in ways consultations are structured;
  - Prepare people for consultations (prompts, results);
  - Reach poorly served people.
- How have people with CVD been informed about local changes in the delivery of their care? Have they been involved in the local design of the project?
- How have people with CVD been engaged in delivering the project? What have been the successes and challenges in working with people with CVD in this way?

A2.7.2 Implementation

- What are the main activities you/local practices have undertaken since our last visit as part of your project? Explore: number of GP practices engaged in BHF programme, training undertaken, events, direct work with practices, developing links with wider services.
- Have any further organisational changes been made in practices since our last visit? Prompt for:
  - IT changes;
  - Updated policies and procedures;
  - Role of the steering group and wider groups e.g. evaluation groups
- What role have local facilitators played in implementation? Have others played a part? E.g. local champions, exemplar practices
- Can you describe the different approaches practices have taken to organise their appointments to fit with the CSP process?
- What has worked well in implementing a CSP approach?
- Have there been any challenges with implementing a CSP approach? How have they been overcome?
- What are your current reflections on 'drop off' between appointments at practices? Is this being seen locally? How has/can this be overcome?
- What is the difference between the cohort eligible for CSP appointments and the one that is invited to the appointments? What are the criteria for inclusion/exclusion? What are the characteristics of the cohort that is not invited?
- What progress have been made with train the trainer?
- What steps have been taken to address health inequalities through the project? What steps do you plan to take going forward?

A2.7.3 Wider infrastructure

- Can you describe developments in the approach your area is taking to the 'more than medicine' element of the House. What activities have been undertaken to:
  - Understand what services and types of support are available in the local area;
  - Map these services and types of support making them more findable
  - Improve HCP awareness of, and access to local services and support, and community assets;
  - Link people more effectively to services and support.
- What have been the successes and challenges in working with the wider community?
- Do you think that there is sufficient resource in the wider community to support patients who identify support needs arising from a CSP conversation?
- Is there anything else that would need to be in place to help working with the wider community to support patients?
- A number of people mentioned during interviews that implementing HoC approach to CSP requires a culture change in general practices.
  - What does "culture change" mean to you?
  - How does it manifest itself?

A2.8 Emerging and expected outcomes and impacts

Use these questions to focus on the project's emerging and expected outcomes and longer term impacts. Researchers should use projects' logic models to guide this discussion. Focus on: identifying which outcomes are most important (to whom) and why; identifying any early evidence of short-term/intermediate outcomes; and exploring the likelihood of achieving impact in different areas.

- What are the main outcomes you have seen? Explore outcomes for:
  - People with CVD (social, emotional and biomedical);
  - HCPs (including their relationship with people who have CVD/long term conditions (LTCs))
  - Practices and practice teams;
  - The wider healthcare sector;
  - The voluntary sector / community assets.
- What evidence is there (including indicative / anecdotal evidence) of these outcomes?
  - Positive HCP feedback on YOCP training;
  - Improved local knowledge and understanding of CSP;
  - Establishing organisational processes to enable a CSP process with preparation for the patient;
  - Better patient / staff experience of consultations including any feedback from patients
- What outcomes have you not seen that you would expect to have seen? When might you expect to see evidence of these outcomes?

- Have there been any unexpected outcomes? Or any outcomes different to original intentions?
- Are there any particular changes/improvements which you feel have been most powerful in terms of impact?
- To what extent do you think these outcomes would have been achieved without the HoC programme?
- How are these outcomes linked to in-kind resource provided?
- What external factors might influence these outcomes?
  - Policies and programmes locally;
  - Services people with CVD might access, disease trajectories;
  - Other national drivers.
- Have different partners prioritised different outcomes? What evidence is there of this?
  - Explore the priorities for: people with CVD, HCPs, different stakeholders, and the wider healthcare system
- What evidence is there of outcomes at the 'strategic' level? What 'extra' outcomes are achieved due to:
  - The use of the HoC model;
  - The influence of BHF;
  - The programme model (e.g. probe for the value of interactions between the different sites);
  - The role of YOCPs.
  - GMC contract changes in Scotland and Sustainability and Transformation Plans in England

Resource analysis

- How reflective of other practices involved in the BHF programme are your findings from the resource analysis work? Probe for single vs MM approach and their definition of these terms (including co-morbidity).
- What was your experience of undertaking this work?
- What lessons have emerged from doing the resource analysis with practices? Will these lessons/skills be useful for other work locally?

