The House of Care - The evidence base and impact in the UK

Care and support planning delivered via a house of care (HOC) approach was derived from the Chronic Care Model (CCM)[1]. This summarises a wealth of international evidence into 6 core components which all need to be in place to deliver better outcomes for people living with long term conditions (LTCs). Support for self- management is the strongest independent variable within this complex intervention but the headline message is that all the components need to come together as 'productive interactions' between 'empowered and activated patients' and 'proactive systems'. This hypothesis has been given further weight by a recent Cochrane Review of care planning[2] which found improvements in physical health and depression as well confidence and self-efficacy when all the steps of care planning were in place, and it was integrated into routine care.

The Year of Care Programme (YOCP)[3] successfully showed how to make this the norm for everyone living with one to more LTCs. They developed the HOC framework as a way to make the 'dry' CCM model practical and accessible to grass roots teams and local communities.

The HOC provides the framework both for local teams to redesign the way they work using CSP and also as a means of transferring this reproducible approach to new communities[4]. Because introducing CSP involves changes to attitudes (mindsets), skills and clinic infrastructure it is a powerful lever for culture and systems change within teams and across the wider community. More recently new communities focussed on introducing CSP have learnt by experience that wider changes and a whole system approach are necessary to maximise its potential.

Impact

CSP delivered via the HOC approach has immediate benefits in terms of improved patient and staff experience. Changes in healthy behaviours begin after one cycle but changes to population level intermediate clinical measures take longer to demonstrate. The headline messages are that there is

- Improved experience of care
- Real changes in self-care behaviour.
- Improved knowledge and skills and greater job satisfaction for health care professionals
- Better organisation and team work
- Improved productivity: care planning is cost neutral at practice level: there are savings for some.
- CSP takes time to embed: changes in clinical indicators across populations may be seen after two or three care planning cycles.

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[1] Wagner EH, et al. Organizing care for patients with chronic illness. Milbank Q. 1996;74:511-514

[2] Coulter A, et al. Personalised care planning for adults with chronic or long-term health conditions. *Cochrane Database of Systematic Reviews* 2015, Issue 3. Art. No.: CD010523. DOI: 10.1002/14651858.CD010523.pub2.

[3] Year of Care. Report of findings from the pilot programme. 2011 http://www.yearofcare.co.uk/sites/default/files/images/YOC_Report%20-%20correct.pdf

[4] Coulter A, et al. Delivering better services for people with long-term conditions. London: Kings Fund; 2013

Most of the available data comes from diabetes because the YOCP pilots were focused on developing CSP (2007-2010) and testing the transferability in diabetes (2009-2011). Subsequently the approach has been shown to be generic and has been introduced in other single conditions and for people living with multimorbidity within multidisciplinary community teams or within general practice (2012 – 2014), from where significant data is only just emerging. However the examples below from diabetes demonstrate consistent changes in support of the headline messages (above) despite the local populations and organisation (each 'local HOC') being very different.

Tower Hamlets *(95% of practices)*

	2009 (QOF with exemptions)	2012 (Dashboard – no exemptions)
HbA1c <7.5%/58mmol/mol	**37%**	**55%**
BP ≤145/85	**70%**	**90%**
Cholesterol <5mol/l	**65%**	**83%**
3 combined		**35% (national 19%)**

Also:

- Patient perceived 'involvement in care' rose from 52-82%
- Diabetes Care processes: 2006 – in worst 10% in England. 2012: Best in England
- *'YOC is a great idea because it is focused around the individual. I'm happy that I get more of a say in my care.' (*Person with diabetes from Bengali community - TH submission*)*
- *Each time I get a greater understanding of my condition and …..and how I can go about maintaining and improving it. (Person with LTC)*
- *I focus less on the disease and take a more holistic perspective (PN)*
- *It's 100% better for me and the patients – GP*

Berkshire West *(70% 0f practices)*

	June 2012	June 2014
HbA1c <60mmols / mol	47%	57%
Cholesterol <5mmols	46%	79%
BP ≤ 140/85	66%	78%
Prescribing savings		£800,000