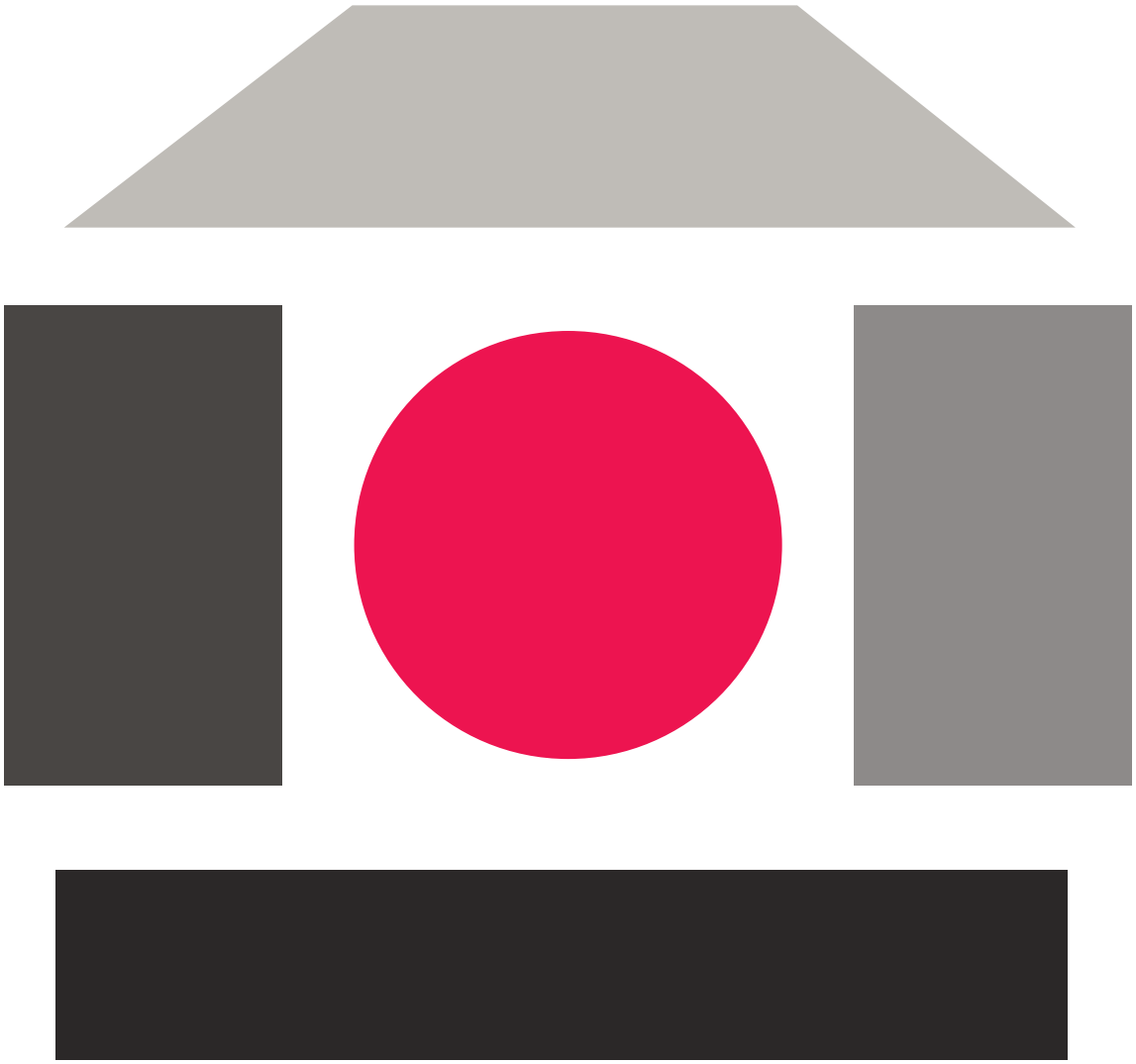
Supplementary resource
December 2015

Building the House of Care

How health economies in Leeds and Somerset are implementing a coordinated approach for people with long-term conditions

Angelina Taylor



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Useful resources

There are a number of websites, publications and other resources that may be useful in thinking about how to deliver care and support planning for people with long-term conditions. Here is a small selection:

- *A practical guide to self-management support*, Health Foundation: www.health.org.uk/publication/practical-guide-self-management-support
- The Year of Care Partnerships: www.yearofcare.co.uk
- National Voices: www.nationalvoices.org.uk
- *Personalised care and support planning handbook*, NHS England and Coalition for Collaborative Care: www.england.nhs.uk/wp-content/uploads/2015/01/pers-care-guid-core-guid.pdf

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Executive summary

This paper explores how the House of Care, a coordinated approach to personalised care and support planning, can transform the health and care of people with long-term conditions (LTCs). It contains case studies of evolving practice in Leeds and Somerset, both of whom are dedicated to a new way of working to support people with LTCs.

There is growing recognition that new ways of working are needed to meet increasing health care demand and cost pressures, while continuing to provide a high quality service that meets people's needs. Pilots of the House of Care in 2007 improved the experience of care and self-care behaviour of people with diabetes, as well as the knowledge and skills of health care professionals. The pilots suggested the House of Care could help localities to work differently.

Implementing a new model in local health economies in the current climate is as challenging as it is necessary. Despite the significant resource pressures, Somerset and Leeds are starting to find ways to embed the approach into their local systems, with Somerset at an earlier and more exploratory stage than Leeds. So far they have made good progress, with commitment at all levels from multiple partners and sectors. Practices are engaged in the approach and health care professionals are harnessing local community assets to enable the whole system to support people with LTCs.

To make the model relevant to the local context and draw on local resources, they have both adapted the model to varying degrees. Leeds has maintained the original House of Care model to a greater extent, whereas in many areas of Somerset there has been some deviation. In Somerset, non-clinical staff are carrying out the care and support planning consultation, a change made in response to GPs' and other health care professionals' time pressures, as well as locally available resources. While some adaptation of the model may be necessary, how flexible it is to adaptation is not yet known.

Both case studies present three broad system approaches to spreading the House of Care across the local health economy: financial incentive, nudge and encouragement. In Leeds South and East CCG ('financial incentive') practices have signed up to the House of Care relatively quickly; somewhat slower in Leeds North CCG and Leeds West CCG ('nudge'); and in Somerset various approaches to the House of Care are emerging ('encouragement'). It remains to be seen which of these approaches is most successful for spreading and embedding the model.

This paper perhaps poses more questions than answers at this stage: it specifically explores how to embed a new model into a pre-existing system, to what extent can and should the model be adapted to the local context, and what is the best approach to achieving spread. However, the case studies provide good examples of how two localities are normalising a new way of working in health and social care through an enabling and coordinated approach. The House of Care is one way of energising local stakeholders to think and work differently; other health economies may also be inspired to transform their own systems.

Introduction

This paper explores how the House of Care, a coordinated approach to personalised care and support planning, can transform the health and care of people with long-term conditions (LTCs).* It contains case studies of evolving practice in Leeds and Somerset and seeks to understand how two whole health economies – individuals, communities, health and social care services and others – are working to manage the rise in the number of people with multiple LTCs and enhance their care experiences. The paper is intended for clinical commissioning groups (CCGs), public health teams, other front-line providers and national bodies.

