# Putting people at the heart of their care

The BHF House of Care programme

British Heart Foundation

bhf.org.uk/houseofcare

# Foreword

**Thanks to advances in treatment, research, care provision and public health, we are all living longer. But with greater longevity has come a rise in long-term conditions (LTCs).**

The traditional care model, reliant on one-off episodes of care, often in acute settings, does not routinely provide the holistic care that best supports people living with LTCs for years or even decades.[1-3] Such holistic support can reduce unnecessary hospital admissions and improve wellbeing. It is widely recognised that people wish to be more involved in their care and that services need to be better integrated to support them.[4,5]

The British Heart Foundation (BHF) wants to help this vision become a reality. Between 2015 and 2018, we funded a £1.5 million programme in five health communities across England and Scotland to offer a new way of delivering person-centred care for people with heart and circulatory LTCs.

This new approach is called care and support planning, a model pioneered by the Year of Care Partnerships. It sees healthcare professionals and people with LTCs come together as equal partners. Central to this is a collaborative conversation to discuss what matters to the individual and work out the care and support from which they might benefit.

Our programme encouraged the adoption of care and support planning using the House of Care, a framework describing what needs to be in place to undertake those conversations.

Over the past three years, 41 general practices across the five sites have successfully introduced a care and support planning approach as part of our programme. All sites have made sustainable shifts towards person-centred care.

Overall, the programme met its aim of providing better quality care for people with heart and circulatory LTCs. We were encouraged to see that the move towards care and support planning also had a positive impact for healthcare professionals.

Experience to date suggests that extending the approach to multiple LTCs could further enhance the patient experience, reduce costs and save time through improved working practices.

Here we share findings from the final independent evaluation of the programme, consider the legacy for participating sites and summarise key lessons learned for future implementation.

**Jacob West, Director of Healthcare Innovation**
**British Heart Foundation**

# Highlights

By 2025, the number of people living with one or more serious LTCs in the UK will increase by nearly one million, from 8.2 million to 9.1 million.[6]

Traditionally, the healthcare system provides care to people with LTCs based on the specific condition they present with. But this model of focusing on the condition, rather than the person, can sometimes be at the expense of holistically addressing people's physical, mental and emotional health and care needs. Rather, it can lead to reactive, episodic care, which many agree is a model not fit for the future.

The BHF House of Care programme was established to build on learning from the Year of Care programme in diabetes.[7] The BHF programme tested the hypothesis that a person-centred approach to heart and circulatory disease – deploying care and support planning via the House of Care framework – can provide better quality care.

Beginning in 2015, the BHF programme took place over three years in five health communities with populations of 50,000 people or more. In England, these were NHS Hardwick Clinical Commissioning Group (CCG) and NHS Gateshead CCG.[a] In Scotland, the sites were in NHS Greater Glasgow and Clyde, NHS Tayside and NHS Lothian (in collaboration with the Thistle Foundation), with national programme support from the Health and Social Care Alliance Scotland and the Scottish Government.

BHF funding ended in March 2018 and the programme has been independently evaluated by ICF International using a combination of self-evaluation by sites and interviews with patients, healthcare professionals and key stakeholders from each site.[8]

Change in survey results between baseline and follow-up

**41**
practices introduced care and support planning as part of this programme[b]

**75%**
said they were 'better' or 'much better' able to understand their condition[13]

**68%** +5%
of patients were happy with the information they received[12]

**13,061**
people received a care and support planning review[9]

**60%** +4%
of patients felt their care and support was 'almost always' joined up[11]

**41%** -8%
felt 'very confident' managing their health[c 14]

**59%** +4%
of patients 'almost always' discussed what was important for them[10]

[a] NHS Gateshead and NHS Newcastle CCGs merged in 2015. The evaluation focuses only on work in Gateshead as this was a single site at the time of funding.
[b] 41 practices were specifically included as part of the BHF programme and the evaluation, but more practices have adopted the approach across these five sites.
[c] Lower confidence was linked to factors such as uncertainty over what results meant or stress/anxiety about being more involved in the conversation. Further encouragement to boost confidence to self-manage with support may be needed. **See p11 for more**.
Source: Patient survey results at follow-up (after care and support planning had been embedded in sites), compared to surveys at baseline (when sites were establishing care and support planning). '75%' result baseline data only. For full data and limitations, see the programme evaluation report via **bhf.org.uk/houseofcare**.