Output data

- What was your experience of providing output data to BHF? Were there any challenges associated with this – probe for: coding, IT, support from practices
- What lessons have emerged from using this output data? How has this been used locally? Probe for analysis e.g. reviewing attrition rates and any reflection / review of data done locally and within practices. What are your plans for collecting and using output data in the longer term?

Questionnaires

- What was your experience of using questionnaires? Were there any challenges associated with this?
- How is data from these questionnaires being used locally?
- What lessons have emerged from using data from these questionnaires?

A2.9 Lessons learned

- What has worked well/less well in relation to CSP? What have been the challenges and enablers for success?
- Why did your site approach it in the way that you did? In retrospect was this the way to do it?
- In general, what approach have practices taken to implement CSP for CVD?
  - Are there commonalities in the approaches taken by practices?
  - What variation in approaches are there?
  - How has the approach been tailored locally? Why?
  - What learning has this provided for what works?
  - Which approach do you think is more effective?
  - Single condition vs multi-morbidity approach
- What do you think are the key ingredients without which CSP cannot be implemented locally? Do you think your site had these? What were the facilitators and barriers to this?
- What are the most important lessons you have drawn from the programme? What do you think has been the key learning to emerge from HoC: a) about CSP b) about process and implementation?
- If you were to start your project again, would you change anything? If so, what? (with the knowledge they have acquired over the last 3 years?)
- What are your thoughts on the replicability of the approach elsewhere?
- What are your reflections on the added value of BHFs involvement? What are your views on the partnership with BHF for this programme?
- What are your thoughts on how CSP helps to address health inequalities?

A2.10 Sustainability

- What plans are there to sustain the project and outcomes achieved? What activities have been undertaken? Explore sustainability at a practice as well as local level, progress with train the trainer, local funding, developing new roles, embedding ways of working, spreading CSP.
- What else is required for further development and spread of CSP in the community?
- What are the major risks to sustainability? Explore: progress in relation to train the trainer, confidence about sustainability of current training regime at end of funding, current context, local facilitators and barriers, engagement from local teams, (in Scotland - make reference to primary care transformation, in England - STPs).

- Do you feel connected to senior decision makers/able to make decisions re: sustainability?
- How has being part of the programme contributed to CSP becoming normal practice?
- Has CSP added value locally – if so, how?

A2.11 CSP and CVD

- Do you think that CSP is transferable to CVD? Are there any particular challenges or benefits that have arisen from implementing the CSP with patients with CVD? What are your views on implementing a multi-morbidity approach for embedding CSP in CVD care?
- How has the HoC programme/CSP contributed towards the overall system change required to offer people with CVD more holistic, coordinated care? What else might be required?
- How might it contribute in future?
- Is there anything else that would be beneficial for you to understand around CVD more widely?

A2.12 Recommendations

- What (if any) recommendations do you have for:
  - The BHF programme team;
  - Year of Care Partnership;
  - Health and Social Care Alliance Scotland;
  - The Scottish Government; and,
  - ICF.
- Finally, do you have any further points you would like to make in relation to the topics discussed, or is there anything else you would like to raise?

Thank the interviewee for their time and close.

General topic guide – for use with wider stakeholders

This topic guide is designed for use with wider stakeholders. It is intended to be used as a broad, general topic guide. Researchers should tailor their questioning according to the knowledge and experience of their interviewee. To support this, researchers should ensure that they are familiar with the HoC, care and support planning (CSP) and the local context in to which this has been introduced. Interviewees should ensure they are able to prompt interviewees, as appropriate, on different aspects of the House.

The focus of these interviews will be less on design and implementation and much more on outcomes, challenges and enablers, lessons learned and sustainability.

These interviews should be undertaken face-to-face during a site visit and are likely to last for about an hour. If a particular interviewee is not available on the date that the site visit has been arranged for, then arrange to speak to them over the phone.

Interviewers should emphasise that interviewees can withdraw at any time, and that participation in the study does not affect the funding they receive from BHF. Interviewees are being interviewed on the basis that whilst individual organisations may be identified, no individuals will be and that all quotations used will be made anonymous. Please ask permission to record the interviews.