There is increasing awareness of the rise in the number of people with multiple LTCs and the associated high use of health services.† This poses a significant challenge for the sustainability and coordination of health and social care services. Prevention must be a priority, but how can the system best meet the needs of people with existing LTCs? People living with an LTC spend on average only three hours per year in contact with health and social care services.[2] Service contact is therefore a small part of people's lives, and yet it is often a time when important decisions are made about future care and support. The majority of people would like more involvement in decisions about their care,[3] but only 5% of patients with an LTC report that they helped to put together their written care plan.[4]

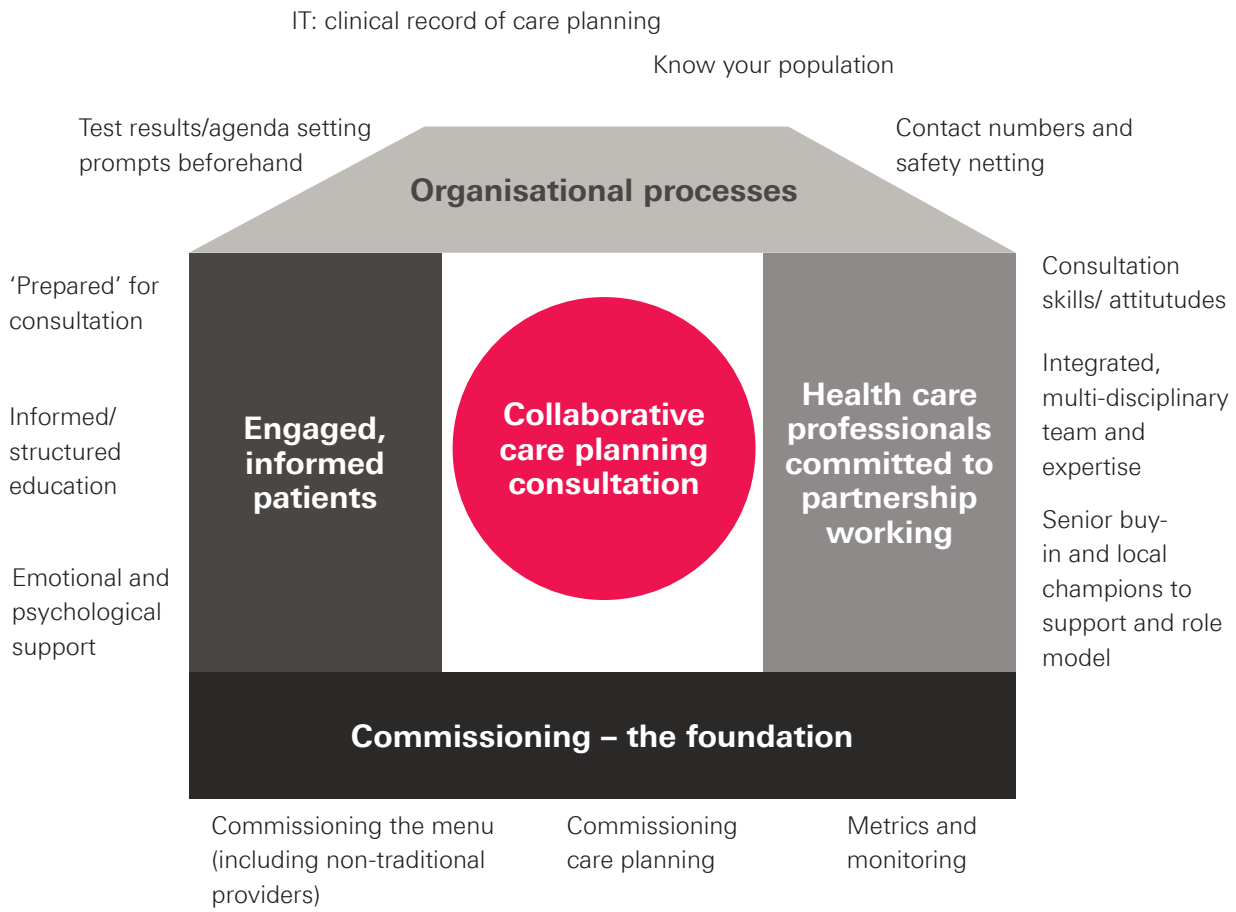
There is clearly a need to engage the people who know their own lives and experience of their conditions best. Such engagement would help to harness local resources available in the community and create a whole system that is enabling, to ensure services are as beneficial for individuals and sustainable for the system as possible. There is growing national interest in working differently: NHS England's *Five Year Forward View* set out its commitment to empowering people with LTCs and engaging communities to work in new ways.[5] Care and support planning is a method for focusing on the whole person and can lead to improvements in the physical and psychological health of people with LTCs.[6]

> *What we know is that our current models for delivering long-term care aren't sustainable. We can't keep being paternalistic and wanting to fix everybody and expecting everybody to just comply with our medical models of care for those conditions.* (Somerset-10)

* People and organisations tend to use different language and models for the House of Care and use it in different ways for different purposes. In addition, some localities refer to the model as the Year of Care or the House of Care, or use the Year of Care to refer to right-hand wall of the 'house' (such as in Leeds). Here we will use the term 'House of Care' to refer to the model and use the Year of Care Partnership's conceptualisation (see Figure 1).

† Almost one quarter of England's population has a long-term condition (LTC) and the number of people with multiple LTCs is set to rise from 1.9 million in 2008 to 2.9 million in 2018. Currently, LTCs account for 50% of all GP appointments, 65% of outpatient appointments and 70% of all inpatient bed days.[1]

Figure 1: The Year of Care Partnership's House of Care model*



The House of Care is a coordinated delivery system for personalised care and support planning for people with LTCs. The 'house' acts as a checklist to help practices think about how they can adapt their whole system and all its components to enhance the health and wellbeing of people with LTCs. This requires the engagement and commitment of multiple partners and sectors, including NHS providers, social care, and public health and other local government stakeholders. The house's purpose is to act as an enabler of care and support planning rather than an end in itself. The house components include the right-hand wall, an enabling workforce committed to partnership working; the left-hand wall, the engaged and informed patient; the foundation, the commissioning processes and services; the roof, the suitable organisational and administrative processes; and at the centre, the collaborative care and support planning consultation (see Figure 1). This latter component is underpinned by the idea that if patients are prepared for their consultation, they will be more able to contribute to decisions about their care.

> *But it just makes sense that if people are prepared… It really makes sense when you think about the rest of a person's life. You wouldn't go in blind to get a bank loan or anything – you would know what the situation was.* (Leeds-3)

* The original Year of Care Partnerships House of Care model is available from: www.yearofcare.co.uk/house

It's about all the parties and fabric around the health and social care system being sort of within the same environment and making the same thing happen. (Somerset-7)

What is care and support planning?

Care and support planning is a systematic process that enables people living with one or more LTC and health and care professionals to have more collaborative and productive conversations. They discuss traditional clinical issues along with support for self-management focused on the person's life goals and what matters to them. They also discuss what the patient can do to stay well and to prepare and make choices about care at the end of life. The health care professional may also signpost activities and social services within a community. The patient is given time to prepare for conversations. A care plan template is often used to document the conversations.[7, 8]

The House of Care was first developed by the Year of Care Partnerships, who piloted it in 2007 for three years with three primary care trusts (PCTs) for people with diabetes in primary care.[9] Notable findings from the pilot include: the model worked across diverse populations; people with diabetes had an improved experience of care and self-care behaviour; and health care professionals reported improved knowledge and skills and greater job satisfaction.[2] The Year of Care Partnerships offers support and Year of Care training to help local areas implement the House of Care for various LTCs, and has worked with both Leeds and Somerset.

These case studies are based on interviews with key stakeholders who are implementing the House of Care, including stakeholders from Leeds CCGs, the public health team at Leeds City Council, and Somerset CCG. Interviewees include CCG strategists and programme managers, public health consultants and practitioners, lay members, and Year of Care trainers. A member of the Year of Care Partnerships team was also interviewed to provide background and context to the Year of Care programme. Interviews took place between April and September 2015. Quotations from interviewees are included in this paper, referenced by their locality and a given number.