Section 1

# What is the House of Care?

# Care and support planning and the House of Care

**Care and support planning** is a new approach to care. It moves away from the traditional, paternalistic model of a healthcare professional advising a person on how to manage their health. Instead, it champions a collaborative partnership where patients and healthcare professionals contribute equally.

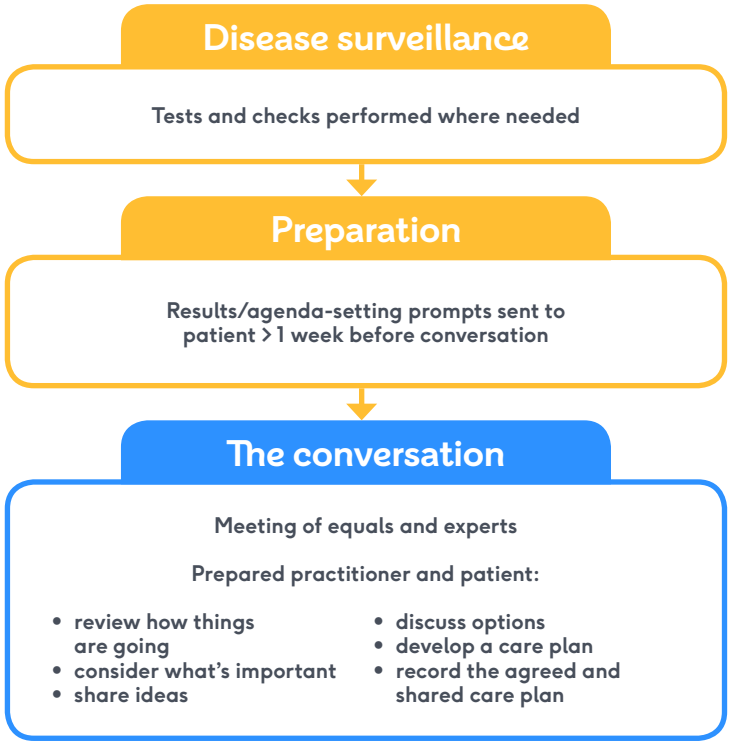
The patient brings experience of living with their condition and is supported to focus on what is important to them. The healthcare professional brings clinical expertise and experience. Together, they have a collaborative conversation to review how things are going, share ideas and discuss goals, which are summarised in a care plan.

**The House of Care** is a framework that can help practice teams and organisations adopt a care and support planning approach for people living with LTCs. It sets out what needs to be in place for this approach to happen.

At the heart of the House of Care is a collaborative conversation where the healthcare professional supports the person with LTC(s) to fully explore and describe what matters to them. The healthcare professional still brings clinical issues to the conversation. But through building empathy and listening carefully, they and the patient can co-create an optimal care plan, which will not only manage the person's condition(s) but will support them to thrive in their day-to-day life.

The House of Care framework was developed by Year of Care Partnerships with the original aim of helping people to self-manage their diabetes, but it can be applied to all LTCs. It was based on evidence that people with LTCs have better outcomes when there is partnership working between an engaged patient and an organised, proactive healthcare system.[4,5]

## Care and support planning process




Adapted from an original diagram produced by Year of Care Partnerships.
For more information about the process visit **yearofcare.co.uk/process**

# The House of Care framework

The collaborative care and support planning conversation sits at the centre of the House. To facilitate this conversation, four components need to be in place.


The House of Care framework was first developed by the Year of Care Partnerships, with the original aim of helping people manage their diabetes.

**The left wall** represents the informed, engaged patient and the preparation needed for them and their carers to feel equipped to contribute fully to the care and support planning conversation. For example, this means providing test results in an accessible format, with explanatory information, alongside agenda-setting points to help patients reflect on what they want to discuss in the consultation.

**The right wall** represents a commitment by healthcare professionals to move from a medical focus towards a person-centred approach. It also reflects the training in care and support planning they require and the knowledge-sharing that needs to happen to provide integrated, bespoke care based on what is important to the patient.

**The roof** is the infrastructure that needs to be in place, such as IT systems for sharing data and effective administration for sending out test results and coordinating appointments. It ensures that the people and processes required to deliver care and support planning consultations are in position.

**The foundation** recognises that people's needs are likely to stretch beyond the current medical model. It demands planning and commissioning of services that fully meet the clinical and psychosocial needs of the local patient population. These are delivered through local health, social and community providers, and should be shaped by care and support planning conversations. This is often referred to as social prescribing, also known as More than Medicine.[17]

The intention is that a care and support planning approach will allow better use of existing assets within the community (including the agency of people with LTCs themselves). It will enable people with LTCs to be better informed and more confident in self-managing their conditions, supported by health and social care professionals.