A2.13 Background

- Please describe your background, and role in this project (if the stakeholder has not been interviewed previously).

A2.14 Context

Interviewers should familiarise themselves with the local context for projects outlined in the previous report. The purpose of this section is to ensure we are up to date with any **changes** in context – including policies, programmes, and local structure – that have occurred since the last visit.

- Has the local context for the HoC programme changed since our last site visit? If yes, how? [Probe for new policies, programmes and initiatives, any changes in the financial climate etc]. What implications do these new developments have for the HoC programme?
- What else is going on locally related to HoC? How are other local policies and initiatives that have links with CSP (e.g. around cardiovascular disease (CVD) care, person-centred care, social prescribing etc, care navigators, primary care development) progressing? What achievements have there been in the last year? What challenges?
- How has local partnership working developed over the last year? For example, local organisations working together to signpost patients to other services.
- How has the HoC project integrated with other priorities and activities locally?

A2.15 Rationale, design and inputs

The purpose of this section is to refresh our understanding of their perspective on the rationale and design of the HoC approach to CSP, to gather reflections from

interviewees on the HoC's initial design, to track any changes to design that have been made in the last year, and to reflect on local translation of the HoC approach to CSP.

- Looking back, what are your overall reflections on the design of the BHF programme? Has it been fit for purpose locally? What limitations has it had, if any? How have these limitations affected local approaches for BHF practices?
  - Explore: each aspect of the HoC approach to CSP and the approach as a whole;
  - Explore if and how local adaptations to the approach have been made and ability to make these:
  - Why did you need to introduce these local adaptations? In response to what?
  - What would have happened if you were unable to do these local adaptations?
  - What learnings have you made (in terms of adaptations) that you could share with others e.g. how is it best approached?
- Do you think that your project has benefitted from being part of a larger programme; if so, how? If not, why not? Which elements have been most helpful?
- What in-kind resource has been used to implement and sustain the BHF practices involved in the project?
- What aspects of the programme management and support have been beneficial; are there any elements that have been detrimental?

  Probe for:
  - Role of BHF programme manager
  - CDC, HSE lead activity
  - Workshops and events
- What role has your steering group played throughout the programme?

A2.15.1 The role of BHF, YOCP, the Health and Social Care Alliance Scotland and ICF

Use this section to explore sites' views on the roles of BHF, YOCP, the Health and Social Care Alliance Scotland and ICF throughout the programme, including what has worked well and less well, and any additional support they might need.

- How do you find the on-going support from BHF/YoCP/ICF/Scottish Government and Health and Social Care Alliance? Explore:
  - What has worked well?
  - What has worked less well; any suggestions on how this could be improved?
  - Any additional support needs that haven't been addressed.
- How do you find the on-going support from the local project manager/local facilitators? Explore:
  - What has worked well/ less well?;
  - Any additional support needs that haven't been addressed.

A2.16 Implementation

The purpose of this section is to understand what sites have been doing since our last visit, and how they are doing it. Researchers should adapt their questioning according to the knowledge of their interviewee.

A2.16.1 Background to introducing CSP

- How has awareness of CSP been raised locally?
- What activities have been undertaken with people with CVD to:
  - Engage people in CSP as an approach;
  - Prepare people for changes in ways consultations are structured;
  - Prepare people for consultations (prompts, results);
  - Reach poorly served people.
- How have people with CVD been informed about local changes in the delivery of their care? Have they been involved in the local design of the project?
- How have people with CVD been engaged in delivering the project? What have been the successes and challenges in working with people with CVD in this way?

A2.16.2 Implementation

- Can you describe the different approaches practices have taken to organise their appointments to fit with the CSP process?
- What has worked well in implementing a CSP approach?
- Have there been any challenges with implementing a CSP approach? How have they been overcome?
- What steps have been taken to address health inequalities through the project?

