



# Get Engaged

GP Clusters

Care  
Co-ordination

19th  
October  
2016



## Introduction to the day

NHS Warrington CCG recognises the importance of involving and engaging patients and the public in our work and commissioning developments.

In addition to ongoing engagement activity throughout the year the CCG hold their annual public Get Engaged event.

As well as providing information and updating the public, provider colleagues and Third Sector Organisations on the CCGs financial position and priorities the event was an opportunity to showcase the newly developing GP Clusters. The event was an opportunity to discuss the GP Clusters and ask how they should work and what other services could be included. The slides from the day are in Appendix 1.

One area of work that has been recognised could greatly benefit patients within clusters is Care Co-ordination. Get Engaged discussions focused on this area; we asked the attendance what benefits Care – Co-ordination could offer patients, what services and organisations could do to work together to offer the best for the patients and what needs to happen to ensure 'Excellence for Warrington'. To understand the importance of Care Co-ordination 'Sam's story' from the Kings Fund was shown, [click here](#) to see the video.



To support the discussions case studies were used of patients who would benefit from Care Co-ordination.

## Attendees

There were approximately 75 people in attendance on the day, these ranged from individual members of the public, PPG representatives, Third Sector organisations, including Trans\* Warrington, Hearing Voices, WIRED Carers, Warrington Disability Partnership and Footsteps. Also in attendance were colleagues from our partners and providers including Warrington Borough Council, Healthwatch Warrington, LiveWire, 5 Boroughs Partnership NHS Foundation Trust and Bridgewater Community NHS Foundation Trust.

## Feedback

During the event there was opportunity to ask questions to CCG staff, for all of these questions please see Appendix 2.

For all the feedback from the day and the case studies used to aid the discussions please see Appendix 3.

## Themes

The Care Co-ordination discussions can be grouped into five main themes:

1. Role of the Care Co-ordination
2. Communication and information
3. Accountability

#### 4. Barriers

See below for summaries of the discussions including quotes and suggested tweets.

##### 1. Role of Care Co-ordination

#PuttingPatientsFirst  
#LiveLongLiveWellLaughLots

There was a strong feeling the Care Co-ordinators need to be a central team that everyone owns and as the role is coordination it doesn't necessarily need to be clinical. The Co-ordinators should be whoever is best placed to positively impact on the patient's care, suggestions were Link Workers, Health and Wellbeing Mentors, Nurses, Social Workers etc. However they should all have access to the same training and information.

"Link between coordinator and Primary Care; working together as one and easy access"

The service will need to work flexibly – not an office based service, needs to be outreach service, and will need to link to all other services, community, social care, mental health, Third Sector etc.

Consideration needs to be given to timescales of intervention, this should be on an individual basis. Due to the nature of the role Care Co-ordinators will need access to other health professionals and organisations on behalf of the patients, this should not be delayed - all organisations need to work together

##### 2. Communication and Information

Nothing about me without me #Together

Increased communication and information was felt to be vital in delivering Care Co-ordination and the desire to talk to each other, both professionals and patients.

There needs to be an investment in culture change of health professionals and the public.

There was a strong feeling that Care Co-ordination needs to be co-produced with patients and the public, including carers and families – not done to.

Need partnership working, sharing of best practice and good news.

Regarding information all Care Co-ordinators need access to the same information: a directory of services for signposting was thought to be vital.

"Good communication with co-production of services. Everyone involved in designing"

##### 3. Accountability

#OneWarrington

"One care organisation. Local leaders need to take it seriously."

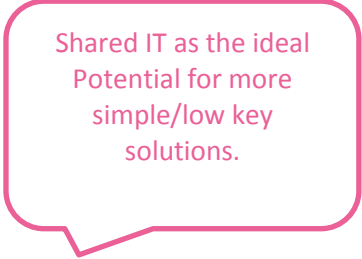
Local leaders need to take this seriously and prove it is a priority.  
All organisations need to work together.

## 4. Barriers

#WorkingBetterTogether

The three main barriers discussed on the day were:

- technology
- funding and
- capacity



Shared IT as the ideal  
Potential for more  
simple/low key  
solutions.

IT systems that are compatible across organisations is vital. However data sharing agreements across organisations are also needed. The increased use of technology enables remote and virtual meetings and consultations which would benefit certain patients.

Attendees asked will there be joint funding for Care Co-ordination, so each patient's care and needs can be identified?

Capacity of staff was identified as an issue, depending on who the Care Co-ordinators are will capacity be released by organisations?

### How to Get More Involved

The CCG recognise the importance of involving and engaging local people and Third Sector organisations in all area of their work. There are many ways to get involved, the CCG have a monthly Health Forum which is the CCG 'sounding board'. Consultations, service reviews and information on new services are taken here to discuss and gain opinion.