Learn more about the House of Care framework by visiting **yearofcare.co.uk/house**

Section 2

# Aims of the BHF programme

# Aims and approach

The BHF House of Care programme provided funding to support the introduction of a care and support planning approach into routine care for people living with heart and circulatory conditions in the UK.

We wanted to ensure that people with heart and circulatory disease received a collaborative care and support planning consultation. One that focused on what was important to them and supported them to learn more about their condition and access community-based services and activities to help them achieve their goals.

The programme aimed to:

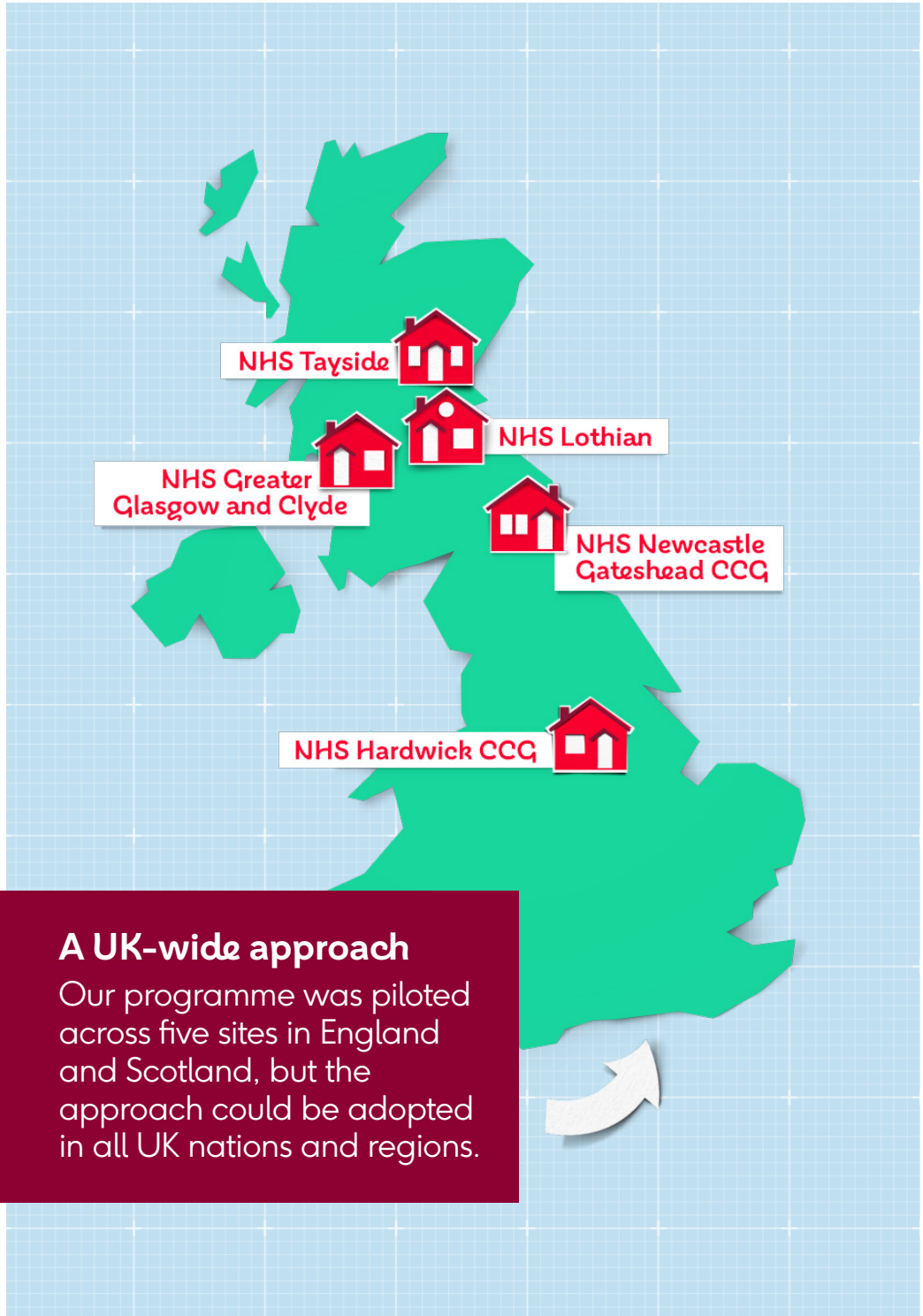
1. introduce care and support planning into routine care
2. change local care pathways for heart and circulatory diseases, driven by care and support planning
3. encourage practices to build relationships with local community and voluntary services to provide a wider range of activities that support people to self-manage their condition(s).

