Scotland's House of Care Programme

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The Health and Social Care Alliance Scotland

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REALISTIC MEDICINE

CAN WE:

CHANGE OUR STYLE TO **SHARED DECISION-MAKING?**

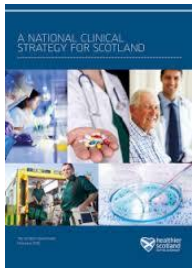
BUILD A **PERSONALISED** APPROACH TO CARE?

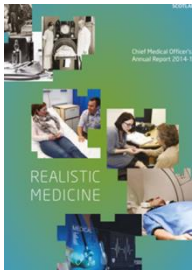
REDUCE HARM AND WASTE?

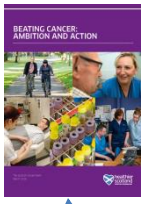
REDUCE **UNNECESSARY VARIATION** IN PRACTICE AND OUTCOMES?

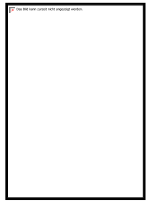
MANAGE RISK BETTER?

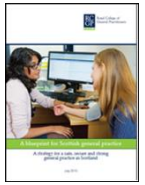
BECOME IMPROVERS AND INNOVATORS?











OUR VOICE

Cancer

Palliative and EOL Care

Diabetes Improvement Plan

Shared decision making

LTCs

Collaborative Conversations

Self Management Support

Links Worker Programme

Self Directed Support

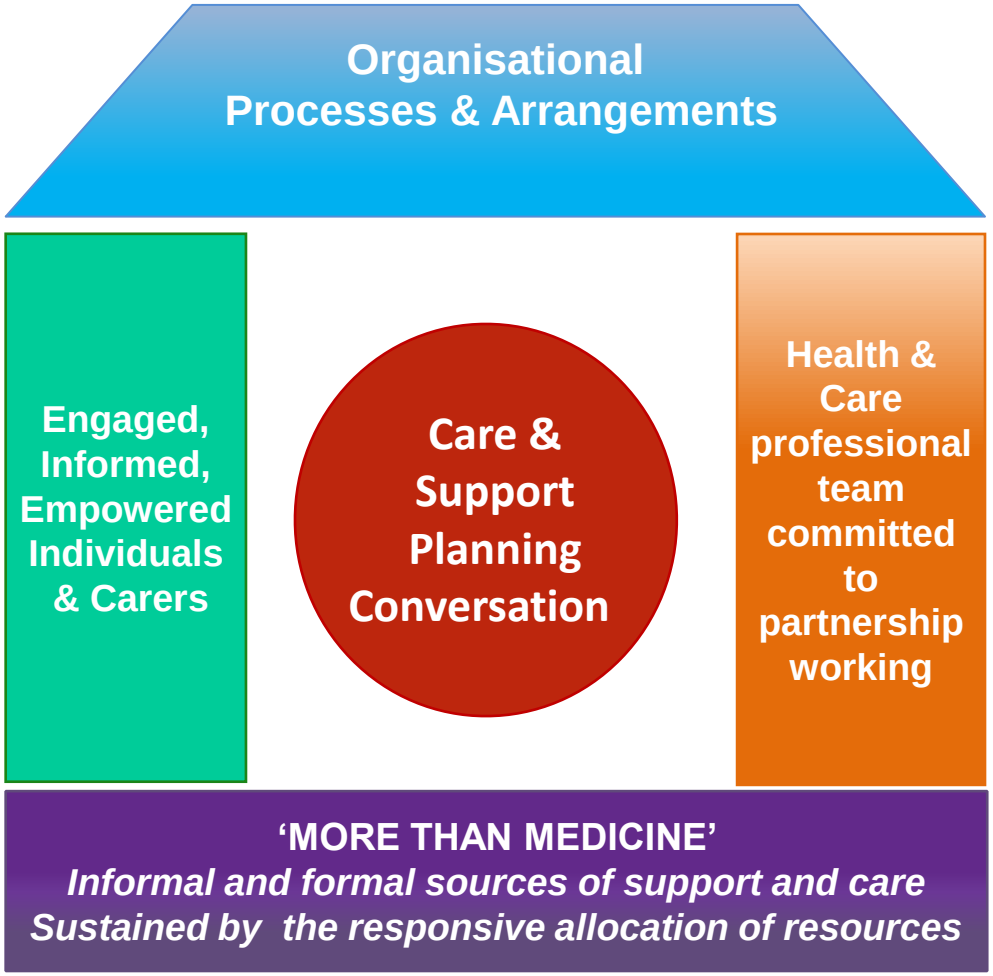
Primary Care Transformation and New Models