The CCG also attend many Third Sector meetings and events throughout the year to gain experiences which are then fed back into the CCG.

Patient Participation Groups, within GP Practices, are also a great way to influence their local Practice but also to get involved in wider health discussions. The CCG facilitate a PPG Network which brings together PPG representatives, see Appendix 1 for a PPG presentation that was presented at Get Engaged.

Health providers also have opportunities, each Trust has a membership scheme for patients to get more involved.

For more information on how to get more involved please contact Katie Horan, Engagement Manager on 01925 843745 or email [katie.horan@warringtonccg.nhs.uk](mailto:katie.horan@warringtonccg.nhs.uk)

### Next Steps

The report from the day will be shared across stakeholders including our partners and providers, Third Sector organisations, CCG Health Forum, PPGs and patients and the public.

The outcomes from today's event will form part of the project scoping to define and ensure a quality care co-ordination service for our patients.

Once the project has been developed and a pilot phase has commenced the CCG will share this with the CCGs Health Forum and PPG Network for their involvement.

## Appendix 1

### Warrington Context

#### National

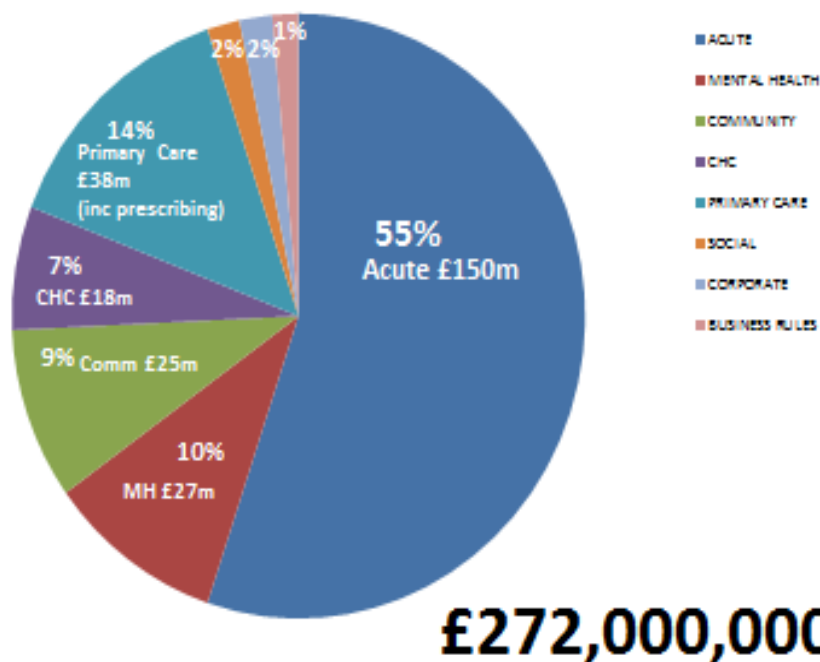
- A funding shortfall of £30bn predicted by 2020/21
- Emergency Departments under significant pressure
- Rising demand – increasing ageing population
- GP shortage

#### Local

- NHS Warrington CCG underfunded
- Local Authority suffered further funding reductions
- Increasing population – largest growing town outside of London
- Ageing population – increased complex needs
- Warrington – under doctored by 29 GPs now... and 37% due to retire in the next 5 years



### Warrington – The NHS £'s



## The £'s In real terms

# £272,000,000

= £1,283 p.p. in Warrington ... for everything !