The ambition was that in the long term people with heart and circulatory conditions would be supported more effectively in the community, and that care and support planning would become the routine experience of care.

Throughout the programme we followed the journey of staff and stakeholders at each site as they introduced care and support planning and captured lessons learnt. Initially, the programme was intended to run for two years but was extended to allow more time for sites to make and embed the necessary changes for success. More detailed information about the establishment and operation of the programme is included in the ICF evaluation report, available via bhf.org.uk/houseofcare.

The final evaluation in March 2018 included a mixture of self-assessment by sites and participant interviews and questionnaires. These included people with LTCs, general practitioners (GPs), nurses, pharmacists, healthcare assistants (HCAs), project managers, practice managers, receptionists, clinical commissioners and other service providers.

Through its evaluation we hope to highlight the benefits and challenges of using the House of Care framework to share learning with other health communities considering adopting the care and support planning approach.




## A UK-wide approach

Our programme was piloted across five sites in England and Scotland, but the approach could be adopted in all UK nations and regions.

# Our pilot sites

The five pilot sites in the House of Care programme were selected because they serve populations with some of the highest levels of deprivation and deaths from heart and circulatory conditions in the UK.[18]

**NHS Hardwick CCG:** covers 100,000 people living in some of the most disadvantaged areas of Derbyshire. The area has higher rates of heart attack, heart failure admissions and stroke admissions than the East Midlands average.

**NHS Newcastle Gateshead CCG**[d]: serves a population of 525,000 with high levels of deprivation, unemployment and a growing elderly population. Death rates from circulatory diseases are much higher than the England average.

**NHS Greater Glasgow and Clyde:** serves a population of 1.2 million, with around 240 GP practices. Around 35% of under-75s in this area live in some of the most deprived areas of the UK. The population is more elderly than the Scottish average and has poorer life expectancy and greater mortality rates for coronary heart disease.

**NHS Lothian:** serves a growing and aging population of 850,000, with the number of over-75s expected to increase by 22% between 2013 and 2020. Obesity, poor diet, limited physical activity and high smoking rates are major challenges.

**NHS Tayside:** serves around 170,000 people in the urban area of Dundee. The population is older and has shorter life expectancy than the Scotland average.

Scottish Government and the Health and Social Care Alliance Scotland have funded and supported two further Scottish House of Care sites.

[d]Gateshead and Newcastle CCGs merged in 2015. The evaluation focuses only on work in Gateshead as this was a single site at the time of funding.
Source: Data was provided by sites at a programme launch event in March 2015 and reflects the picture on the ground when funding commenced in 2015.

Section 3

# Evidence and findings

# Improved care for people with LTCs

In three years, the five sites have made good progress towards implementing a care and support planning approach to support people with LTCs. Care and support planning is now live in 41 practices[e] and 13,061 people received a review through the programme.[9]

Across all sites, people with LTCs reported a good level of involvement in their own care.[19] Sites used evaluation tools[f] to record project impact, including questionnaires at baseline (in 2016-17, as sites were establishing care and support planning) and at follow-up (in 2017-18, after care and support planning had been embedded in sites).

> “The nurses are very good and they do seem to treat you as an individual, as a person.
>
> **Patient**

An analysis of questionnaire responses across sites found that between baseline and follow-up, there was an increase in people feeling their care was ‘almost always’ joined up (from 56% to 60%).[11] They said appointments felt less rushed and 59% of patients said they ‘almost always’ discussed what was important for them in managing their health.[20] After the care and support planning consultation, 75% said they were ‘better’ or ‘much better’ able to understand their conditions.[13]

The ‘preparation’ step of the House of Care approach is a key element. Here, people can prepare for the collaborative conversation, receiving their results – fully explained – in advance along with agenda prompts that encourage reflection on what they want to discuss in their care and support planning review. In Gateshead, 94% of patients said that the preparation letter was ‘very useful’ or ‘somewhat useful’.[21] Some people said this led them to do more research about aspects of their health they hadn’t considered before, such as lifestyle changes.[22]

It also helped healthcare professionals “shift from a ‘fixer’ to a ‘facilitator’”[22] who helps the person maximise their own health and wellbeing through the collaborative conversation.