Case study: Leeds

Background

Leeds has a population of 751,500 people, with higher levels of deprivation and lower life expectancy than the England average.[10] It is a largely urban area. Leeds City Council is striving to work differently and innovatively.[11] It is one of NHS England's first Integrated Care Pioneers (ICPs), sites testing out new approaches for delivering person-centred, coordinated care.[12] The 'Inspiring Change' campaign to make Leeds 'the best city for health and wellbeing'[13] is ambitious and illustrates Leeds' approach to multi-sector and multi-organisation working. Partners from across Leeds work together to improve the population's health and social care through the Leeds Health and Social Care Transformation Programme.[14] Partners include Leeds City Council, social care providers, the third sector, NHS trusts and three CCGs – Leeds West, Leeds North and Leeds South and East.

The public health team first introduced the House of Care model to Leeds city stakeholders through a workshop in 2012. It brought together diverse representatives from a number of sectors and senior buy-in was obtained at this early stage. The stakeholders mapped out their own city's 'house' together and identified gaps and areas of strength in each of the house's features. Right from the beginning, stakeholders were clear that the whole system had to be in place for the House of Care to be successful.

Citywide commitment to the House of Care was secured with the formation of the self-management steering group, a sub-group of the Leeds Health and Social Care Transformation Programme, and responsibility for the House is therefore held by a number of stakeholders across the city. The public health team secured funding from the PCT for the Year of Care Partnerships' training and to implement the approach in GP practices across Leeds.

In April 2013, the health architecture underwent significant changes as a result of the Health and Social Care Act 2012. Leeds' PCT split to form three separate CCGs and the public health team was transferred to Leeds City Council. Despite these organisational changes, key figures remained in Leeds.

> *I look back now at 2012, 2013 and the way that the NHS has changed within that time and how we have kept this going despite all of that, and we have got this far within primary care. I think it is something about the people who have stayed.* (Leeds-3)

Right from the beginning, the public health team has been central to establishing the House of Care in Leeds. Part of its inspiration for the approach came from being involved in Nesta's 2011–13 People Powered Health, a programme to design and deliver innovative approaches to services and support for people with LTCs.[15] Most of the stakeholders described how it was the drive, passion and clinical experience of this team, along with a few other central figures in Leeds, that has got them to where they are now.

What have they done so far?

Following its formation, the self-management steering group set out to explore how the House of Care could be tailored to its local population. Stakeholders felt that the model must fit the demographics of the population and local organisations and structures, and they drew on clinical and various other input during this design stage. As part of tailoring the model for Leeds, they developed a standard care plan template for the whole city. In addition, across Leeds, the care and support planning process is consistent, as shown in Figure 2, and all patients have access to social prescribing,* the Leeds directory (a directory of local services to help people live independently), peer support groups and neighbourhood networks, and healthy living interventions. All three CCGs have the same engagement scheme to offer backfill for training a GP, practice nurse, a health care assistant (HCA) and practice manager. However, while there is some consistency and a shared vision across Leeds, each of the CCGs has slightly different engagement schemes to implement the approach (see table overleaf).

Figure 2: The Leeds care and support planning process

First visit	**Information gathering**	**Disease surveillance** Health care assistant performs annual review test
	↓	
Between visits	**Information sharing**	**Preparation** Patient sent results and prompts before consultation
	↓	
Second visit	**Consultation and joint decision making** **Agreed and shared goals and actions (care plan)**	**Care planning**

* Social prescribing is the health care professionals' prescription of emotional, social and practical services to meet patients' needs, such as befriending or self-help groups. www.ncbi.nlm.nih.gov/pmc/articles/PMC2688060/

Leeds South and East CCG

The approach: The CCG felt early on that the model would help to improve their local population's health and it is being used to address their large health inequalities. The CCG signs practices up to the approach through financial rewards. Practices are required to offer the House of Care to all of their patients with one LTC, and are given greater reward for patients with more than one LTC. Stakeholders said that the approach was chosen to ensure it is sustainable and to catalyse sign-up across the area. They reported that member practices adopted the approach as a vehicle to reduce inequalities in LTCs in their locality.

The care and support planning process: Each GP practice has or will be training a practice nurse, one GP and a practice manager on the House of Care as a minimum to ensure that it is a multi-disciplinary approach. For details of the process, see Figure 2.

Progress so far: The CCG has the greatest number of practices trained and implementing the model in Leeds. 42 out of 43 practices are trained. 38 of these are implementing for level 1 patients [people with either diabetes or Chronic Obstructive Pulmonary Disease] and 36 for level 2 patients [people with three LTCs]. They are currently waiting for practices to implement the House of Care for level 3 patients [people with more than three LTCs]. Moving forward, the CCG will encourage all practice nurses and GPs from each practice to attend training to sustain the system and process for patients.

Leeds West CCG

The approach: Leeds West is active in promoting the House of Care to GP practices, mainly by making a case for improving their outcomes. They chose this approach as a way to engage practices in the House of Care of their own accord. Practices can choose which LTC(s) they wish to focus on for the House of Care care and support planning.

Care and support planning process: For details of the process, see Figure 2.

Progress so far: Around 19 out of 38 practices are implementing the House of Care, and 12 more will be completing training in 2015. They had expected more resistance, but found that there is good sign-up to the training. Most practices have started offering the House of Care to people with diabetes.

Leeds North CCG

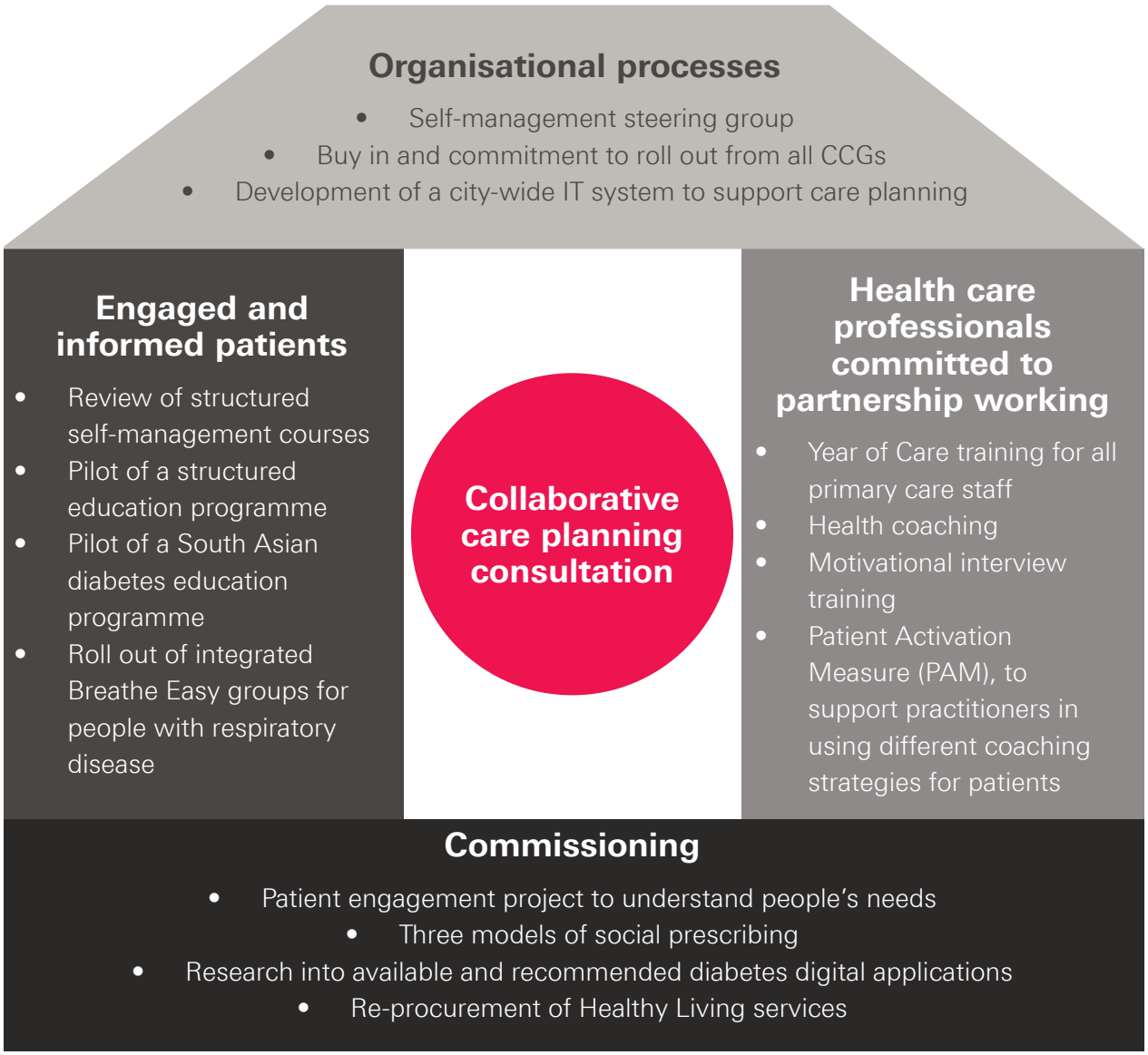
The approach: Leeds North encourages GP practices to implement the House of Care. This approach was chosen since some stakeholders felt it would lead to genuine embedding within their practices. Spread across the area has been slower than other CCGs.