A2.16.3 Wider infrastructure

- Can you describe developments in the approach your area is taking to the 'more than medicine' element of the House? What activities have been undertaken to:
  - Understand what services and types of support are available in the local area;
  - Map these services and types of support making them more findable
  - Improve HCP awareness of, and access to local services and support, and community assets;
  - Link people with CVD more effectively to services and support.
- What have been the successes and challenges in working with the wider community?
- Do you think that there is sufficient resource in the wider community to support patients in the way a CSP approach requires?
- Is there anything else that would need to be in place to help working with the wider community to support patients?

A2.17 Emerging and expected outcomes and impacts

Use these questions to focus on the project's emerging and expected outcomes and longer term impacts. Researchers should use projects' logic models to guide this discussion. Focus on: identifying which outcomes are most important (to whom) and why; identifying any early evidence of short-term/intermediate outcomes; and exploring the likelihood of achieving impact in different areas.

- What are the main outcomes you have seen? Explore outcomes for:
  - People with CVD (social, emotional and biomedical);
  - HCPs (including their relationship with people who have CVD/long term conditions (LTCs))
  - Practices and practice teams;
  - The wider healthcare sector;
  - The voluntary sector / community assets.
- What evidence is there (including indicative / anecdotal evidence) of these outcomes?
  - Positive HCP feedback on YoCP training;
  - Improved local knowledge and understanding of CSP;
  - Establishing organisational processes to enable a CSP process with preparation for the patient;
  - Better patient / staff experience of consultations including any feedback from patients
- What outcomes have you not seen that you would expect to have seen? When might you expect to see evidence of these outcomes?
- Have there been any unexpected outcomes? Or any outcomes different to original intentions?
- Are there any particular changes/improvements which you feel have been most powerful in terms of impact?
- To what extent do you think these outcomes would have been achieved without the HoC programme?
- How are these outcomes linked to in-kind resource provided?
- What external factors might influence these outcomes?
  - Policies and programmes locally;
  - Services people with CVD might access, disease trajectories;
  - Other national drivers.
- Have different partners prioritised different outcomes? What evidence is there of this?
  - Explore the priorities for: people with CVD, HCPs, different stakeholders, and the wider healthcare system
- What evidence is there of outcomes at the 'strategic' level? What 'extra' outcomes are achieved due to:
  - The use of the HoC model;

- The influence of BHF;
- The programme model (e.g. probe for the value of interactions between the different sites);
- The role of YoCPs.
- GMC contract changes in Scotland and Sustainability and Transformation Plans in England

A2.18 Lessons learned

- What has worked well/less well in relation to CSP? What have been the challenges and enablers for success?
- Why did your site approach it in the way that you did? In retrospect was this the way to do it?
- In general, what approach have practices taken to implement CSP for CVD?
  - Are there commonalities in the approaches taken by practices?
  - What variation in approaches are there?
  - How has the approach been tailored locally? Why?
  - What learning has this provided for what works?
  - Which approach do you think is more effective?
  - Single condition or multi-morbidity approach
- What do you think are the key ingredients without which CSP cannot be implemented locally? Do you think your site had these? What were the facilitators and barriers to this?
- What are the most important lessons you have drawn from the programme? What do you think has been the key learning to emerge from HoC a) about CSP b) about process and implementation?
- If you were to start your project again, would you change anything? If so, what? (with the knowledge they have acquired over the last 3 years?)
- What are your thoughts on the replicability of the approach elsewhere?
- What are your reflections on the added value of BHFs involvement? What are your views on the partnership with BHF for this programme?
- What are your thoughts on how CSP helps to address health inequalities?

A2.19 Sustainability

- What plans are there to sustain the project and outcomes achieved? What activities have been undertaken? Explore sustainability at a practice as well as local level, progress with train the trainer, local funding, developing new roles, embedding ways of working, spreading CSP.
- What else is required for further development and spread of CSP in the community?
- What are the major risks to sustainability? Explore: progress in relation to train the trainer, confidence about sustainability of current training regime at end of funding, current context, local facilitators and barriers, engagement from local teams, (in Scotland - make reference to primary care transformation, in England - STPs).

- Do you feel connected to senior decision makers/able to make decisions re: sustainability?
- How has being part of the programme contributed to CSP becoming normal practice?
- Has CSP added value locally – if so, how?