Integrated health and social care

Basics

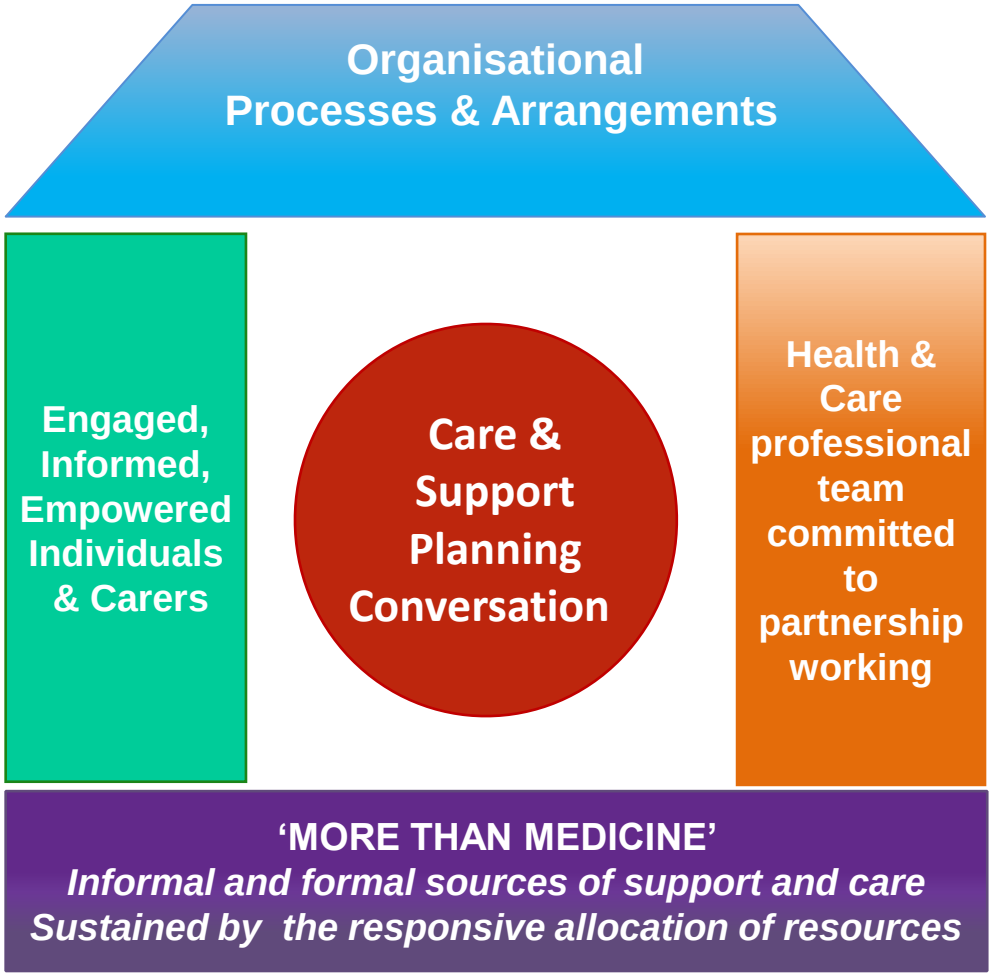
- The House of Care has proved very memorable, providing a strong visual image for a check list, with four equally critical structural elements, protecting the conversation at the centre

- Many have made use of it, and adapted it in lots of ways
- People build their own house in their own context


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

The purpose of support is to ensure that people have what they need to be able to live (and die) well on their own terms with their long-term condition(s).

