Delivering better service for people with long-term conditions

Building the House of Care

Summary of the Kings' Fund Findings - October 2013

Background

- The need to improve the treatment and management of long-term conditions (LTC) is the most important challenge facing the NHS.
- Improving care for people with long-term conditions must involve a shift away from a reactive, disease-focused, fragmented model of care towards one that is more proactive, holistic and preventive, in which people with long-term conditions are encouraged to play a central role in managing their own care.
- Despite calls for change; there has been little/no progress in last 10 years. Many of the elements necessary for change have been developed but remain isolated and fragmented.
- A practical, robust, reproducible and transferable delivery model is available, based on the House of Care (HoC) model developed by Diabetes UK and the Department of Health – active involvement of patients in developing their own care plans through a shared decision making process with clinicians.
- The HoC provides CCGs with a roadmap for developing a responsive, whole-person delivery system.
- The HoC has now been adopted as a central metaphor in the NHS of England's plans for improving care for people with LTCs.

Policy Context

- Chronic diseases are now the most common cause of death and disability in England - more than 15 million people have an LTC.
- In England, the number of people with LTCs is projected to be stable over next decade but those with multiple conditions set to rise from 1.8 to 2.8 million by 2018.
- Increasing evidence shows the importance of effective self-management of LTCs.
- The call for a more person-centred, better co-ordinated approach to managing care for people with LTCs has largely been universal
- To achieve this, the King's Fund believe the following are required:
    - Patients engaged in decisions about their care
    - Supported self-management
    - Co-ordinated care
    - Prevention, early diagnosis and intervention
    - Emotional, psychological and practical support.
- The government's mandate for NHS England requires *it 'to ensure the NHS becomes dramatically better at involving patients and their carers, and empowering them to manage and make decisions about their own care and treatment'*

Building the House of Care

- To date, any efforts to effect a change to the service delivery system have been unsuccessful.
- There still needs to be a transformation in the relationship between patients and clinicians.
- The HoC metaphor was developed specifically to help those in primary care adapt their chronic care model.
- People with LTCs are central to the process and self-management support and the development of collaborative relationships between patients and professionals are at the heart of service delivery.

- The HoC delivery system aims to ensure each individual is involved in a unified, holistic care planning process with a single care plan.
- Evaluation of the HoC pilot programme revealed improvements in patients' experience of care and in self-care behaviour.
- Professionals gained new knowledge and skills and got greater job satisfaction.
- Practise organisation, teamwork and productivity all improved.
- Embedding the HoC requires fundamental changes to the organisation, the delivery and commissioning of primary care.
- The HoC was created to visualise the requirements.

The components of the House of Care

- **The centre - Personalised Care Planning:** this is a collaborative process designed to bring together the perspectives of the individual and the professional, offering tailored personal support to develop the confidence and competence needed for effective self-management. Care planning gives two broad outcomes – a personalised solution for each individual AND a means of identifying the variety of support needed in a local area.
- **The left wall - engaged, informed patients:** while the overall care plan is cyclical, the need to ensure individual engagement is two-stage:
    1. Seeking out the person's views and providing them with personalised info i.e., decision aids, reflective sheets, etc
    2. Building in time to reflect and discuss with family and friends.
- **The right wall - professionals committed to partnership working:** clinicians need to learn to practise a consulting style that is curious, supportive and non-judgemental, which uses problem-solving and coaching techniques. Effective leadership from professional bodies will be key to embedding the type of culture change that is needed if personalised care planning is to become the norm.
- **The roof - robust organisational systems:** which are essential to ensure efficient processes. The ability to record, analyse and use information in new ways is another key aspect in making the system work efficiently, ensuring the patients receive the right level of support. This may involve reviewing/upgrading IT systems. IT issues remain the biggest challenge for participants after professional engagement.
- **The foundations – responsive commissioning:** many commissioning bodies see considerable potential for improving efficiency by reducing demand for unscheduled hospital admissions and A&E attendances. The HoC model integrates personalised care planning for individuals with responsive commissioning for populations. Individual needs and choices identified during the care planning process (micro-level commissioning) are aggregated to provide a local commissioning plan. Aggregating the support needs identified by individuals into a commissioning plan for a locality requires robust electronic records and systems for data-sharing. It also requires the identification of a portfolio or menu of local services for people to choose from and a willingness on the part of commissioners to fund non-traditional services. CCGs will need to be ambitious if they are to change traditional ways of working and realise the benefits in terms of better outcomes and greater value for money.

Monitoring Progress

- The purpose of personalised care planning is to ensure that people with long-term conditions are given personalised support to develop the knowledge, skills and confidence they need to effectively manage their health.
- Use of appropriate metrics for monitoring progress is essential in any quality improvement programme, and the HoC model is no exception.
- Commissioners may want to use indicators to monitor the impact of this new way of working on population health.

- CCGs might also want to encourage their providers to focus on improving these metrics for people at low levels of activation or with low health literacy, thus driving the system to reduce health inequalities.
- Local providers and commissioners need to ensure that all the components of the HoC are in place if the desired impacts are to be achieved. This will involve:
    - Acknowledging the philosophy and principles of systematic support for self-management
    - Identifying accountable leadership
    - Identifying the population involved - risk stratification
    - Identifying the capacity of individuals to engage and supporting them to do so
    - Identifying the multidisciplinary teams involved and the roles and responsibilities of each team member in order to ensure that care is personalised and co-ordinated
    - Using available evidence-based and quality-assured training
    - Identifying robust metrics, data collection methods, analysis and feedback to drive improvement.

Putting the components of the House of Care in place - impact

Local providers and commissioners need to ensure that all the components of the house of care are in place if the desired impacts are to be achieved, this will involve:

- acknowledging the philosophy and principles of systematic support for self-management (the driver of the delivery system)
- identifying accountable leadership
- identifying the population involved (risk stratification)
- identifying the capacity of individuals to engage in the necessary processes and supporting them to do so
- identifying the multidisciplinary teams involved and the roles and responsibilities of each team member in order to ensure that care is personalised and co-ordinated
- using available evidence-based and quality-assured training
- identifying robust metrics, data collection methods, analysis and feedback to drive improvement.

The Way Forward

The report concludes by highlighting the three main needs identified as necessary to make to make the HoC a reality:

1. Clear narrative describing care planning and the infrastructure needed to support it
2. ‘Hub’ for disseminating this narrative, providing a source of support and co-ordinating activities
3. ‘Coalition of the determined’