A2.20 CSP and CVD

- Do you think that CSP is transferable to CVD? Are there any particular challenges or benefits that have arisen from implementing the CSP with patients with CVD? What are your views on implementing a multi-morbidity approach for embedding CSP in CVD care?
- How has the HoC programme/CSP contributed towards the overall system change required to offer people with CVD more holistic, coordinated care? What else might be required?
- How might it contribute in future?
- Is there anything else that would be beneficial for you to understand around CVD more widely?

A2.21 Recommendations

- What (if any) recommendations do you have for:
  - The BHF programme team;
  - Year of Care Partnership;
  - Health and Social Care Alliance Scotland;
  - The Scottish Government; and,
  - ICF.
- Finally, do you have any further points you would like to make in relation to the topics discussed, or is there anything else you would like to raise?

Thank the interviewee for their time and close.

HCPs and other staff topic guide

This topic guide is for use with HCPs and other staff who have undertaken YoCP training, and been implementing CSP within their practices. The interviewees could be GPs, nurses, practice managers or administrative/ support staff. Questioning should be tailored accordingly.

These interviews are being used to allow us to understand interviewees' perspectives, different approaches to implementing CSP in different practices and to provide some insight into outcomes.

Interviewers should emphasise that interviewees can withdraw at any time. Interviewees are being interviewed on the basis that whilst individual organisations may be identified, no individuals will be and that all quotations used will be made anonymous. Please ask permission to record the interviews.

A2.22 Background and context

- What is your background? Explore: clinical/ professional background, previous and current involvement/training in CSP.
- Explore the interviewee's practice – size, local population, areas of expertise / interest, challenges faced, and strengths.

A2.23 Rationale

- What was your knowledge of the HoC (and CSP) before you heard about this project? How did you first hear about the HoC approach to CSP?
- What is your understanding of CSP
- Why did you decide to take part in the HoC?
  - Explore: challenges and opportunities within their practice/local area; personal aspirations; wider policy drivers.

A2.24 Experiences of training

- What was your experience of the training you attended?
  - Who took part, was attendance as a team or individually?
  - Explore: aspects of training which were most/least helpful e.g. content, facilitators; course practicalities e.g. location, length.
  - What were the strengths, what were the weaknesses?
  - What improvements would you like to see?
- Have there been any knock on effects from the training for the practice? If so, what?

A2.25 Implementation

- How is CSP being put in to place within your practice? What changes have you made? How have you found this process?
  - In relation to the different elements of CSP: information gathering, information sharing and patient preparation, the conversation within the CSP consultation and how discussions and actions are discussed and recorded in a care plan.

  - Explore: have there been any practice specific adaptations to the CSP process
  - Focus on how the CSP approach may be different and how it feels
- Why have you taken the approach (describe approach of that practice) to implementing CSP?
- What would have happened if you were unable to do these local adaptations?
- What learnings have you made (in terms of adaptations) that you could share with others e.g. how is it best approached?
- What is the difference between the cohort eligible for CSP appointments and the one that is invited to the appointments? What are the criteria for inclusion/exclusion? What are the characteristics of the cohort that is not invited?
- What do you think are the key ingredients without which CSP cannot be implemented? Explore: changes in appointments, buy in, different uses of HCPs.
- [For clinical staff] Has this had any impact on your personal consultation skills?
  - Explore: impact on consultation length, effectiveness, style
- What has worked well? Why? Explore for examples related to:
  - The different elements of CSP: information gathering, information sharing and patient preparation, the conversation within the CSP consultation and how discussions and actions are discussed and recorded in a care plan.
- What are the key challenges you have faced in implementing CSP? How have these been overcome? Probe for challenges related to:
  - The different elements of CSP: information gathering, information sharing and patient preparation, the conversation within the CSP consultation and how discussions and actions are discussed and recorded in a care plan.
- What have been the key facilitators/enablers in implementing CSP?
- What have been the costs of implementation for the practice?
  - Explore: time spent in meetings, changes to process, backfill for training, sharing of learning, in-kind resource (both one off and ongoing)
- A number of people mentioned during interviews that implementing HoC approach to CSP requires a culture change in general practices.
  - What does “culture change” mean to you?
  - How does it manifest itself?
- How have people with CVD been informed about changes in the delivery of their care? Have they been involved in the supporting its introduction into the practice e.g. design of materials

A2.26 Outcomes and impact

- What has been the impact of introducing CSP in your practice, on:
  - **Patients –** changes in the style of consultation, use of care plans, better care experiences, frequency of GP visits, relationships with HCPs, ability to self-manage, participation in decision making, understanding of LTCs. Have there been any barriers or challenges to this?