Entwistle VA, Cribb A, Watt IS et al, Supporting people to live well with long term conditions: a brief account of a refreshed way of thinking about support for self-management. Manuscript in preparation shared 6 August 2015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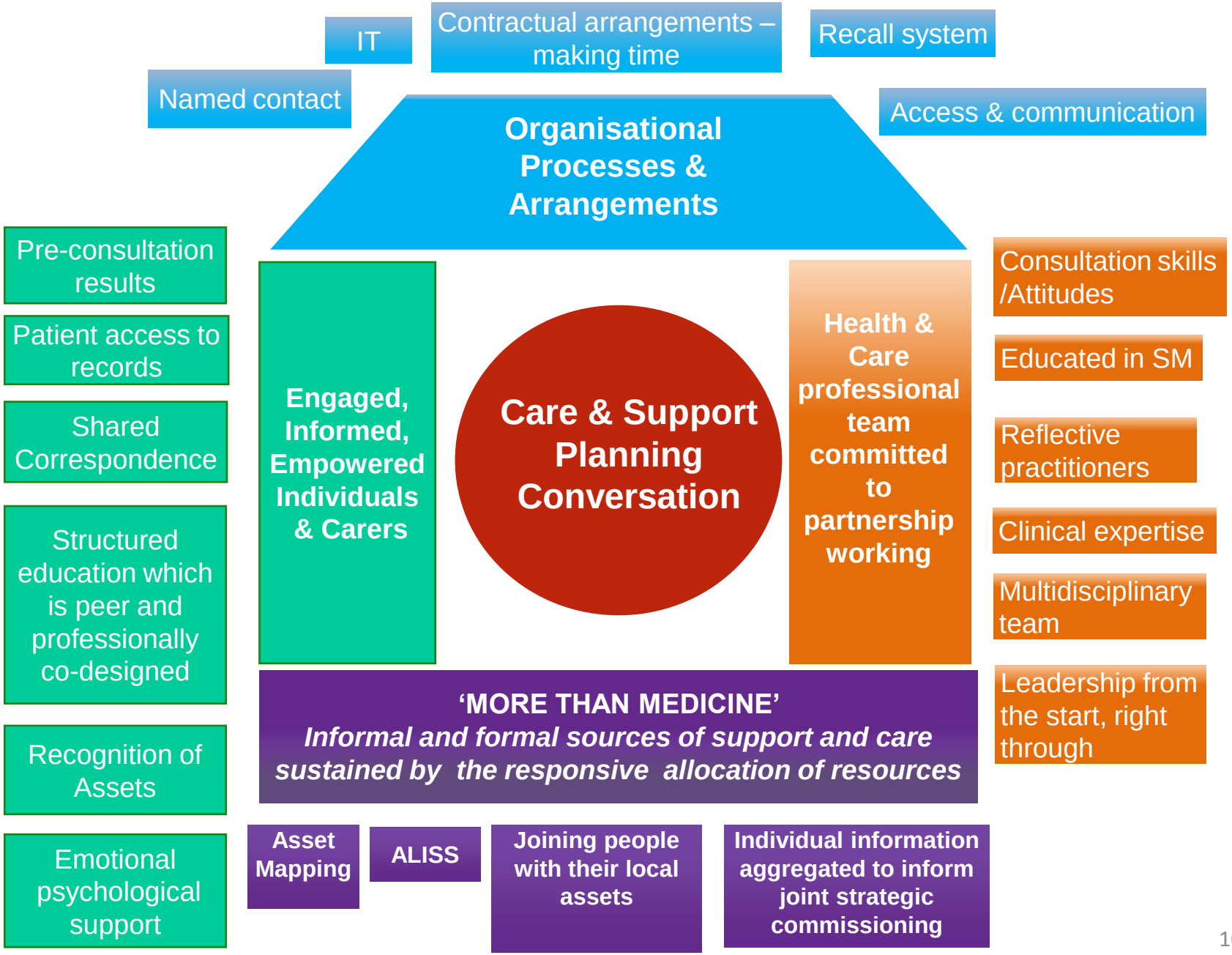
IT
Contractual arrangements – making time
Recall system
Named contact
Access & communication
Organisational Processes & Arrangements
Pre-consultation results
Patient access to records
Shared Correspondence
Structured education which is peer and professionally co-designed
Recognition of Assets
Emotional psychological support
Engaged, Informed, Empowered Individuals & Carers
Care & Support Planning Conversation
Health & Care professional team committed to partnership working
Consultation skills /Attitudes
Educated in SM
Reflective practitioners
Clinical expertise
Multidisciplinary team
Leadership from the start, right through
'MORE THAN MEDICINE'
Informal and formal sources of support and care sustained by the responsive allocation of resources
Asset Mapping
ALISS
Joining people with their local assets
Individual information aggregated to inform joint strategic commissioning