The care and support planning process: For details of the process, see Figure 2.

Progress so far: Eight out of 28 practices have now implemented the approach and half to three-quarters of practices have attended training.

The public health team has an overview of all of the city's activities and stakeholders and has been working hard to ensure that across Leeds they have a strong 'house' (see Figure 3 for details of activities). The right-hand wall – focusing on the workforce – is being built in partnership with Health Education Yorkshire and Humber. They are currently implementing a Train the Trainer model with people to become health coaches in the community trust, mental health trust and in public health to gain reach beyond primary care. On the left-hand side – focusing on people having the skills to manage their own condition – they have done a great deal of work, including reviewing structured education courses in the city and as a result of patients' requests are piloting a number of programmes, including education sessions to support people to manage their own LTC and the Expert Patients Programme.*

Figure 3: Leeds public health team's House of Care for Leeds



* www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/expert-patients-programme.aspx

What have they found so far?

Stakeholders all spoke positively about the House of Care. Some felt that it had really impacted on the way health care professionals communicated with patients.

> *I think Leeds gets it now. Leeds are really getting that collaborative conversation, working with patients and not telling patients what to do. I think we're – after two years or whatever it is – I think they get it now.* (Leeds-4)

Stakeholders felt the model has been accepted.

> *I think the thing for me is the commitment to the longevity of the model as well, that it is here to stay, it's not a one-hit wonder inside one year and off you go and do it. We're monitoring it, we're living and breathing it, and coming back to the basics of it.* (Leeds-7)

> *There is top-level buy-in and then there is the actual support around implementation in practice. I think that has come from now, the people – the nurses and the doctors – are asking to do something differently. Things are really changing. It is a swell, like any change, you get early input, early adopters. So I think we are finding now we have got somewhere initially with the training, we were struggling to fill the places, now every one is full.* (Leeds-3)

They also conceded that it requires a significant culture shift and change in mindset, but that as soon as people received training, they felt it was an approach that made sense. A few others spoke about how patients are already benefiting from the care and support planning. One patient felt the House of Care has transformed their relationship with their condition and care experience:

> *I was climbing a mountain and at one time I couldn't get to the top. But now I feel like I've got to the top because someone else is listening to me. Someone else is taking my problems on board. I feel very strong and empowered that I can manage it [LTC]. A lot of people are gonna think like that. Because it's the only way forward, it's the only way you can think. Because you're actually doing something you've never done before.* (Leeds-6)

Most stakeholders felt proud of the way they have designed and implemented the approach in Leeds so far, but a couple felt there were a few changes they would make if they were to do it again, such as focusing thoroughly on just a couple of practices first. There were some mixed views on the speed of spread across practices, with some people feeling that it might be more successful to work slowly from practice to practice to help fully shift culture and embed within the practice.

The public health team has commissioned an evaluation of the House of Care approach, including the experiences of patients, with results shared with the teams in November 2015 (but currently unavailable publicly). This found that the median age range for patients involved is 65–69 years, just over half are male, a slightly lower percentage than the Leeds population were 'white' (75%), and although a range of diseases were registered, the most common was diabetes (55%). People were also often registered with multiple LTCs, which indicates mature implementation of the approach in Leeds.

The Patient Activation Measure (PAM) is also being used for 6,000 patients across Leeds to test its use in different settings, which will include an evaluation of the House of Care.

What is the Patient Activation Measure (PAM)?

- A structured questionnaire used to describe the level of patient involvement and confidence in managing their health and health care. People who have high levels of patient activation, as measured by the PAM, are more likely to engage in positive health behaviours.
- The PAM can be used to evaluate whether interventions change people's level of activation and can also be used to target particular groups with low levels of activation and tailor interventions that best meet their needs.

For more information, see *Supporting people to manage their health: An introduction to patient activation.* The King's Fund, 2014. www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/supporting-people-manage-health-patient-activation-may14.pdf

See also: *Independent evaluation of the feasibility of using the Patient Activation Measure in the NHS in England – early findings*. NHS England, 2015. www.health.org.uk/programmes/projects/independent-evaluation-feasibility-using-patient-activation-measure-nhs-1

Case study: Somerset

Background

538,000 people live in Somerset and have lower levels of deprivation and higher life expectancy than the English average.[16] It is a largely rural area. Somerset CCG is made up of 75 practices, each of which falls under one of nine federations.

The House of Care approach was first introduced to Somerset by a key figure in the CCG who had known about the Year of Care Partnerships for some time and was passionate about the approach. The CCG was already supporting motivational interviewing and was familiar with personalised care and support planning, both first steps towards building the House. The CCG hosted preliminary meetings at the end of 2013 and the beginning of 2014 to engage various stakeholders from the community, secondary care, primary care, voluntary sector and Somerset County Council in the approach and to design the pathway together. It was an approach that people in Somerset felt made intuitive sense.

> *What happened then was that it became apparent that this was something that the health community as a whole felt was worth investing time, money and effort into, as the way forward.* (Somerset-2)

In 2014, Somerset CCG set out its plans for the next five years, which committed to ensuring Somerset's population experiences joined-up health and social care services and that they are enabled to play an active role in their own care.[17] The House of Care is a key vehicle for delivering Somerset's commitment. South Somerset gained Vanguard status in March 2015, a programme that aims to join up GP, hospital, community and mental health services.[*]

The CCG formed two groups key to the design and implementation of the House of Care: The Wizard group, representing patients' and public participation; and the House of Care Working Group, representing doctors and other professionals. Both groups are housed by the CCG, which is the central coordinator of Somerset's House of Care activities. Somerset's commitment to patient involvement through the Wizard group is one of the defining features of their design. The House of Care is led by a programme manager and overseen by the deputy director of clinical and collaborative commissioning. The CCG's ambition is to achieve full coverage of the House of Care.

[*] Vanguards are an NHS England initiative. Fifty sites across England were selected in 2015 to lead on the integration of services in order to deliver NHS England's plans, as set out in the *Five Year Forward View*.

