@NHSSouthwarkCCG

NHS
Southwark
Clinical Commissioning Group

Developing care coordination with people with multiple long term conditions

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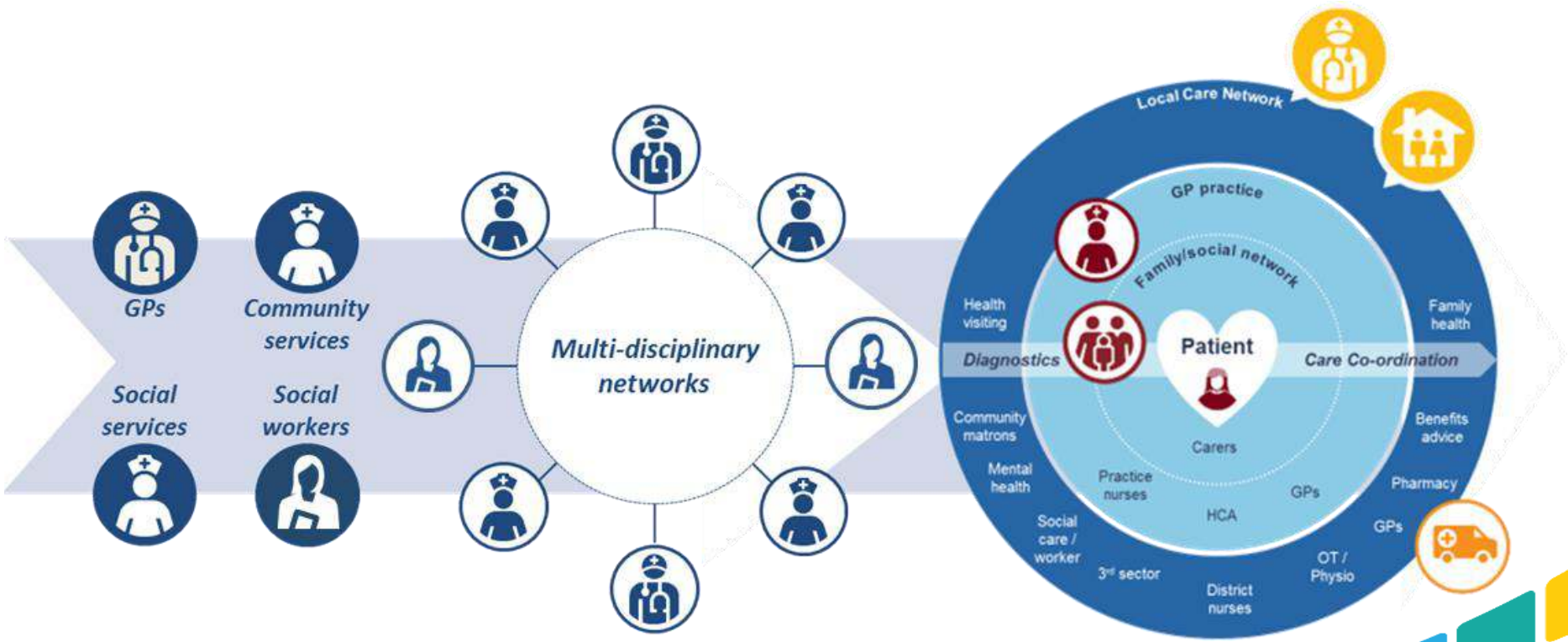
The best possible health outcomes for **Southwark people**