  - Staff – confidence, satisfaction with new ways of working, change in responsibilities, upskilling of staff, increased use of skills mix, retention.
  - The practice - relationships within practice teams, practice staffing levels, changes in number of appointments, links with other services.
  - The local health economy **more broadly**

- Is CSP changing involvement with wider services in the community? How? Where are there still gaps in community assets?
- Have there been any unexpected outcomes? Or any outcomes different to original intentions?
- Are there any outcomes you expected to see that you haven't?

A2.27 Lessons learned and sustainability

- What are the key lessons arising from implementing CSP in your practice so far?
- What are your future plans for CSP? Will it be sustained in your practice?
- Is there anything else that would help to support and sustain CSP within your practice?
  - Explore: incentives, protected time, local/ national policies

A2.28 Reflections on CSP

- Do you think that CSP using the framework of HoC is transferable to CVD?
- Are there any particular challenges or benefits that have arisen from implementing the CSP with patients with CVD?
- Do you think you would have made the changes that have taken place in the absence of the programme? (chosen to implement a CSP approach)
- What has been your experience of implementing the CSP approach in the current primary care climate:
  a) Has anything about the current primary care context made it easier?
  b) Has anything about the current primary care context made it more difficult?
- What are your thoughts on how CSP helps to address health inequalities?
- Is there anything else you would like to discuss?

Thank the interviewee for their time and close.

Patient topic guide

This topic guide is for use with patients who have experienced a CSP review for CVD. A person-centred ethos underpins the HoC approach to CSP; people with LTCs are at the heart of the CSP approach with a focus on collaboration and shift in emphasis of 'what matters to you, not what's the matter with you.' To be effective, patient engagement is key.

These interviews are being used to understand the patient perspective and explore how CSP is understood by those who matter most. This will help to broaden our understanding of the programme from the patient's perspective, and ensure the patient voice is represented at a programme level. Please try to confirm that a patient has definitely been part of the CSP process prior to interview.

Interviewers should emphasise that interviewees can withdraw at any time, and that participation in the study does not affect the care they receive. All interviews are confidential, no individuals will be named and that all quotations used will be made anonymous. Please ask permission to record the interviews.

A2.29 Introduction

Explain that we have asked to talk with them as their practice has recently changed the way it delivers review appointments for people with LTCs. Their reviews should now involve two separate appointments – one to gather information and a consultation appointment where they would discuss the results of the tests they received and agree a care plan. In between appointments they should have received an information letter and test results. Please try to capture some demographic information about the patient, where appropriate, for example age, gender and ethnicity and whether any interviewees come from hard to reach groups.

A2.30 Prior to the introduction of CSP

- Understand whether patients had been aware that there had been a change.
- [If aware of change] How did you learn about the change to your review process?
- Were you happy with that approach? How could that be improved?
- Do you understand why it changed?
- Before the new appointment process, how was your condition/s reviewed? What were your views on this approach?

A2.31 CSP reviews

- If the process for your review has changed, how has this changed?

  Explore:

  - Style/length of consultation
  - Combining conditions – e.g. receiving a review for diabetes alongside CVD
  - Receipt of information to enable preparation for the appointment e.g. prompts to think about concerns and issues, test results
  - Changes in the staff involved in the process
  - Production of a (care) plan towards the end of the consultation

- Given any information about / supported to access wider services (e.g. in the community, social prescribing, link workers) that could help them live well with their long term condition?

- How were you prepared for your review?

  Explore:

  - Did patients receive their test results prior to their second appointment? Was this explained?
  - Was any other information shared? If so, what? What format did this take? E.g. information to support patients to reflect on concerns and issues

- How would you describe your role in your review appointment? How would you describe the role played by your HCP?

  Explore:

  - Patient felt listened to, enabled, supported, in control, influenced, controlled, like an equal partner
  - Professional was open, supportive, facilitative, encouraging, directive, authoritative

- Did you feel involved in the consultation as much as you wanted to be? If not, how would you like to be more involved in future consultations? If you preferred not to have an active role, why is this?