What have they done so far?

It is early days in the implementation process in Somerset but it is clear already that people are enthusiastic about the approach and many are working differently.

> *There is a very clear message in Somerset that this is what everybody wishes to happen. Somerset-4*

The Wizard group, with input from key stakeholders, is drafting Somerset's House of Care care and support planning template *My Life Plan*, which will be shared across the area once ready. The decision to have a single care and support planning template for use across Somerset was agreed by 70 senior representatives from key stakeholder organisations at a meeting in April 2014. Somerset CCG has commissioned the South West Commissioning Support Unit (South West CSU) to deliver their Year of Care training across the region. The South West CSU was trained by the Year of Care Partnerships team. Almost 50% of practices have received training.

Several different approaches to the House of Care are forming in different parts of the area (see table on pages 14-15).[*] While this may make for a slightly confusing picture, it potentially represents the different assets and resources across the region and could be beneficial in identifying what works best at a later stage. Somerset is having an independent assessment of the most suitable pilot and general strategy for their locality and on that basis will tighten the model.

> *There is quite a lot of stuff going on at the same time [in Somerset], all with similar aims and all coming underneath the Somerset House of Care umbrella. And although that's part of the beauty of the Somerset House of Care model in that it can be individualised, I think that is one of the risks of it potentially as well.* (Somerset-10)

> *So everyone's working at the moment to see how we can work better together. There's a lot of change going on, and that's probably why it's coming across to you as messy and mixed, but actually we've got to go through this learning process in order to move forward.* (Somerset-9)

Additionally, the flexibility and permission to try something different may help to engage providers with the approach.

> *The one thing you're allowed to do, although you don't wish to do, is fail within a Test and Learn.*[†] *In a way you're allowed to try something and if that doesn't work, say 'Okay, fine, we'll go and do something different'. I think the structure has to be flexible enough to not be threatening to people who're trying something different which, let's face it, two years ago none of us had really heard anything about. I think if you were to say, 'Right Dr X, your income next year is going to be determined by whether the House of Care succeeds or fails within your area next year' no one would touch it with a bargepole. It's too big a risk.* (Somerset-2)

[*] In this report the term 'approaches' will be used to describe the different interpretations or pilots, although the language used by stakeholders varied.

[†] 'Test and Learn' are pilots of different House of Care approaches taking place in Somerset.

Symphony in South Somerset

The approach: Symphony is an integrated primary and acute care systems Vanguard site in South Somerset. The Symphony project started with a focus on collecting data on people's LTC costs and service use, but as part of it being operationalised has embraced the Somerset House of Care approach. It uses the House of Care care plan template and framework and receives Year of Care training, and stakeholders in Somerset consider it to fall within the House of Care umbrella. Symphony received additional funding to purchase Patient Knows Best, a patient portal for sharing medical record with patients, and which allows care plans to be stored on GP practices' pre-existing IT systems.

The care and support planning process: Key workers carry out the care and support planning conversation.

Progress so far: The South Somerset Symphony project started its data analysis some time before the House of Care and has been a Vanguard site since March 2015. As well as supporting South Somerset Symphony project, the Somerset CCG has also supported the development of three other integrated care hubs, all of which are Test and Learn pilots. These are all overseen by local implementation groups across Somerset, each with a slightly different approach. For example, the Taunton Deane Symphony is a primary, community and acute integrated care model.

Frome Medical Practice

The approach: The practice is a House of Care 'enthusiast'. Anyone with serious LTCs and high frailty scores is offered the House of Care care and support planning.

The care and support planning process: Various professionals carry out the care and support planning consultation, including doctors. Nurses in the chronic disease clinic are trained in the House of Care and carry out care and support planning at the same time as chronic disease management appointments, which take place annually. They also carry out some care and support planning consultations at home. They have a community resource database, which they use to signpost patients to local services.

Progress so far: The practice introduced a coordination hub, which other practices contribute to and which identifies people by reviewing discharge summaries. Identified patients are then referred to the relevant health care professional for care and support planning. So far, the practice has not started using *My Life Plan*, although one of the GPs has tested an early version with patients in the community hospital.

Federation of GPs in Taunton Deane

The approach: The federation is a Test and Learn site and is active in implementing collaborative care and support planning in its practices. The federation represents 14 practices in the Taunton Deane area. It has a local implementation group, along with the secondary care trust and the Somerset Partnership, their local community provider.

The care and support planning process: Key workers will be carrying out the care and support planning conversation for people with three or more conditions. Key workers will be non-clinical but will have a background in primary care. They plan to have a flag on their system to identify patients. The patient would keep a paper copy of the care plan and work through it with the GP during their consultation. Care and support planning would therefore be a two-step process.

Progress so far: The group is currently enrolling key workers.

Mendip Symphony

The approach: Mendip is a Test and Learn site and one of Symphony's integrated care hubs. It is based on the Frome Medical Practice model.

The care and support planning process: GPs and nurses carry out the care and support planning conversations and refer patients to see Health Connectors at central health hubs. Health Connectors socially prescribe patients for services such as peer support, and walking and knitting groups. Health Connectors work Mendip-wide and are not connected with specific GP practices.

Progress so far: Mendip has built a strong left-hand wall so far.

North Sedgemoor*

North Sedgemoor is at an early stage of implementation and all components of the House are therefore not in place yet. Village Agents are trained individuals who work in parish 'clusters' and support lonely or vulnerable individuals. They carry out the care and support planning consultations in North Sedgemoor and are associated with specific GP practices.

West Somerset Living Better

West Somerset Living Better is at an early stage of implementation and all components of the House are therefore not in place yet. Age UK staff conduct the care and support planning consultations. They work across a specific geographical area but are not linked with specific GP practices, although they work closely with GPs and other local practitioners in a virtual multidisciplinary team.

* A select number of people were interviewed, and it was therefore not always possible to get full information on each approach. The information here may therefore not be reflective of the true extent of implementation at these sites.

One of the defining features of most of the different pilots is that Somerset has drawn on non-health care professional individuals to carry out the care and support planning consultation. Stakeholders described how they had enlisted their help because of resource and time pressures on GPs, and in part because GPs do not necessarily always have full knowledge about the non-health services available in their area. Somerset has clearly adapted the Year of Care programme somewhat for its region, partly based on available resources. In Somerset there is a very active voluntary sector and it is likely this has influenced the House of Care.

> *I think it is a different flavour. The Year of Care programme it wants to hone in on the GPs and QOF. With us we've sort of said to practices, 'Look, get people who want to turn up – health, voluntary sector, peers. And figure out your own way of doing it.'* (Somerset-6)

Another feature of Somerset's approach is that most practices have adopted the Somerset Practice Quality Scheme (SPQS) in place of the Quality Outcome Framework (QOF) – a GP performance management and payment system. Some people in the CCG felt that QOF was a barrier to the House of Care and to generally working more creatively as it was perceived by some to limit consultations to a biomedical rather than person-centred approach. In 2014 the CCG successfully negotiated with NHS England to introduce its own pilot quality scheme.