Local Care Networks

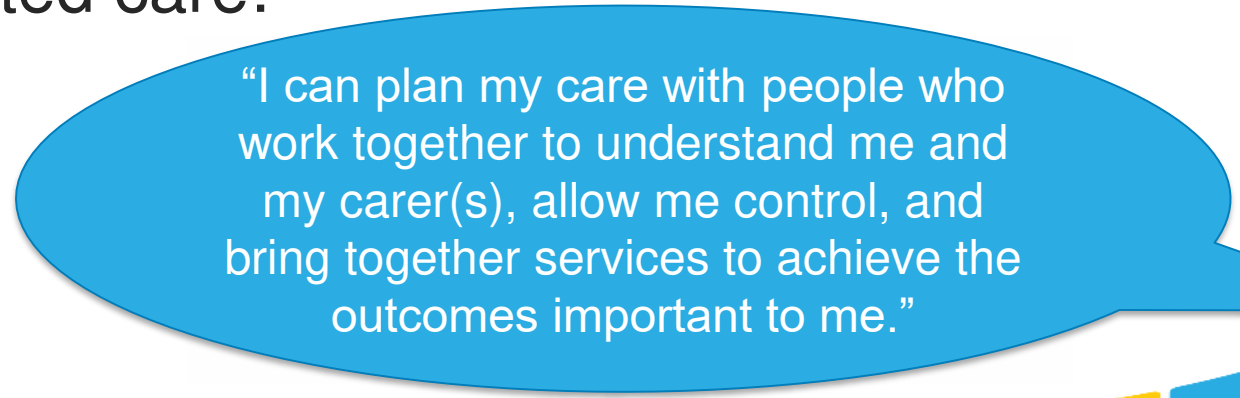
- Two LCNs have been set up in Southwark to:
  - improve integration of health and care services
  - achieve better patient experience
  - achieve better health outcomes
- Partners include:
  - King's College Hospital NHS Foundation Trust
  - Guy's and St Thomas' NHS Foundation Trust and Adult Services
  - South London and Maudsely NHS Foundation Trust
  - GP federations – Quay Health Solution and Improving Health
  - Pharmacies
  - Southwark Council - Adult Social Care
  - Voluntary sector & Healthwatch

Local Care Networks



Joining up care

- Improving joined up care for people living with 3+ long term conditions
- Using Transforming Primary Care in London: a Strategic Commissioning Framework, which builds on work by National Voices and their narrative for patient centred co-ordinated care:



Rapid co-design approach

- Patient stories and films
- Clinical review of patients and sharing findings
- Patient workshop
- Joint clinical, voluntary sector and patient workshop
- Clinical training – behaviour change, motivational interviewing, managing frailty and medicines
- Tested material and approaches
- Current evaluation

Clinical engagement

Patient stories

- Working with Healthwatch Southwark and Revealing Reality, we collected 30 patient stories, using ethnographic approaches
- Revealing Reality made a film of 5 people talking about their lives and their health as well as individual films

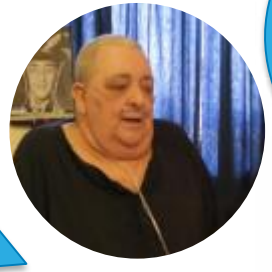
Patient stories

Patient stories

"I would do anything to come off some of that medication."

"I once took the wrong pills and ended up in hospital "

"I used to tell the doctor I didn't smoke any more because I didn't want to listen to another lecture"



"IBS is by far the worst – I have to spend hours in the morning preparing before I can leave the house"

"I wish I could do more exercise, but I just don't know where to go or how"

"My brain doesn't work as well as it did when I was 64"

Case Study: *Azra*

Southwark | *Age: 62*

'I liked my carer because we could laugh together.'

'I can only talk about one problem but I have so many'

PROFILE

Azra came to the UK from Turkey in the 70s. She is a widow and now lives with her 3 sons, who help to look after her.

She knows she has to take a lot of medication but is not sure why. She is tired all the time and quite lonely – sometimes she spends all day crying.

HEALTH CONDITIONS:

- Diabetes
- High Cholesterol
- Back problems
- Recent liver operation

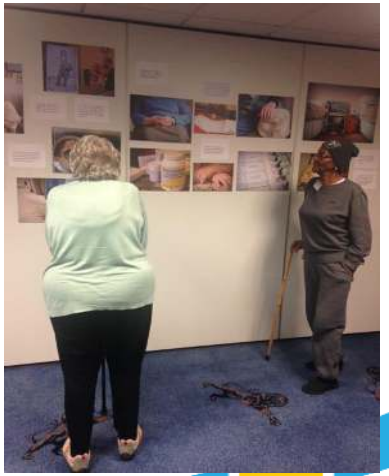
HEALTH TOUCHPOINTS:

- GP: Rarely
- Nurse: Once a month for injection
- Social services: Never came to fit her shower
- Home care: After liver operation – great job, loved having company

WHAT DID WE LEARN FROM THIS STORY?