GP Appointment = £45

Hospital Out Patient Appointment = £168

A&E Attendance = £122

Hip replacement = £6300

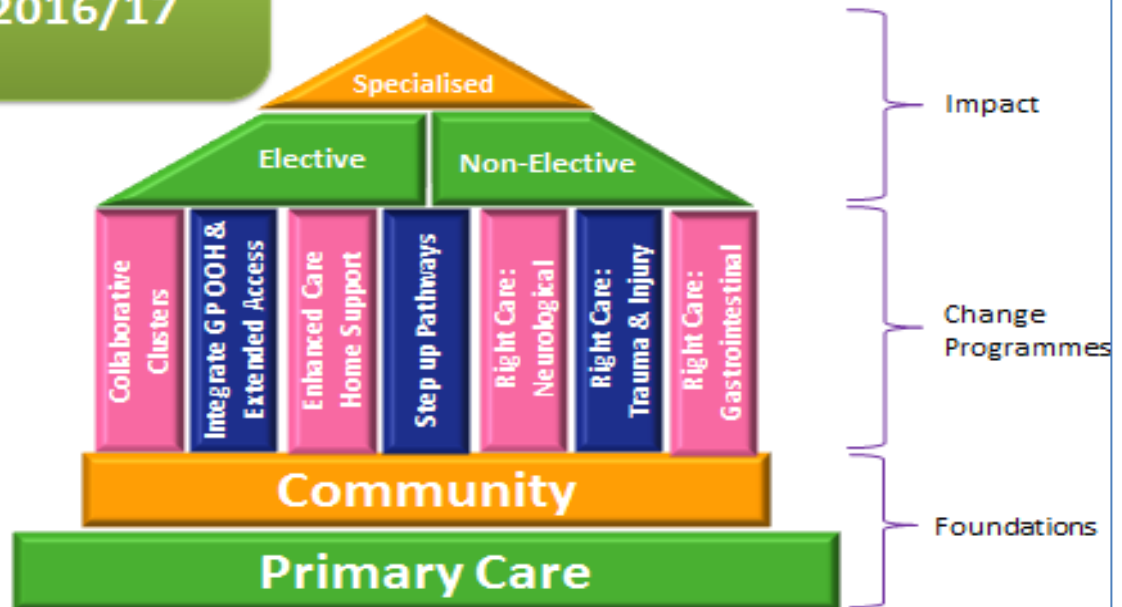


Prescription per item =  
£9.20 and only 12% of people pay for prescriptions!

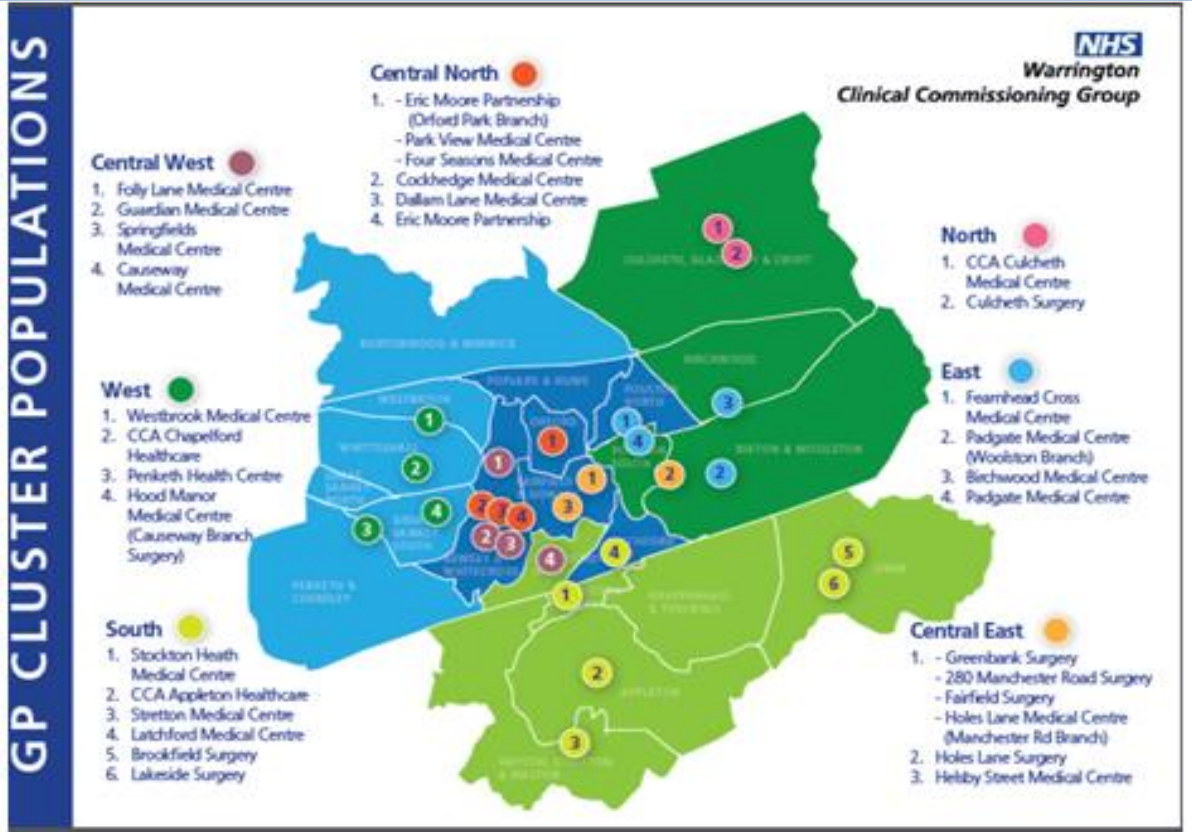


Emergency Ambulance x 1 = £226

## Our Priorities 2016/17



# How Health & Social Care are working to address the challenges in Warrington



## What are Clusters?

- Wrapped around a population of around 30,000 patients
- Supports deliver of primary care across Practice boundaries
- Enables the involvement of wider services around the registered list
- Local populations which provide a vehicle for care co-ordination that includes integrated social care, community services, public health, mental health and third sector services

## Collaborative Clusters ... & Care co-ordination Marie-Ann Hunter, Senior Commissioning Manager



[Sam's Story.....](#)  
How do we make this a  
reality for  
Derek Warrington





# How to get more involved?

- CCG Involvement
- Healthwatch Warrington
- Patient Participation Groups and the PPG Network

## Patient Participation Groups and PPG Network (PPGs + PPGN)

- What is a PPG?
- Why do we have PPG's?
- What is the PPGN in Warrington?
- The Future?