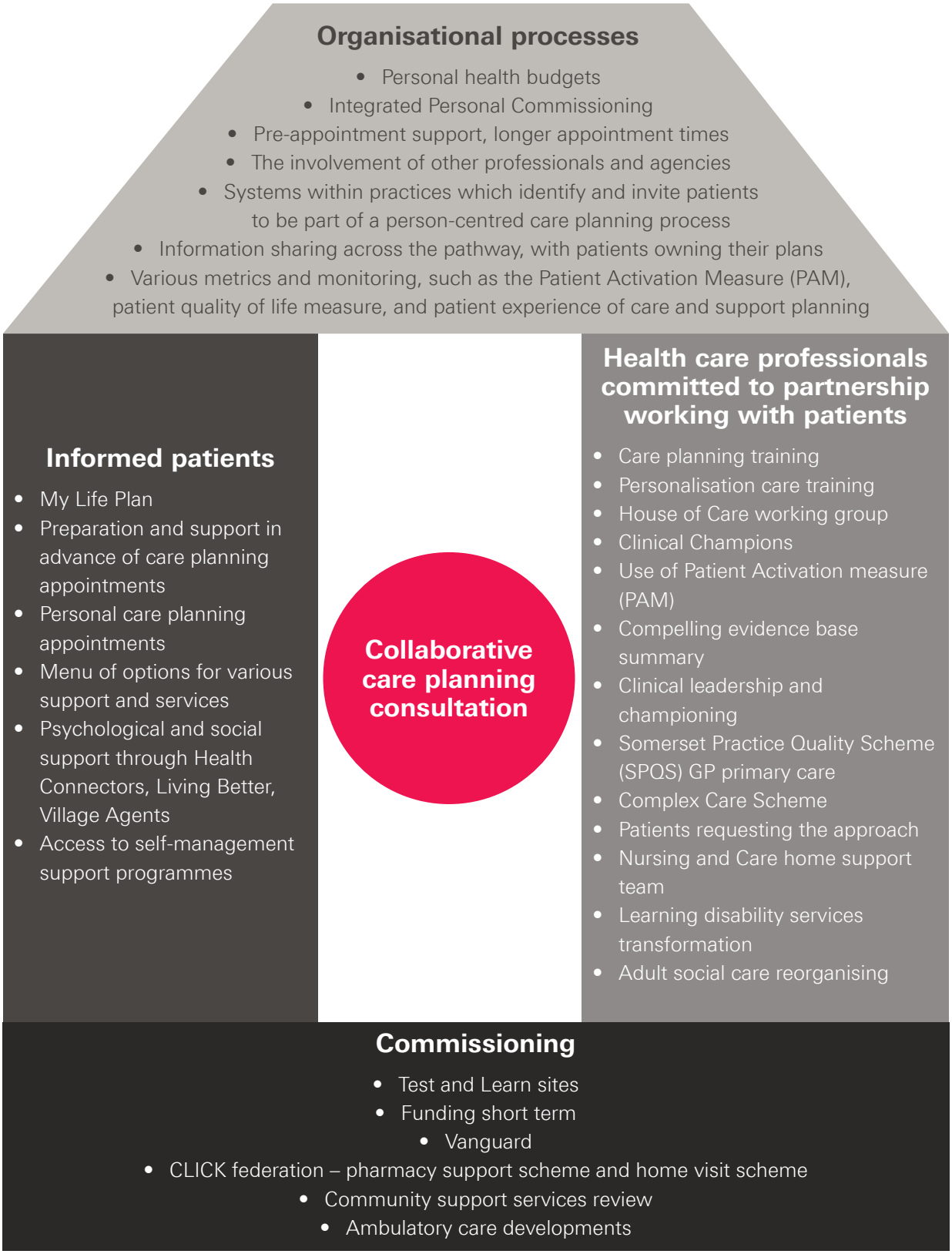
> *We've used a variety of methods [to get spread across the CCG area]. One of those has been through a switch of contract. And so as part of that we have given them the space to innovate and explore different models of delivering primary care, and so as part of that some of them have then chosen to devote time to undertaking training and starting to deliver a different model of care using the House of Care methodology.* (Somerset-7)

Somerset plans to develop and introduce a capitated budget, outcomes-based commissioning approach* for all people with LTCs, which will financially incentivise providers to redesign care models and the House in line with outcomes that they will identify themselves. The CCG anticipates that this will lead to greater involvement of the third sector in the House of Care.

> *We want to move towards an outcomes-based commissioning approach where the commissioning system would set the outcome and then the provider community would respond by redesiginng the care model or care models in Somerset; design the House to a set of outcomes. Which I think is a way of trying to get it embedded by incentivising the providers to deliver the House.* (Somerset-1)

* Outcomes-based commissioning is an approach to commissioning health care using outcomes, a population approach, metrics and learning, payment and incentives, and a coordinated delivery. For more information, see: *Need to nurture: Outcomes-based commissioning in the NHS*, www.health.org.uk/sites/default/files/NeedToNurture_1.pdf

Figure 4. Somerset's House of Care



Please note: This diagram has been slightly shorted and excludes some initiatives and work not mentioned in the interviews. See for the original diagram for further detail, available from: www.nhsiq.nhs.uk/media/2669376/joined_up_person-centred_care_initiatives_measures_and_enablers_-_ch_21_....pdf

What have they found so far?

At this early stage, Somerset has reported some good progress in parts of the locality.

> *There is some momentum beginning to build.* (Somerset-9)

Some felt that people are already seeing the benefit and at one GP practice they now have a more proactive approach. They are ambitious that the House of Care will be spread across Somerset. A service user had heard from patients that they felt very positive about the approach and felt more confident, empowered and now had more choices. Two stakeholders said that, based on patients' accounts, there was some indication that the House of Care has reduced demand on traditional services, although an evaluation would be required to substantiate this. Trainers' anecdotes were also encouraging about providers' experiences:

> *The anecdotes that people are coming back with about what's been successful have been really inspiring around how much more satisfied they've been in their work, the sorts of comments patients have made about it being the best consultation I've ever had. And a staff member, a GP, spoke with us last week said this was the first – she'd come back, she'd done day one and two [of the training] – and she said sort of with slightly teary eyes – and this was a very experienced GP – that this was the first time in ages, years, that I had really enjoyed my job.* (Somerset-10)

However, overall, people did stress that it is still very early days and that implementation has not been perfect.

> *I think it's patchy [implementation across the CCG area], and that's because it's about people's ability to put time into implementing a new model of care at the same time as there are a lot of other things going on in terms of… it's been such a busy winter, and if it's not presented in the right way people might see this as another thing to do.* (Somerset-7)

> *Ultimately what we would love to see is that this is rolled out across Somerset, but I think the original plan for the training roll-out and implementation might have been ambitious.* (Somerset-10)

In addition, it should be noted that although a care plan is being developed, this is only one aspect of care and support planning, and it will be useful to see how this progresses in Somerset.

Somerset is a Patient Activation Measure (PAM) pilot site and has 10,000 PAM licences.* It has started evaluating PAM scores for people with LTCs. Practices and some Village Agents and Age UK Somerset staff collect data to produce scores as part of the care and support planning process. The scores are used in this way to determine whether the House of Care is making a difference to people's knowledge, skills and confidence to manage their conditions, as well as to identify which Test and Learn models work best. PAM scores are also used by some practices to plan services for individual patients and work through their goals and create the right care plan. The Vanguard site is also using the Clinician Support for PAM (CS-PAM), a tool to assess clinicians' beliefs in the importance of patient activation, as part of their staff recruitment. Using the PAM is a key component of Somerset's plans for outcomes-based commissioning for people with LTCs.

* PAM is a commercial product licensed through Insignia Health: www.insigniahealth.com

Discussion: How can local health economies implement change?

Both Somerset and Leeds are dedicated to a new way of working. They are operating within a national system that is pressured and needs to work differently to ensure the sustainability of services and to enhance people's health. The House of Care is one means to re-shaping the local health economy and coordinating health, social care and other services around people's needs. Interviews with stakeholders suggest that they are energised knowing that they have a vehicle for a new way of thinking and operating.

> *I think as primary care has become overwhelmed it's become more interested in working differently.* (Somerset-7)

Both have already created change and shifted some old ways of working. This has not been without challenges, and there are a number of obstacles.