Goal setting	Date:

What do you want to work on?
What do you want to achieve?
How important is it to you? Not important 1 2 3 4 5 6 7 8 9 10 Important

Action plan

What exactly are you going to do?
What might stop you and what can you do about it?
How confident do you feel? Not confident 1 2 3 4 5 6 7 8 9 10 Confident

Review of goal/action plan: When: Where:

Half of what a person is told is forgotten[1] and half of what they remember is misunderstood[2]

1. Kessels RP. Patients' memory for medical information. J R Soc Med. May 2003;96(5):219-22.
2. Anderson JL, Dodman S, Kopelman M, Fleming A. Patient information recall in a rheumatology clinic. Rheumatology. 1979;18(1):18-22.

Removing the hurdles - Making it Easy

- Highlights the hidden problem of low health literacy and the impact that this has on our ability to access, understand, engage and participate in our health and social care.
- Explains that low health literacy leads to poor health outcomes and widens health inequality.
- Calls for all of us involved in health and social care to systematically address health literacy as a priority in our efforts to improve health and reduce health inequalities.
- Sets out an ambition for all of us in Scotland to have the confidence, knowledge, understanding and skills we need to live well, with any health condition we have.

The Hurdles

- Modern health and social care can place daunting hurdles in our way
- ….We may struggle to make sense of information about our health conditions, or be unable to communicate effectively with our clinical and care staff. ……..
- And this undermines our ability to manage our own conditions safely and effectively, and is a cause of health inequality.

1. Clear information provided to people
2. Mutually agreed upon goals
3. An active role for the person
4. Positive affect. Empathy and encouragement from professional

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"You feel you're in control of your health and your goals, what you are wanting to aim for health wise "

