

Building the House of Care for people with long-term conditions:

the foundation of the House of Care framework

WHAT IS THE HOUSE OF CARE?

The House of Care (HoC) is a framework for a coordinated service model that enables patients with long-term conditions (LTCs) and clinicians to work together to determine and shape the support needed to enable them to live well with their condition.¹ Based on the internationally well-known Chronic Care Model² but specifically adapted to fit UK primary care, it uses the metaphor of a house to describe the components that need to be in place to make coordinated personalised care planning a reality.³ Previous articles in this series have described various components of the House.⁴⁻⁷ This article focuses on its foundation.

People with chronic LTCs play a key role in managing their own health, but how effective this is depends on their level of confidence and skill to manage tasks that are sometimes quite challenging, especially for those with multiple conditions. They are more likely to feel confident and competent if they are fully engaged in articulating their needs and capacities, deciding on priorities, agreeing goals, and jointly developing a plan for achieving these. The evidence shows that this type of supportive, collaborative relationship can lead to improved health outcomes, especially when it is fully integrated into primary care delivery.⁸

The care planning conversation (clinicians and patients working together to co-produce health) is at the centre of the House, supported by the right wall (effective teams of healthcare professionals skilled in partnership working with patients), the left wall (engaged, empowered, and well-supported patients), the roof (appropriate and robust organisational systems and processes), and the foundation (responsive commissioning and support from statutory and voluntary organisations, community groups, and peers).⁴

The HoC aims to integrate personalised care planning for individuals with commissioning for populations, but it can

only achieve this if it is embedded in a clearly defined community strategy. Care planning and the systems, training, and resources needed to support it must be explicitly commissioned, local voluntary and community groups must be actively involved, and a robust approach to outcomes measurement must be in place. These are the foundation stones on which the House is built, ensuring that individual needs and choices identified during the care planning process can be aggregated to inform a commissioning plan that meets the needs of all those with LTCs in the local community.

COMMUNITY ASSETS

The foundation of the House includes the rich set of resources in local communities that contribute to people's health and wellbeing. Providing for the needs identified during the care planning process need not be confined to those normally supplied by traditional health services. Community and self-help groups can often provide the type of support to people with LTCs that statutory services tend to ignore.⁹ Primary care staff need to be aware of community resources and willing to help their patients engage with them. Examples include cookery classes to help those struggling to eat a healthy diet, gardening projects to encourage physical exercise, volunteer befriending schemes to combat social isolation and loneliness, advice centres, and peer-led self-help groups.

Community signposting, also called social prescribing, depends on staff having good knowledge of what groups and services are available locally and sufficient confidence to refer patients to them. It also requires a willingness on the part of NHS commissioners, local authorities, or health boards to link with, and if necessary fund, informal sources of support. Primary care staff often start with low levels of awareness of community resources and may not see them as capable of offering reliable support to their patients. However, the Links project

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in Glasgow and Fife showed that it was possible to increase the use of these local assets in a relatively short period of time by adopting a systematic approach to building knowledge and relationships.¹⁰

Providing electronic health directories with details of local community resources to facilitate signposting and referral is an important component of the HoC. The Health and Social Care Alliance Scotland has worked with local people to develop ALISS (A Local Information System for Scotland) to bring together information about sources of support for people with LTCs, including statutory, voluntary, and community services and activities, and share this on other websites. Work is underway to integrate ALISS into existing GP practice IT systems.

Although practices are perfectly situated to make community connections for people, it may be difficult for GPs and their staff to devote sufficient time to the complex process of identifying need, matching resources, and connecting individuals with those resources. Support from specially-trained advisors working alongside practice teams may be a feasible solution. For example, Stockport Council employs trained advisors whose job is to assess people's health needs and connect them to community resources to help them achieve their health goals.¹¹ Link workers such as these can also help to build stronger collaborative relationships between general practices and their local communities.

MONITORING PERFORMANCE AND OUTCOMES

Aggregating the support needs identified by individuals into a commissioning plan for a locality requires robust electronic records and systems for data-sharing. The systems should allow patient access and be sufficiently flexible to record individual goals and outcomes, producing informative reports for various purposes at different levels of aggregation: for individuals, diagnostic groups, practices, communities, and local health economies. NHS England has set out a framework for achieving this with a deadline of 2020 for all care records to be digital, real-time, and interoperable.¹² In the meantime bespoke solutions are being developed in various parts of the UK, for example, in Kent where the local authority is leading on integration of records across health and social care, and in Cumbria where health information can now be shared across the local health economy.³

These systems should also enable regular collection of outcomes data for

use in performance monitoring and quality improvement. The aim of personalised care planning is to ensure that individuals receive the support they need to manage their health effectively and live well with their LTCs. Numerous standardised questionnaires have been developed to measure attributes such as self-efficacy, relational care, social integration, and quality of life.¹³ Some of the best known include the Patient Activation Measure (PAM), the Patient Enablement Instrument (PEI), the Patient Assessment of Chronic Illness Care (PACIC) questionnaire, and the Consultation and Relational Empathy (CARE) measure.

The best patient-reported outcome measures have been developed and tested with patients, but they are usually intended for analysis at an aggregated level and may be less useful for monitoring clinical outcomes at the individual level. An alternative approach is to ask patients to record their priorities or goals at the outset and then to measure whether these have been achieved.¹⁴ Examples include Goal Attainment Scaling (GAS), Measure Yourself Medical Outcome Profile (MYMOP), and the Schedule for the Evaluation of Individual Quality of Life (SEIQOL). This type of questionnaire may be useful at an individual level but the results are harder to interpret when aggregated up.

CONCLUSION

Experience in the Year of Care for diabetes programme, where the HoC was first developed and tested, suggested that it could lead to improvements in the knowledge and skills of primary care staff, in practice organisation, teamwork, and productivity, but it also highlighted the complexity of the task and the interdependence of the components.¹ If the roof leaks, the walls are weak, or the foundation is shaky, the structure will not be fit for purpose.

Building a strong foundation means looking beyond traditional services and making better use of community assets, developing information systems that are easy to share and sufficiently flexible to record individual goals and action plans, agreeing local strategies for measuring performance and outcomes, and ensuring that these are implemented across the local health economy. General practices can do much to build effective roofs and walls but they will need to draw on wider support from commissioners, health boards, local authorities, voluntary organisations, and local communities to secure firm foundations for effective care of people with LTCs.

Further information

The House of Care approach is currently being promoted by various bodies including NHS England and NHS Scotland, and the RCGP in both England and Scotland. For further information and implementation support see: Year of Care partnerships (<http://www.yearofcare.co.uk/>), Coalition for Collaborative Care (<http://coalitionforcollaborativecare.org.uk/>), and Joint Improvement Team Scotland (<http://www.jitscotland.org.uk/resource/many-conditions-one-life-living-well-multiple-conditions/>).

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