Almost all stakeholders spoke about the pressures general practices are facing, and that this hampers the headspace to consider new approaches and tightens the resources available. A few stakeholders even felt the size of the practice has an impact on the availability of resources, the ability to release staff for training and to dedicate the whole practice to the House of Care – with smaller practices less able to do so. In addition, Leeds is currently challenged with a nurse shortage, putting the nurse-reliant House of Care in Leeds under further pressure.

In addition, most stakeholders highlighted that the approach requires significant cultural change.

> *You can't underestimate the cultural and attitudinal change involved in any of this, whether you're a person with long-term conditions or whether you're a health or care professional.* (Leeds-5)

> *I think if somebody comes into the training feeling stressed because they have got a lot on at work, it is very difficult for them to take on this whole idea of changing everything back at the practice because it is a whole change.* (Leeds-1)

Despite these challenges, both sites have made progress: they have brought together multiple partners and sectors to commit to the House of Care in their CCG's strategies; they have redesigned care plans; come up with future plans; engaged GP practices in the approach; looked at local community assets; in places commissioned new services; and considered or started evaluating the impact of person-centred care. They are both clearly at different stages of implementation, with Somerset two years behind Leeds, but they still present early pictures of their approaches and general direction.

Each has taken slightly different approaches to the House of Care and even within both sites there is some variation, which raises three key questions about implementing change in a local health economy:

- How do you embed a new model into a pre-existing system?
- To what extent can and should the model be adapted to the local context?
- What is the best approach to achieving spread?

How do you embed a new model into a pre-existing system?

Both sites are implementing the House of Care into a pre-existing, complex system with multiple voices, initiatives, networks, individuals, structures and resources. The House of Care is what May[18] describes as a 'complex bundle of material and cognitive practices' and implementing it into this pre-existing complex environment can therefore be messy and non-linear.

The Normalisation Process Theory helps to explain the processes by which complex interventions in health care become embedded in practice.[19] The model describes two components relevant to the process of embedding into a pre-existing system: *Execution*, which is concerned with the practicalities of integration, and *Realisation*, which considers the negotiations required to modify existing systems and practices and reduce the disruption and risk of change. Embedding the House of Care successfully therefore requires both of these components to be sustained. For example, the integration of the House of Care needs to be systematically and thoroughly planned for, and ideally disruption to pre-existing systems should be minimised. The Health Foundation also learnt from our Co-Creating Health programme, which sought to sustain and spread self-management support for people with LTCs, that there is added value in integrating concurrent initiatives.[20]

Two factors frame the implementation and operationalisation of the House of Care: nationally driven initiatives and policies, and the local context. These system components may present and be perceived as barriers or enablers to change. Vanguards and Integrated Care Pioneer initiatives, which are active in Somerset and Leeds respectively, are national initiatives implemented in some localities across England. New national initiatives are not introduced in isolation: Somerset is finding ways to integrate the Vanguard with the House of Care, whereas the Integrated Care Pioneer initiative seems directly complementary to the House of Care in Leeds. The Direct Enhanced Service (DES) is mandated nationwide and is the Department of Health's own care plan for 2% of each practice's patient population who are at most risk of unplanned admissions. The DES was perceived by a few stakeholders as a simple tick-box document that contrasted strongly with the House of Care care and support planning. Some also felt it added to their burden of bureaucracy, but a few Leeds stakeholders described how they had eased the burden of DES by integrating it into their House of Care care and support planning. Somerset's agreement to not report QOFs is also an example of where they removed what was perceived to be a nationally mandated barrier to embedding the House of Care locally, and also illustrates how localities respond differently to national initiatives and policies.

The local context is also an important factor. In Leeds there are 120 different care plan templates and there are also numerous templates in Somerset. Introducing yet another through the House of Care is unlikely to be easy. There is currently some work underway in Leeds and Somerset to review all of these, which may help to ensure consistency of tools and vision. This is only one step – albeit an important one – in the care and support planning process. Both sites are at early stages of making their IT systems compatible with the care plan so that care and support planning is both efficient and effective. In some areas of Somerset they are using paper copies of the care plan without integration into any of the existing IT systems, but the CCG is looking into solutions for storing and easily sharing the care plan. Getting the IT right is essential to ensure systems integrate and that there is successful information flow. While one GP stakeholder in Leeds had spent some time investing in an IT system that supported the House of Care and had found it worked well, it seems this is an issue that many practices are facing and would benefit from shared, coordinated and consistent action locally and nationally.

In these case studies it seems that both sites have therefore made attempts to *execute* and *realise* integration in order to normalise the House of Care, but that it is not a simple task.

> *The trouble is, in primary care there are just so many competing things that they've got to do – priorities – and all the rest of what's happening, and so some bits at the same time. So you kind of get lost in that kind of like, 'Oh gosh, how many care plans do they have? How many templates do they have to have? How many initiatives do they have to have?'* (Leeds-5)

> *You get multiple strands of work coming from nationally, and you've got to somehow weave them all together. It's actually a nightmare trying to get them to fit together. You've got to have someone really quite senior and strategic who's got in their head the way it all fits together. The House of Care is frankly how you get these to function in the same way.* (Somerset-6)

Introducing a new way of working into this complex, ever-changing environment and coordinating and identifying synergies between approaches, initiatives and national requirements is clearly challenging and time-consuming. It is also the responsibility of system influencers and policymakers to create an environment for local health economies that is supportive of local change, such as setting appropriate targets and introducing initiatives that support rather than compete with local activity; and removing barriers, such as conflicting policies. This need was clearly stated recently by NHS Clinical Commissioners, who said that it is 'about being smarter in the way that the system works to support CCGs to be leaders of local change across health and social care'.[21] The above examples indicate that Somerset and Leeds are starting to find ways to align and integrate different features of the system and facilitate embedding of the model. Leeds has embedded the House of Care to a greater extent than Somerset – with Somerset still in planning and early implementation stages – but this may be accounted for by the fact that it has been running longer in Leeds and change clearly takes time.

To what extent can and should the model be adapted to the local context?

These case studies also pose a question about the fidelity to and flexibility of the House of Care model: how much can the model be adapted? The model does assume adaptation to the local context[22] but it is not known what the parameters are.

The House of Care model has specific components: the right-hand wall, an enabling workforce; the left-hand wall, the informed patient; the foundation, the commissioning processes and services; the roof, the suitable organisational and administrative processes; and at the centre, the collaborative care and support planning consultation. Both sites have some features in common: the Year of Care training, care plan templates, social prescribing and singposting services, care and support planning consultations, senior level and strategic commitment.

However, both sites have reworked the care plan to make it more relevant for their area. Another deviation from the model is that, on the whole, non-health care professionals carry out the care and support planning consultations in Somerset. Some are attached to GP practices and some work within a geographical area. Embedding the House of Care within primary care is one of the Year of Care Partnerships' original model features, and Somerset presents a deviation to this.

Stakeholders spoke about how GPs do not always have the time to consider the social aspects of people's lives in a consultation and that it helps for that responsibility to be handed over to other staff.

> *We felt that this need not be a clinical member of staff, and indeed it would be extremely expensive clinical time, and given the fact that a number of concerns of patients really are not necessarily clinical concerns, they may be social concerns. So it was felt that it was a reasonable place to start. This whole project comes under the title of Test and Learn, and we're testing and learning, and we may be doing the wrong thing, but we're starting here and seeing how it evolves.* (Somerset-2)

While these approaches could help reduce the pressure on GPs or nurses, there is a risk that having non-health care professionals could fragment information flow to GPs, in particular for non-health care professionals not associated with particular GP practices. There is also a risk that any fixed and traditional consulting approaches of health care professionals are not addressed.

