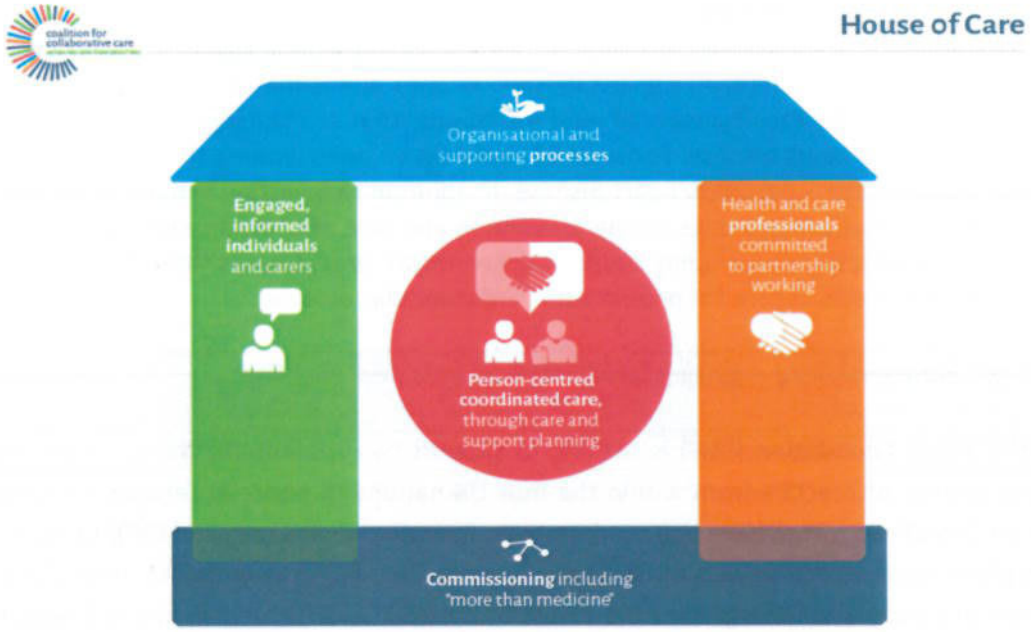
Key elements of the House of Care project:

- **Care and support planning as routine care –** with an emphasis of delivery of care planning in primary care to support QOF checks and recommendations from Transforming Primary Care (2014)
- **Service redesign** , driven by care and support planning and including integration of cardiovascular disease services
- **Development of support for self- management services** including the third sector



The British Heart Foundation House of Care project is funded by the BHF and supported by the Year of Care Partnerships Team (YoCP) http://yearofcare.co.uk/ and will inform the Coalition for Collaborative Care (C4CC) http://coalitionforcollaborativecare.org.uk/

The Year of Care Programme (YoCP) has already shown how to deliver personalised care in routine practice for people with Long Term Conditions (LTCs), using diabetes as an exemplar. This project aims to test how the Year of Care model can be successfully implemented for CVD patients as part of a systematic change across the local community.

The British Heart Foundation House of Care project will deliver a holistic and integrated approach to care and support planning for people at high risk of developing, or who already have established cardiovascular disease (CVD) as defined by national health and social care strategies in the four nations related to long term conditions and cardiovascular disease.

These include: Heart Failure, Atrial Fibrillation (and other cardiac arrhythmias), Coronary heart disease (including post myocardial infarction and angina), Hypertension, At Risk of developing CVD as identified through an NHS health check, Stroke, Vascular Dementia, Hypercholesterolaemia, Chronic Kidney Disease, Peripheral Arterial Disease, Inherited Cardiac Conditions – including Familial Hypercholesterolaemia.

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