A2.32 After a CSP review

- What changes (if any) have there been to your knowledge about/understanding of your condition as a result of the review?
- What changes (if any) have you made to the way you manage your condition as a result of the review?

  Explore:

  - Do they intend to use the plan produced during the visit? How?
  - If goals were discussed and agreed how useful was this? If not, would it have been useful if it had been?
  - Have they focused on goals created during their review?
  - If they agreed goals, have they been monitoring progress against their goals created during their review? How are 1) they monitoring this, and 2) their HCP reviewing this with them?
  - Signposting to support needed if relevant e.g. weight loss, smoking cessation etc.

- Have you accessed any local community services following your review?

  Explore:

  - How were these services identified? What were views of this?

- What would you have liked to access that wasn't available?

- Has the review process made a difference to your general health and wellbeing? If so, how? What difference do you think it will make?
- How confident are you in your ability to manage your condition?

  Explore:

  - Knowledge of when and where to seek support
  - Medication management
- How would you describe the way in which different services work together to deliver your LTCs care?
- What role do you see HCPs having in the management of your LTCs? What do you think your role should be?

A2.33 General comments

- How do you feel the new review process compares to reviews you had previously?
- How do you feel the new review process fits with and meets your needs?
- Can you see any benefits of this new review process in comparison with the previous one?
- How did you think the approach suited people from different backgrounds?
- Is there anything that would make the process better? If so, please describe

Thank the interviewee for their time and close.

Strategic stakeholder interviews

This topic guide is designed for use with strategic level stakeholders. This is the topic guide for use in the final set of stakeholder interviews, which will take place at the end of 2017/early 2018. The overall aim of the interviews will be to generate an understanding of progress, outcomes and learning from the programme. This is to help inform BHF and wider stakeholders about learning from the programme in implementing CSP for people with CVD.

Interviews will be semi-structured, be undertaken by telephone and will last around one hour. Interviewers should emphasise that interviewees can withdraw at any time. Interviewees are being interviewed on the basis that whilst individual organisations may be identified, no individuals will be and that all quotations used will be made anonymous. Please ask permission to record the interviews.

A2.34 Background

Establish the interviewee's professional role and their role within the programme: which organisation do they work for, what is their role and which element(s) of HoC have they been engaged in? (If unknown/unclear)

This will form the focus for the discussion from then on.

A2.35 Context

- Has the national context for the HoC programme changed? If yes, how? [Probe for new policies, programmes and initiatives, any changes in the financial climate etc]. What implications do these new developments have for the HoC programme?
- What else is going on nationally related to HoC? How are other local policies and initiatives that have links with CSP (e.g. around cardiovascular disease (CVD) care, person-centred care, social prescribing, care navigators, primary care development) progressing? What achievements have there been in the last year? What challenges?

A2.36 Implementation

<u>Looking back over the whole programme:</u>

- Which elements across sites have been implemented well / less well and why? Probe for different parts of the house – organisational processes, engaged patients, HCPs committed to partnership working and commissioning/more than medicine.
- What has helped in terms of implementation, what (if anything) has hindered? How have any challenges been addressed/overcome?
- Did implementation proceed broadly to plan or were elements of intended changes altered in implementation (if so, what and why)?
- How have different sites integrated as a whole programme?
- What do you think of the different approaches that sites have taken to implement CSP? Why do you think they have taken different approaches? Do you think any approaches work more/less well (any links to outcomes)? What do you think are the key ingredients without which CSP cannot be implemented? Explore: single condition vs multi morbidity, different uses of HCPs.

- What are your reflections on the role of i) BHF ii) YoCP iii) Health and Social Care Alliance Scotland iv) The Scottish Government and v) ICF in supporting the implementation of the programme?
- How have people with CVD been informed about changes in the delivery of their care? Have they been involved in the supporting its introduction into the practice e.g. design of materials.

A2.37 Outcomes and impacts

- What outcomes/impacts do you feel have been achieved

  a) at a site level

  b) for the programme overall?