Overall, patients said they were happier with the information and support they received to help them manage their care and how healthcare professionals explained things (up from 63% to 68%).[12] However, the proportion of people who said they felt ‘very confident’ in managing their own health dropped from 49% to 41%.[14] Sometimes, this was linked to patients being unsure of what their results meant.[22] Others felt some anxiety or stress about being more involved in the conversation.[22] This suggests that patients currently feel that support is in place but confidence to self-manage with this support may be an area that needs further encouragement, including during the care and support planning process.

[e]41 practices were specifically included as part of the BHF programme and the evaluation, but more practices have adopted the approach across these five sites.
[f]Tools included Long Term Conditions 6 (LTC-6), Consultation Quality Index (CQI), Consultation and Relational Empathy measure (CARE) and Patient Enablement Instrument (PEI), combined to make CQI for Lothian, and the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS).[7]

# Motivating healthcare professionals

Across all sites, staff reported positive effects of the programme. A number of healthcare professionals described improvements in their morale and increased enjoyment of delivering LTC care for patients.[16]

In many practices, the roles of practice administrators, healthcare assistants and nurses have been expanded as they take on additional responsibility and are required to work with people with multiple LTCs.[23]

One GP described the House of Care framework as allowing nurses to work "at the top of their licence".[24] Many reported increased job satisfaction because of these expanded roles and the opportunity to focus more on patient needs.[16] Staff also said the House of Care framework improved their efficiency and teamworking.[16]

> "It's about good internal working relationships; a team approach with different roles coming together, with each role of equal value – whether this is admin, HCAs, nurses or GPs. All are valued and there are partners involved across the system.
>
> **Healthcare professional**

# Extending the care and support planning approach to multiple LTCs

Moving from using care and support planning for people with a single condition (such as diabetes) to those with multiple conditions[g] improved the experience of patients in the programme. They appreciated having a single consultation that covered all their health concerns.[15]

In addition, although the programme set out to demonstrate improved quality of care rather than reduced costs, a consistent finding across all sites was that using care and support planning to help people self-manage more than one LTC is where the greatest resource savings look likely.[25]

> “This is not the magic wand that will make people better, but it has put cardiovascular disease on the map. It’s focused primary care to relook at how they manage their LTCs more generally; it will be a stepping stone to managing other LTCs in a similar way in the long term.
>
> **Healthcare professional**

An illustrative analysis by NHS Tayside suggests that a care and support planning approach covering two LTCs in a single consultation could reduce costs by 25% (£2.99).[25] If five LTCs could be covered in a single consultation, this would reduce costs even further – by up to 70% (£21.10).[26]

Sites said the House of Care framework was particularly valuable in helping them to adopt a care and support planning approach for multiple LTCs by giving practices a structure to extend these changes.[15] All sites are now using the House of Care framework for at least one LTC and are planning to include more in the near future.

[g]The House of Care programme introduced the care and support planning approach for cardiovascular disease, which includes LTCs such as coronary heart disease, stroke, hypertension, hypercholesterolaemia, chronic kidney disease, peripheral arterial disease and vascular dementia. Some practices also adopted a care and support planning approach for supporting people with chronic pulmonary obstructive disease and heart failure.

# Embedding culture change and process

One of the main findings from the programme was confirmation that implementing the House of Care framework takes time.[27] Some interviewees commented that the programme was very process-driven and recognised that these changes in approach can only be effective when accompanied by culture change.

In this context, we define culture change as a long-term commitment to a holistic understanding of patient care and partnership working. Partnership working refers to understanding patients as equals in their own care, as well as whole teams and systems working more closely together to embed this shared understanding. In practice this requires engagement at all levels and parts of the system – from senior leaders to front-line staff in health, social care, community and voluntary sectors.

Although there is some evidence of culture change at practice level, the shifts needed to embed the care and support planning approach at healthcare community and system level are only just beginning.

In many cases, this was because so much time was required in setting up the roof of the House – the essential IT infrastructure and other processes. For new sites, it can take new teams at least six months to put systems in place before care and support planning can start and it might be two to three years before it is fully established.

A further challenge was high staff turnover, which meant more time and resource spent engaging and training new staff in the care and support planning approach. Train the Trainer and top-up training delivered by local, well-respected healthcare professionals helped maintain momentum, with at least two sites saying this was central to driving culture change.[28]

> “We’ve been so distracted by the tools, paperwork, the things you fill in. I think we’ve lost sight of the wider things a bit.
>
> **Healthcare professional**

# Towards More than Medicine

Across all sites, momentum is now picking up towards adopting the More than Medicine approach, especially where supported by established and expanding House of Care practices.

