The HOUSE Journal

The newsletter for the **Year of Care Community of Practice**

Issue 5 – BHF Programme - Dec 16

In this issue:

Page 1: Introduction to the programme and sites

Page 2: Shared learning and Theory of Change

Page 3: Resources and evaluation

Page 4: Useful links

"It has been great to see health professionals, who were initially quite sceptical, talking about how their practice has embraced the House of Care and be willing to acknowledge their 'change of heart'"

House of Care Project Manager

British Heart Foundation Programme – Lindsay Oliver, National Director

Year of Care Partnerships are working in collaboration with the British Heart Foundation (BHF) and the Health and Social Care ALLIANCE Scotland, across five communities (two in England and three in Scotland), to implement care and support planning for people with cardiovascular disease (CVD).

BHF have funded these five communities and the evaluation of the programme to demonstrate benefits of the approach, provide best practice examples and share learning for other communities considering implementing care and support planning for CVD patients as part of a multi-morbidity approach.

Each day, across the UK over 7 million people are living with CVD and the majority of these people will manage their condition at home or in the community. The House of Care and care and support planning provide an opportunity to improve the conversations for these people in primary care, around what matters to them, and supports self-management for CVD patients.

The aims of the programme are:

1. to introduce collaborative care and support planning as routine care, mainly within primary care, and develop a holistic review in place of the current tick box surveillance activities encouraged by QOF
2. to redesign local pathways for cardiovascular disease services, driven by care and support planning.
3. to develop engagement with a wide range of activities to support self-management within the community, including the third sector

To date, the programme involves 47 practices covering a range of conditions including heart failure, atrial fibrillation, hypertension, Angina/MI. Across the programme so far over 6,000 people in these practices have received care and support planning.

British Heart Foundation and Year of Care Programme sites

The HOUSE Journal

Meet the team!

Dawn Temple-Scott

Dawn is a Programme Manager working in the Year of Care Partnerships and has supported each of the five BHF House of Care Programme sites.

With extensive experience supporting major culture change programmes, Dawn has held posts as Head of Quality and Training with London Electricity and Head of Business Development with Masterfoods. Within the NHS, Dawn has lead on long term care and rehabilitation with the North East Cardiovascular Network, and was the Mental Health Lead with the North of England Strategic Clinical Network. Dawn combines strong programme management with a passion for engaging and supporting both organisations and people through periods of significant change.

Shared learning

Across the programme, there have been a number of mechanisms set up to share learning during these formative development stages. Project managers from each site meet "virtually" for a networking teleconference on a regular basis, sites are brought together in a series of learning events throughout the programme, and individual sites are also beginning to hold their own sharing events for practices in their own localities to learn from each other. It is hoped that the learning from across the programme will be shareable with you after the evaluation has been completed in March 2018.

At a learning event held in Edinburgh in November, the sites identified a number of opportunities:

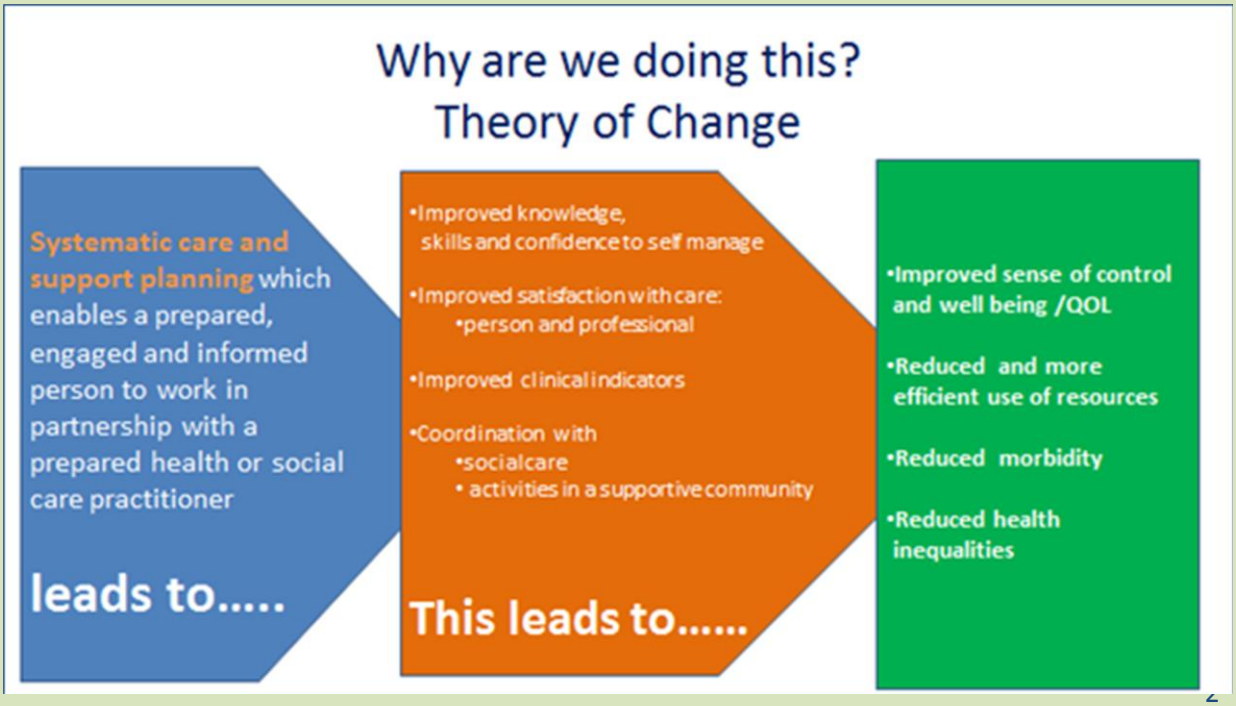
"Building pulse checking into routine information gathering appointments might help us opportunistically check for Atrial Fibrillation across a much wider group of people".