> *[In response to adapting the approach for Leeds] I think you have to recognise that it is not just about demographics and population, it is also about the assets that we have within the city from existing work streams in ways we are aiming to improve health and wellbeing. And also a bit about the politics of the city.* (Leeds-2)

> *It's really important within this model that one size doesn't fit all. So it's about tapping into local knowledge and resources. But yes I think there is that risk ultimately that it can become a bit of a postcode lottery of whether certain practices have chosen to engage with the voluntary sector or not. I don't know if there is a right approach or whether delivering the House of Care model is actually about accepting different individual differences of practices.* (Somerset-10)

> *In a very different context it's [the House of Care] gonna be very different. You can't just impose something from one place to another. But the principles behind it to tackle it I think you can.* (Somerset-7)

We know that understanding context is likely to enhance the success of any intervention,[23,24] and making the House of Care model fit the local area is essential. Local assets, structures and processes, and organisations must be considered. There is some evidence to show that innovations in health care that have been adapted, refined and modified to meet local needs are likely to be adopted more easily.[25] There is a question about trade-offs and what is feasible within the local context. However, there are parameters to the flexibility of any model before the bare bones no longer exist. How flexible the House of Care model is to local adaptation is not yet known and over time we will learn the impact of these changes.

What is the best approach to achieving spread?

There is a final question about how to best engage providers with a new model and achieve spread. The two case studies highlight three different system lever approaches to implementation and spread: financial incentive, nudge, and encouragement. 'Financial incentive' describes an approach where providers will be significantly better off if they adopt the model; 'nudge' describes a soft financial incentive and active promotion of the model; and 'encouragement' describes an approach where the CCG seems to move with the energy of providers. In Leeds South and East CCG, general practices have adopted the model quickly and in high volume with a financial incentive. Some stakeholders speculated that this might lead to lower levels of engagement at a later stage, but the CCG hopes it will lead to greater engagement and that they will soon not need to incentivise practices. In contrast, the other two Leeds CCGs have nudged GP practices to adopt the approach through gentle financial incentives, which includes backfill of staff attendance at the Year of Care training events. Far fewer GP practices have taken on the approach and the pace has been slower, which some stakeholders speculated might lead to genuine adoption of the model later on. Somerset has had an encouragement approach, with the CCG promoting the adoption of the House of Care along with other approaches and pilots.

> *Their approach [the three CCGs in Leeds] is slightly different for most things. In terms of implementation and how you spread and scale up the projects they have completely differing opinions about that.* (Leeds-2)

> *We're in a transitional phase as a CCG. The CCG up until last year or so has been very active trying to get people to do things. I think we're starting to understand now that the commissioner's role is actually to step back and really set the context, to set the outcomes.* (Somerset-6)

In considering which method is likely to be most successful in achieving spread, it is important to remember that the health economies under study are diverse, and that there are a number of further factors that influence spread other than these system levers. Trisha Greenhalgh et al[26] developed a conceptual model to map out these spread factors, which includes aspects such as system readiness for change; the characteristics of early adopters; the outer context, such as

the socio-political climate; and system antecedents for change, such as pre-existing knowledge and skills. Practices in Somerset South and East CCG, for example, also adopted the model because it was part of the CCG's commitment to reducing inequalities, not just due to financial incentives, and Frome Medical practice adopted it in part due to the lead GP's personal interest. Further time and analysis are required to better understand which of the above described broad approaches to spread is likely to be most successful.

We asked stakeholders from Leeds and Somerset whether they had any advice on implementing the House of Care to offer other CCGs, public health teams and other organisations. Their advice ranged from having adequate headspace to consider change to securing additional funding to be able to double-run while introducing the new approach, all of which fall under the seven success factors identified in the Health Foundation's report, *Constructive comfort:accelerating change in the NHS* (see Figure 5).[27] Promisingly, this indicates that stakeholders in Somerset and Leeds are reflecting on their journey of change and are making suggestions that cover the spectrum of success.

Somerset and Leeds are still at early stages of implementing change, and the three questions – How do you embed a new model into a pre-existing system? To what extent can and should the model be adapted to the local context? What is the best approach to achieving spread? – cannot be fully answered yet. However, both case studies provide some food for thought about how to introduce a new model in a stretched system. There is clearly a need for change to ensure the whole system is sustainable and both sites are enthusiastic to see that realised. The House of Care is not a panacea for success in itself, but these case studies suggest that it is a model that can engage multiple partners and sectors in the health economy to work proactively and systematically for not only LTCs but health more broadly. Both Somerset and Leeds are starting to normalise a new way of thinking and working; other health economies may also be inspired to transform their own systems.

Figure 5: Suggestions for implementing the House of Care

Seven success factors	Stakeholders' suggestions
Committed and respected leadership engaging the staff	Ensure all stakeholders are in agreement with the actions, purpose and vision of the House of Care.
	Keep practices informed, involved and on board from the outset.
	Align the House of Care with other initiatives and the policy environment.
Management practices that ensure execution and implementation	Focus on one practice at a time through the support of a facilitator.
	Take a flexible approach to allow initial testing of ideas and approaches.
	Form a patient representative group who can feed into the design, planning and implementation of the approach to ensure local interpretation.
Capabilities and skills to identify and solve problems	Build a team within the CCG with core knowledge.
Data and analytics skills to identify and solve problems	Make patient vignettes available.
	Build evaluation measures into care and support planning.
Resources and support to do the work of transformation	Work in partnership and collaboratively with a range of organisations and sectors.
	Dedicate administrative support to free clinicians to carry out care and support planning with patients.
	Secure additional funding dedicated to the House of Care.
A culture hospitable and supportive of change	Create headspace for people.
	Be passionate about change.
An enabling environment which supports and drives the right kind of change	Empower and enable patients and the community from the start to drive the approach.
	Support people and practices who are willing to be champions.

Annex: Methodology

These case studies are based on qualitative research methodology. They draw on responses from stakeholders in Leeds, Somerset, and one from the Year of Care Partnerships. They are based on one-to-one telephone interviews with 16 stakeholders and one short, pre-recorded interview about a stakeholder's experience of the House of Care in Leeds. Interviews lasted approximately 30–45 minutes and were recorded with the stakeholders' consent. Interviews with stakeholders from Somerset were carried out between April and June 2015, and with stakeholders from Leeds during September 2015.

A known contact from Somerset was first approached to identify potential interviewees in Somerset, who suggested a primary contact. The primary contact identified relevant interviewees following a discussion with them about the types of professionals of interest – including chief executives, commissioners, managers, doctors, nurses, health care assistants, Year of Care trainers, and patients from CCGs and public health teams. The Year of Care Partnerships interviewee identified a primary contact in Leeds, and following a discussion they identified the remaining Leeds stakeholders.

Interviews were carried out using a semi-structured topic guide, focusing on six key areas of interest: the rationale for using the approach; the design and planning phase; implementation; the impact and progress so far; barriers and enablers to change; and next steps for the implementation of the House of Care. Interview data were transcribed. Data were analysed using Framework Analysis, which involved annotating the transcripts, thematically coding data and charting the data in summary tables for comparison of the interviewees' responses.

Quotations have not been attributed to interviewees to allow them to speak freely.

Limitations

There are some potential limitations:

- These case studies explore stakeholders' experiences of the House of Care through self-report, which is open to subjectivity. However, interviews are a valuable method of exploring the context and the how, why, what and who of the implementation of the House of Care, and as such are a necessary and valuable means for obtaining data.
- Stakeholders in Leeds and Somerset were each identified by a key contact. There is a risk that only those stakeholders who were likely to speak most positively of the House of Care, their peers or their organisations were selected, which could bias the results.
- One analyst only analysed the data. There is a risk that their own biases and assumptions could influence the results.

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