More than Medicine is a key component of the House's foundation. This concept is about practices improving their awareness of local community assets and linking people with these. Practices can plan how to use information from care and support planning conversations to influence commissioning of these assets.

Sites reported that the social prescribing aspect of the House has been slower to emerge as it has first required building trust in the approach among healthcare professionals and then expanding knowledge of support services in the community.[29,30]

However, practice nurses are now referring people to these services more frequently in some sites.[31] In one practice, where services didn't exist to meet the needs of people with LTCs, staff took the initiative themselves (see Embodying the More than Medicine approach, right).[32]

Internal audit results report greater awareness of social prescribing among healthcare professionals in the programme.[31] In Scotland, this was the Links Worker approach. In Gateshead, when other activities and services were discussed within the care and support planning conversation, 89% of people found these 'very useful' or 'somewhat useful'.[33] Many healthcare professionals felt social prescribing helped to reduce social isolation, improved support for psychological needs and better met the needs of harder-to-reach groups.[34]

The independent evaluation report recommended that the BHF, Health and Social Care Alliance Scotland and Year of Care Partnerships are well placed to continue supporting the More than Medicine element of this programme.[35] This should build on progress made and develop the wider case for change and further understanding around the role of wider determinants of health and supported self-management.

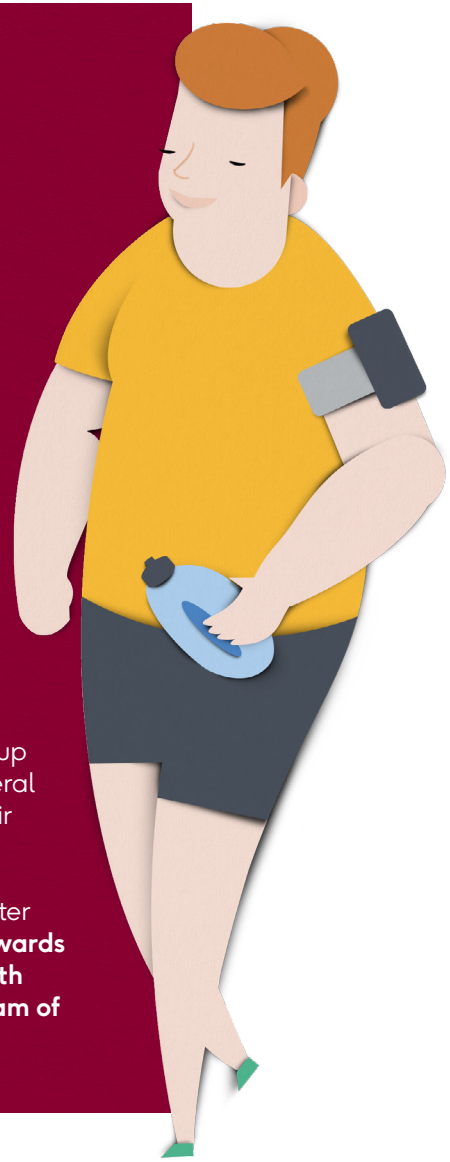
## Embodying the More than Medicine approach

Staff at the Crail Medical Practice in Glasgow were concerned about people who were overweight and had high blood pressure and diabetes. They felt there was no provision in the local community to support these people to manage and meet their own goals.

Thanks to new thinking "driven by the House of Care programme", the practice started a weekly walking group.

It's been highly successful: people enjoy the social aspect of meeting up and have created friendships. Several have lost weight and improved their blood pressure.

The practice team were NHS Greater Glasgow and Clyde **Chairman's Awards gold winner in the Improving Health** and also won the **BHF Alliance Team of the Year 2018** award for this work.



# A supportive landscape

Although funding and workforce constraints continue in the NHS, recent health and social care policy changes across the UK look set to create an environment that will support wider adoption of care and support planning.