- We witnessed how socially isolated she was, despite the fact that documentation would have shown she lived with her sons
- She was not formally diagnosed as depressed, however we discovered she spent whole days crying. She had no idea there might be support for issues like this

Patient workshop



My goals and what is important to me

I want to be able to get out on my own

I want to use my computer to stay connected, it is currently broken

I want to be able to use a mobile phone to text and keep in touch with people

I want to carry on going to my choir and taking part in activities

I want to feel confi about walking pavements – th sometimes very

I want to be able to use the hospital transport and not be waiting around for hours

I want to b healthy and sta healthy

I want to lose weight

I want to do things at my own pace, I don't want to get breathless

I want to carry on travelling with my wife

I would like to go out walking and have support to go as I am blind

I want to be able to see the same doctor each tim when I go to t surgery

I want to continue walking each week, but the hospital tells me not to do too much walking

I want to continue college and volunteering

I need support for people to have assistance to go out

I need services to understand that I want to do things in my own pace

I need green space around me to allow me to get out, socialise and be fit

I need a service to help me exercise, to go for a walk in the park each day

I need support to find other activities I can do that won't impact badly on my health

I need a service that will send a person to sit with me and show me how to use my mobile phone

I need to change my expectations of my GP as it won't always be possible to see the same GP each time I go to the surgery

I need Doctors to use computer systems so it does not matter that I don't see the same GP each time – it is all updated

I need to find services that would help to fix computers or to help people get to a library where there are computers – this includes transport

I need to know about services to support me to get to classes, learn to cook healthy food, be able to talk about my mental health and the voices in my head, including how this affects me when I am out

I need to have easy access to transport such as Dial-a-ride and to link up with people and services to know what is happening nearby to get involved with

I need schools, job centres, colleges, volunteering opportunities to understand how to support people with mental health needs

I need my GP to develop a more efficient appointment system

I need services to understand that my conditions are not the things that make me who I am. I have family, friends and things I like to do and my conditions don't impact on that

What I need to help me achieve my goals

In the afternoon, we were joined by professionals

In adult social care, we look at individual needs and the things people want to achieve. It is about listening to see what would be the best support for them

Adult Social Care

I can't see, so it is far more difficult for me to access things – people need to be mindful of this when working with me

Patient

We need to look at people more holistically … so individuals have care plans with personalise support

GP

A formal care plan can go out of date quickly – digital version allows it to be updated easily and quickly

Southwark Council – Learning Disability Service

We need to communicate within the right timeframe and let patients know what that timeframe is.

GP

We need time and information about services to be able to support patients and to link them in to groups and activities that would help them reach goals

Southwark Council – Learning Disability Service

It is hard to engage with patients with care planning, we have tried many methods. We also need to input the information twice into our computer system and then on to a patient facing document

Nurse practitioner

I wouldn't want to take control of a care plan – I want a professional to look after it and update it for me

Patient

Some people want a third person who is not a professional to help with creating a care plan

Adult Social Care

Can the doctor feedback what was talked about at an appointment? This would help me follow up on what I am supposed to do

Patient

Pharmacists are well placed to help as you can walk in and they know you – sometimes for longer than your GP

Patient

How do we make patients more active and involved when you have a short amount of time with them, we also need to explain things in plain English to help people understand their conditions?

Nurse practitioner

As a clinician, it is hard to know what is available as services end or change so you want to be able to send patients to current services

Nurse practitioner

Patient working groups and on-going evaluation

- Set up working groups
- Series of focus groups to test letters, care plans and paperwork
- New approach started in October 2017
- Stories of those who have had experience of pathway currently being collected by Healthwatch
- Larger evaluation of patients and clinicians being planned

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