"There's a real opportunity to get a CSP approach into specialist cardiac rehab teams, helping people developing plans for themselves rather than a "one size fits all" approach".

This event focussed on identifying best practice and resources for the implementation of care and support planning for cardiovascular patients, including more than medicine, sustainability, legacy and resources which would be supportive for others considering this approach.

Theory of change

Development of the programme and its approach to evaluation has been based on a Theory of Change, with each site developing its own logic model, with a programme level logic model as its basis, to capture the expected changes. Implementing the culture change required of healthcare practitioners as well as patients (who may only experience this approach once or twice over the life of the programme), is a challenge for the evaluation, which aims to gather evidence around the short term gains made, which we believe, in the longer term, will have the impacts shown in the change model below.



Resources and evaluation

"Having the results in writing is definitely helpful…I had it sitting there in front of me and I'm thinking 'I'll need to work on that'"

A patient

"What I find exceptionally useful is the 'consultation framework', which helps a variety of clinicians refine how they partner the person with the LTC during collaborative care and support conversations."

House of Care Project Manager

CVD resources

As a result of this programme, there are now a number of additional cardiovascular – specific resources which are available for you to download via the secure Year of Care website. Your local trainers / project managers will have been granted access to the secure website:

a. Margaret game – a game designed to help people understand the number of appointments / health visits people with multi-morbidity including CVD may experience.
b. Heart failure information sharing resource – results sharing letter for use for people with heart failure.
c. CVD video clips – two new video clips, featuring people with cardiovascular disease, which can be used in training to demonstrate care and support planning conversations.

Mapping Resources for Care and Support Planning

All sites are involved in carrying out a series of resource mapping exercises looking at what "before" and "after" care and support planning looks like. Across the programme there are a wide range of scenarios:

- practices who are supporting people with single conditions as well as those using a multi-morbidity approach
- practices who's "before "pictures involved people receiving regular disease-specific annual reviews as well as those who did not offer reviews at all
- practices who are using healthcare assistants more, practices who have reviewed and changed the skill mix of their teams to get the most out of Care and Support Planning

A programme level review of all these scenarios will be compiled and made available as part of the evaluation.

Evaluation

ICF International has been recruited to carry out an independent evaluation. The evaluation is made up of a number of components:

1. Mapping resources used "before" and "after" care and support planning.
2. Assessing implementation and impact using qualitative interviews with project teams, stakeholders from organisations involved in the programme, healthcare practitioners and patients. A YOCP guide for qualitative researchers can be found on our secure website.
3. Analysing findings from the Year of Care Quality Mark* as a means of tracking progress of implementation.
4. Analysing 'outputs' from the programme - tracking counts of information gathering appointments, results sharing, CSP appointments.
5. Quantitative analysis using a variety of tools to assess impact:
   a. LTC6*
   b. CQI2*
   c. WEBWMS (available from http://www.experiential-researchers.org/instruments/leijssen/WEMWBS.pdf)
   d. PAM (available from: http://www.insigniahealth.com/products/pam-survey)
6. Gathering learning from the programme using qualitative findings from interviews, e.g. exploring issues of "fidelity", and implementation and impact of "more than medicine".

*Copies of LTC6, CQI2 and The Quality Mark can be found on the Year of Care secure website http://www.yearofcare.co.uk/document-library/evaluation-frameworks-and-tools

Helpful links

Detection and Management of High Blood Pressure

Hypertension is an important issue, see https://www.bhf.org.uk/healthcare-professionals/bp-how-can-we-do-better. There was a lot of interest at our Community of Practice Network Event in June and Year of Care Partnerships is keen to work with practices who are interested in this.

We're keen to hear about your experience and solutions to care and support planning for people with hypertension as part of multi-morbidity or as a single condition.

Please contact us at enquiries@yearofcare.co.uk.

Useful links

The British Heart Foundation have available a range of clinical resources to support understanding of cardiac conditions for healthcare practitioners and patients. They will also have a local clinical development co-ordinator who can help develop clinical skills.

There are some other useful pieces of information on the BHF website as follows:

BHF House of Care Programme:

https://www.bhf.org.uk/healthcare-professionals/best-practice/bhf-funds-house-of-care---an-innovative-person-centred-approach

BHF Alliance for Healthcare Professionals:

https://www.bhf.org.uk/healthcare-professionals/bhf-alliance

Best Practice Portfolio for Healthcare Professionals:

https://www.bhf.org.uk/healthcare-professionals/best-practice

Scottish Government and the Health and Social Care ALLIANCE

Year of Care Partnerships are working closely with the Scottish Government and the Health and Social Care ALLIANCE, Scotland who are promoting the adoption of Collaborative Care and Support Planning as an evidence-based approach in meeting the needs of people living with long term conditions in Scotland - more details of this can be found at their website below:

http://www.alliance-scotland.org.uk/what-we-do/our-work/primary-care/scotlands-house-of-care/

"We are looking forward to utilising the knowledge and expertise of our BHF partner colleagues further, so we can offer additional learning opportunities to a variety of professionals involved in caring for and supporting people with CVD."

House of Care Project Manager

Wishing you a Merry Christmas and a very Happy New Year

We look forward to seeing you in 2017!