All the devolved health nations have identified person-centred care as a priority in their latest strategies and many specifically mention the importance of care and support planning. These include:

In **England**, the NHS Five Year Forward View encourages a focus on empowered, personalised care and supported self-management, as well as improvements in the delivery of care for people with LTCs.[36] Sustainability and Transformation Partnerships also represent a new multidisciplinary, community way of working that fits with the care and support planning approach. The new Multispecialty Community Provider contracts being introduced as part of the General Practice Forward View are also intended to integrate general practice services with community services and wider healthcare services.[37]

The National Clinical Strategy, the national self-management strategy for LTCs in **Scotland**, and the Health and Social Care Delivery Plan all support the wider spread and scaling up of care and support planning as part of a wider programme of person-centred care.[39-42] The Chief Medical Officer's Realistic Medicine approach is aimed at "building a more personalised approach to care, in partnership with people through shared decision-making" across Scotland.[43] The ethos of the new GP contract also aligns with care and support planning and will see GPs take on a broader oversight and clinical leadership role, similar to the role GPs have had in this programme.[44]

In its 2017-20 Strategic Plan and the more recent Plan for Health and Social Care, **Public Health Wales** commits to developing and supporting primary and community care services to improve the public's health as a strategic priority, and says it has "a key role to play supporting the development of new models that best support and meet the needs of the public".[45,46]

**Northern Ireland**'s Health and Wellbeing 2026: Delivering Together plan "puts people at the forefront" and states that "where care or support is needed it will be wherever possible provided in the community setting".[38] A strong emphasis is placed on "ensuring the user's voice is heard, as they will play a key role in developing and implementing new services and care pathways".

# A growing evidence base

The evidence to support the implementation of a care and support planning approach is building. National Voices and The Health Foundation have both published summaries of evidence supporting care and support planning.[5,47]

A recent Cochrane review also concluded that "personalised care planning leads to improvements in certain indicators of physical and psychological health status, and people's capability to self-manage their condition when compared to usual care".[48]

These effects appeared to be greater when the personal care planning intervention is more comprehensive, more intensive and better integrated into routine care.[48]

As the NHS moves towards more person-centred care, the BHF programme has added to this evidence base – using heart and circulatory conditions as an exemplar – that care and support planning can be implemented at practice, community and health system level.

"I had a [bereaved] gentleman come in recently for his review and, you know, you sort of say 'how are you?' and he burst into tears and went 'I'm dreadful' and I'm like 'OK'… But that was more important to him, at that time, than looking to see what his blood pressure was or what his cholesterol was or anything else.

**Healthcare professional**

Section 4

# Future implementation

# A legacy for sustained care and support planning

We asked sites to tell us if they would sustain the changes they made during the programme. All sites strongly favoured continuing care and support planning and most sites intend to expand it to a wider population of patients with LTCs or to neighbouring practices and health economies.

**1 in 5**

**Lothian practices received information and training about House of Care**

In **NHS Lothian**, individual practices are beginning to include additional LTCs. At site level, the Lothian House of Care Collaboration is rolling out wider care and support planning training. Work is ongoing to integrate the care and support planning approach with secondary care (initially in cardiac rehabilitation) and to engage other healthcare professionals such as pharmacists.

**7**

**Tayside practices have adopted care and support planning**

**NHS Tayside** has seven practices using a care and support planning approach, a further 14 have received staff training and four of these are planning to introduce the House of Care framework (three for people with heart and circulatory diseases). Most practices felt care and support planning would be sustained in practices where it was already in place.

**3**

**trainers are now in place to deliver care and support planning training**

In **NHS Greater Glasgow and Clyde**, care and support planning is live in 14 practices and they have secured a year's funding to continue the project manager role. Three quality-assured trainers are already in place to support further work. The team is considering whether GP Cluster Leads could play a greater role in driving the spread of care and support planning.


**100%**

**of practices in Gateshead now use care and support planning**

In **NHS Newcastle Gateshead CCG**, all 32 practices across Gateshead are implementing the House of Care for multiple LTCs. Six Gateshead trainers are in place to deliver quarterly top-up training and bespoke support to practices, and the team is producing a film about care and support planning to share the approach more widely.

**1,483**

**people received a care and support planning review**

In **NHS Hardwick CCG**, 11 out of 18 practices have adopted the House of Care framework and some practices are extending care and support planning to include people with other LTCs. The prevalence of LTCs and a strong local track record of person-centred care made care and support planning a priority for this site and more widely across Derbyshire.

# Lessons learnt from implementation

The BHF House of Care programme has contributed to lessons learnt from implementing the care and support planning approach via the exemplar of heart and circulatory conditions and other LTCs. This programme has built upon work by the Year of Care Partnerships to identify critical success factors for implementing the House of Care. The lessons learnt from this programme are:

**Clinical leads are important.** It was vital for clinicians to articulate the vision for care and support planning to facilitate practice buy-in and for staff to receive tailored training from healthcare professionals they respect and trust.