June

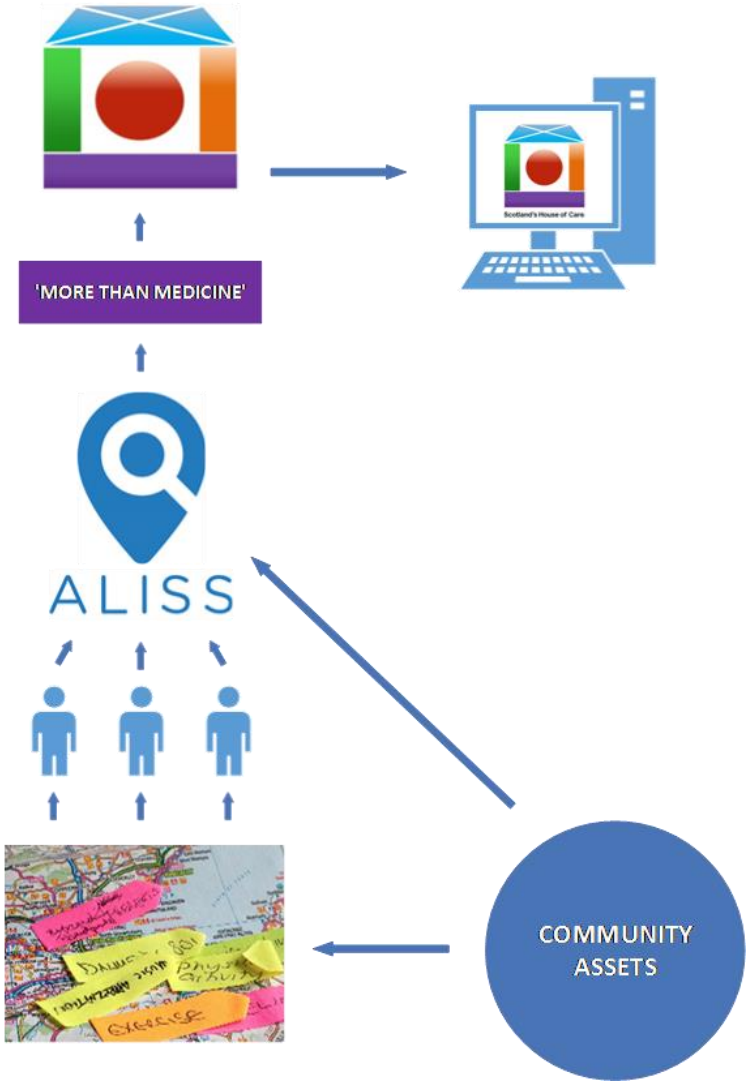

Care & Support
Planning
Conversation

Scotland's House of Care

A fundamental shift in the relationship between person and professional that supports that person to be in the driving seat of their health and social care, with self-management at the heart of it

The Voice of Lived Experience

Helps people find and share information about local services and resources that support health and wellbeing



Links Worker Programme

Building on the Evidence Base

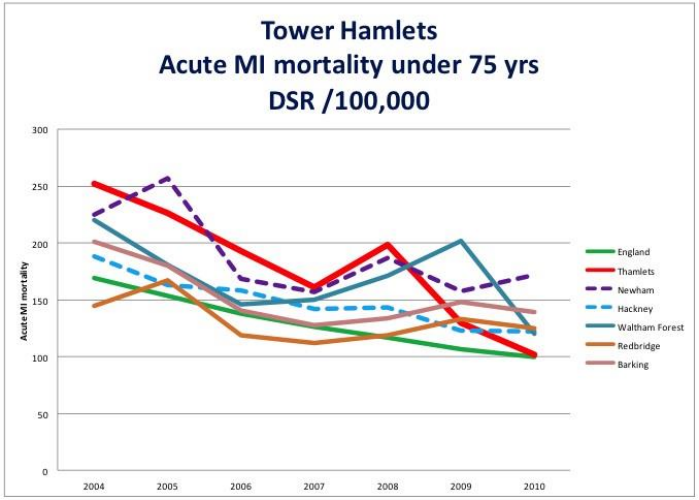
Tower Hamlets

92% of registered population (Type 2 diabetes) taking part in care planning

'Patient perceived involvement in care' rose from 52-82%

72% received all 9 processes in National Diabetes Audit: Best in England (Average 49%)

Attainment of measure	2009 QOF (with exemptions)	2012 Dashboard (no exemptions)
HbA1c below 58mmol/mol	37%	55%
BP below 145/85	70%	90%
Cholesterol below 5 mmol/l	65%	83%



Five Scotland Adopter Sites >50 Practices:
Ayrshire & Arran,
Greater Glasgow & Clyde,
Lanarkshire, Lothian, Tayside

Gateshead (32 practices)

Gateshead (32 practices)