  Explore for:

  - Patients
  - Staff
  - Wider organisation
  - Local health economy more broadly
- Are there any particular changes/improvements which you feel have been most powerful in terms of impact? What would you have expected to see that hasn't emerged?
- To what extent do you think these outcomes would have been achieved without the HoC programme?
- Have there been any unexpected outcomes? Or any outcomes different to original intentions?

A2.38 Sustainability

- What elements of the CSP/programme are being/will be sustained?
- What factors will be necessary to ensure sustainability? Explore how new ways of working are being embedded, the role of critical posts/individuals, dedicated funding etc.
- What are the major risks to sustainability?
- How can sites ensure that outcomes are sustained?
- Are there any plans for further projects/work to build on what has been achieved through the HoC programme?

A2.39 Learning

<u>Looking back over the whole HoC programme</u>

- How might the different sites/programme have contributed to overall change in care of people with LTCs? What else might be required?
- What has worked well/less well in relation to HoC approach to CSP? What have been the challenges and enablers for success?
- What are the most important lessons you have drawn from the programme? What do you think has been the key learning to emerge from HoC?
- If you were to start the programme again, would you change anything? If so, what? (with the knowledge they have acquired over the last 3 years?)

- What are your thoughts on the replicability of the approach elsewhere?
- Are there any other/wider projects or programmes that this work builds on or is impacted by? If yes, please explain.

    Prompt for context including: STPs, Scottish Primary Care Transformation Fund, GMC contract changes, disbanding of QOF
- What learning has HoC approach to CSP provided for BHF?
- What are your reflections on the added value of BHF's/YoCP's/Scottish Government/ Health and Social Care Alliance Scotland's involvement? E.g. role in promoting / supporting system change. What are your views on the partnership with BHF for this programme?
- What further changes or improvements would you like to see being made, building on what HoC approach to CSP has so far achieved?
- What are your reflections on how people with CVD been engaged in delivering the project? What have been the successes and challenges in working with people with CVD in this way?
- What are your thoughts on how CSP helps to address health inequalities?
- Finally, are there any other issues that the interviewee would like to raise?

Thank the interviewee for their time and close

Annex 3 Self-evaluation reports

Submitted as separate documents

Annex 4 Year of Care Partnerships Advice, Support, Training and Facilitation for the BHF House of Care Programme

The British Heart Foundation funded the Year of Care Partnerships to provide the following support, training and facilitation to the BHF House of Care Programme.

1. Sharing of resources developed prior to the BHF programme:

- Practice pack containing templates and examples of patient information leaflets, promotional material, sample letters, reflection tools, IT guidance and instructions, birth month recall etc..
- Suite of smart-tagged IT resources (primarily for EMIS and System1) and associated guidance to automate the production of preparation materials.
- Suite of preparation resources for use across a range of conditions (diabetes, CVD, COPD, multi-morbidity).
- Content for suite of training courses including taster sessions, core training, HCA training, administrator/practice manager training.
- Provision of (secure) website for quality assured trainers.
- Identification of critical success factors and approaches and resources to support this (e.g. guide to steering groups, train the trainers etc.).

2. Direct implementation support:

- Project manager induction and on-going support via a combination of multi-site teleconferences and one to one sessions with local project leads.
- Provision, design and co-delivery with local sites of taster sessions to help recruit practices.
- Delivery of training: core training, HCA/HCSW training, administrator training, facilitation training.
- Delivery and subsequent local quality assurance of trained trainers to support sustainability.
- Participation in local site steering groups.
- Awareness raising with BHF engagement teams.
- Design and delivery of learning sets both across the programme, at a site level and within practices.

Several project sites requested additional core training from the Year of Care Partnerships and this was funded by sites using funding provided by BHF.

3. Further developments (including those produced for other areas and shared with BHF House of Care Programme)

- Guide to the use of qualitative researchers and CSP.
- Structured approach to training needs analysis for nurses.
- CVD specific resources for Heart Failure.
- Training resources around multi-morbidity and CVD (the “Margaret Game”).
- CVD specific training videos demonstrating CSP.
- One day training course designed for practices who have already implemented process changes for CSP.
- Development, design and for some sites production of local practice wisdom reports supporting practice feedback.
- Use of YoCP adapted Normalisation Process Theory (NPT) tools to support implementation – particularly identification of the extent of local coherence of the programme (i.e. understanding what it is and how it differs from previous ways of working).