**Involve people with LTCs.** Patient reference groups played a significant part in championing this approach. In Gateshead they designed leaflets, engaged with receptionist groups, and developed and promoted the OurGateshead community website, which connects people with follow-up services.

The OurGateshead online portal connects people with LTCs to local support services (**ourgateshead.org**)

**Equip the workforce with ongoing training.** In addition to initial Year of Care Partnerships training, short tailored 'top-up' training, Learning Sets and Train the Trainer approaches to support practices were highly successful in equipping professionals to have effective collaborative conversations. Practices need time to learn about how to adopt a care and support planning approach in addition to developing systems and tools.

**Include the whole team.** This helps to establish new processes and culture from the start and reduces the impact of staff changes. It includes practice management and administrative staff, as well as practice nurses, GPs, pharmacists and healthcare assistants.

**Allow time for building the roof.** Teams said it was essential to ensure infrastructure changes are in place before extending the approach to additional practices or sites. It can take at least six months to put systems in place before care and support planning can start, and two to three years before it is fully embedded.

**Project management and practice facilitation are important.** This can be combined with training and practice facilitation roles. Project managers at the different sites were trained and became involved in different ways. All project managers responded to emerging needs and encouraged practices to include more LTCs. They have been kept in post to support the spread and adoption of care and support planning.

**Flex the framework to meet local needs.** While maintaining the core components, some practices tailored these to meet their practice and patient needs. Nurses visited the housebound or included telephone conversations, while others developed a picture format and colour coding system in the results letter to help those with poor health literacy.

# Next steps

## We want the legacy of this programme to lead to sustained change in NHS care across the UK. That starts with you.

**If you are a front-line healthcare professional**, share what you've learnt with colleagues and local patient groups. Discuss how this approach could benefit your patients. Speak to your local health board or commissioning group about whether this approach is being trialled in your area and whether your team can get involved. If it isn't, ask for this to be considered.

**As a healthcare commissioner**, planner or clinical lead, reach out to colleagues in our Health Services Engagement team (see **Contacts and Further Information section**) to discuss how this approach could work for your population and what you'd need to get this started. You can also speak to the Year of Care Partnerships about the support they can provide.

**If you're a patient or a member of a patient group**, ask your local general practice whether they would consider adopting care and support planning. Help to spread the word about how this approach can deliver better, person-centred care. Learn more about what this approach means for your care at bhf.org.uk/personcentredcare.

Visit **bhf.org.uk/houseofcare** for more information, and access the Year of Care Partnerships website at **yearofcare.co.uk** for a wealth of resources around care and support planning and the House of Care.

You'll find inspiration, evidence and useful advice for everything from making the case for change to getting started with your own programme or maintaining an ongoing initiative.

Join the debate on social media, including in our LinkedIn Group for healthcare professionals **linkedin.com/groups/13559187**. Learn from the experiences of others and share challenges and successes.

**It's in your hands.**

Section 5

# Resources and information

# Contacts and further information

**Contacts**

### BHF programme

Want to understand more about how the BHF House of Care programme was run and how our experience could help you deliver this approach in your area?

Our Health Services Engagement team has regional representatives ready to discuss next steps in your area.

bhf.org.uk/houseofcare houseofcare@bhf.org.uk

### Year of Care Partnerships

Year of Care Partnerships (YOCP) is an NHS organisation and part of Northumbria Healthcare NHS Foundation Trust. It is dedicated to driving improvement in LTC care using care and support planning to shape services that involve people in their care, provide a more personalised approach, which supports self-management and links with community support.

The YOCP national training and support team has over a decade of experience facilitating the development and implementation of care and support planning using the House of Care framework. YOCP is available to support you and works closely with organisations to develop a delivery plan. Support available includes core care and support planning training, practice facilitation and supporting commissioners and practice teams.

yearofcare.co.uk/about-us enquiries@yearofcare.co.uk

### Health and Social Care Alliance Scotland

The Health and Social Care Alliance Scotland (the ALLIANCE) is the national third sector intermediary for a range of health and social care organisations. It has more than 2,200 members including large, national support providers as well as small, local, volunteer-led groups and people who are disabled, living with LTCs or providing unpaid care.

alliance-scotland.org.uk
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**Further information**

Year of Care Partnerships yearofcare.co.uk

Getting to Grips with Year of Care: A Practical Guide yearofcare.co.uk/key-documents

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## Thank you

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