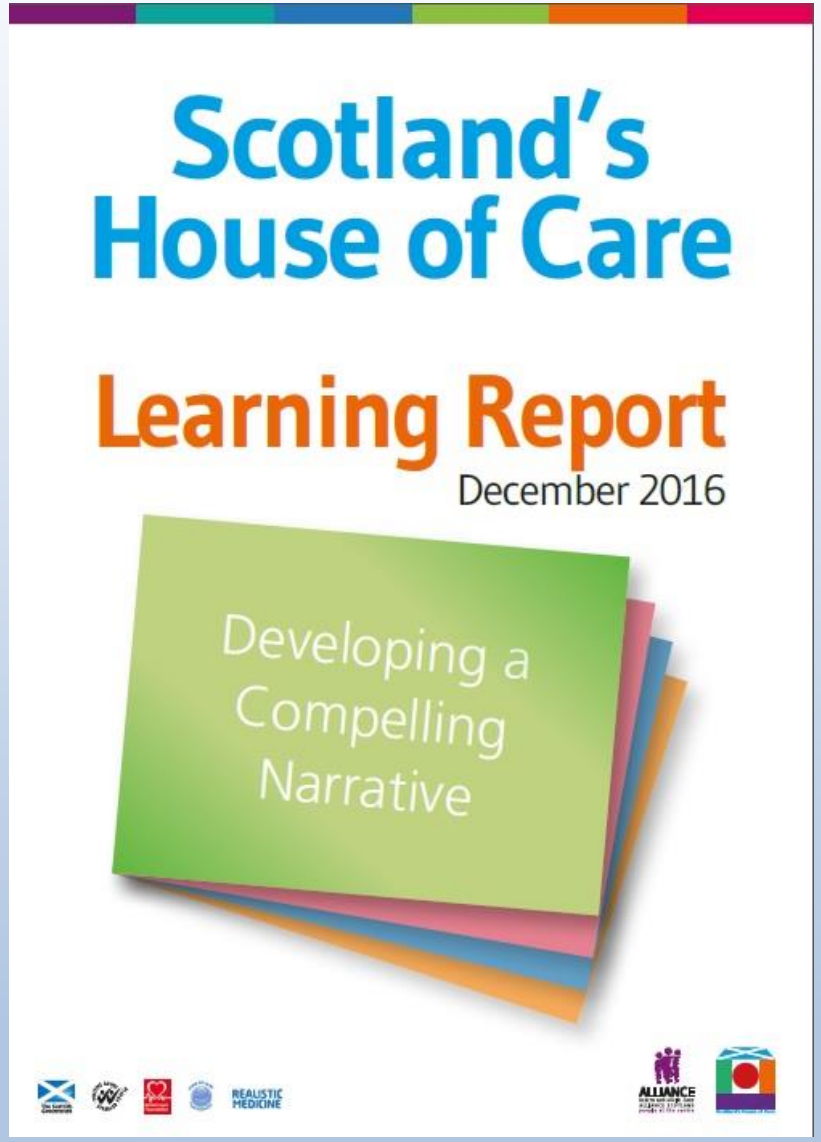
Hardwick (16 practices)

Improve outcomes for people with CVD & LTCs:

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

Reproducible intervention (prototype):
UK National Training and Support Team
>3000 practitioners and >40 quality assured trainers

The Voice of Lived Experience



Staff Experiences

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"It's working along the way that we are all trained to work, but it's within a safe foundation"

Andrea, Practice Nurse

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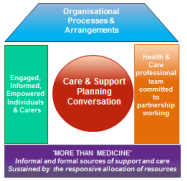
"We're on an even footing and that's so powerful"

Sue, GP on Collaborative Care and Support Planning



Lothian/Thistle and the House of Care Programme

- Building the Scottish capacity for self management and asset based approaches
- Partnership across third sector, health & social care, and professions
- Strong foundation in Lothian
- Wellbeing, asset based approach