## What is a PPG?

PPG is made up of patients & practice staff who communicate at regular intervals to consider ways of making a positive contribution to the services and facilities offered by their practice to patients. Not every group will be the same. Each group will evolve and develop to address the needs of the practice & its local community. Members of the PPG should meet face to face with practice colleagues on a regular basis. Some PPGs make use of electronic communication channels now available through the internet to form a virtual group to complement the physical group but not to replace!

## What is a PPG?

Patient participation is a unique partnership between patients, GPs and their practice which is essential to and results in high quality and responsive care.

**Patient Participation Groups (PPGs)** work in partnership with their practices to:

- help patients to take more responsibility for their health.
- contribute to the continuous improvement of services and quality of care
- foster improved communication between the practice and its patient
- provide practical support for the practice and help to implement change
- The first PPGs were established around 1972 by GPs in England and Wales. Since then the PPG movement has grown rapidly. Experience shows that successful practices and effective PPGs go hand in hand.

## What is a PPG?

- PPGs are about implementing real, positive change in their communities. Patients have long valued the relationship with their GP and general practice. However the dynamics of this relationship have changed over recent years – patients today rightly want more say in their own healthcare, they are better informed and expect to be treated as whole people, not just as a condition or ailment.
- PPGs have an increasingly important role to play in helping to give patients a say in the way services are delivered to best meet their needs, and the needs of the local community.
- PPGs can help GPs to develop an equal partnership with their patients. They can help them to communicate accurately and honestly with individual patients, and with the wider community about key health matters. They can also help to reduce costs and improve services by identifying changes that the practice may not have considered, allowing resources to be used more efficiently. What is more, they can develop mutually supportive networks for patients and the practice, outside of individual appointments.

## What can a PPG do?

In practice, PPGs can play a number of roles, including:

- Advising the practice on the patient perspective
- Assisting with Flu clinics etc.
- Organising health promotion events i.e. Life is a Rollercoaster
- Communicating with the wider patient body
- Running volunteer services and support groups to meet local needs
- Carrying out research into the views of those who use the practice (and their carers)
- Influencing the practice or the wider NHS to improve commissioning
- Fundraising to improve the services provided by the practice
- Funding for these groups is commensurate with their activities and are normally met by the practice. In the majority of cases costs are minimal. Recognition of the worth of an active PPG as a viable and necessary feature of practice, normally results in obtaining adequate funding.

## Why have a PPG?

- Since April 2011 having a PPG has been an enhanced service i.e. an optional clause, in the GP contract which attracted extra funding – 35p per registered patient. From April 2016 the funding has been reinvested in the standard contract.
- PPG's aren't forums for complaints, moaners or whingers pursuing individual agendas and special interests. They are about liaison between patients and the practice for mutual benefit.
- They provide access to the patient population, acting as an intermediary and contributing to continuous improvement

## Present PPGs in Warrington

- Out of the 29 GP Practices within Warrington it is recognised that approx. 15 have “active” PPG's who contribute to both their practices' operation and to the wider CCG requirements.
- Out of the Clusters we have discussed today all 7 have at least 1 active PPG, with the remainder varying between active, virtual or just developing



## What is the PPG Network in Warrington

- The majority of active PPG's have joined together to ensure that a common voice is heard, for the benefit of patients, GP Practices and the CCG
- Regular meetings, sponsored by the CCG, are held and it is also a statutory item on the Agenda of the local Health Forum
- It allows a central contact point for the CCG and Healthwatch through to the PPG's, enabling assistance with Quality reviews, local Hospital topics/concerns etc.

## PPG Network – Points of Contact

Katie Horan – CCG

[katie.horan@warrington.nhs.uk](mailto:katie.horan@warrington.nhs.uk)

Esstta Hayes – Healthwatch Warrington

[Esstta.Hayes@healthwatchwarrington.co.uk](mailto:Esstta.Hayes@healthwatchwarrington.co.uk)

2016/17 – Peter Wilson  
Audrey Fitzpatrick  
Kevin Goucher  
Anne Robinson

Springfield PPG  
Fearnhead PPG  
Culcheth PPG  
Holes Lane PPG

## **Appendix 2 – Questions and Answers from the day**

Q. Are any other areas focusing on cluster work or is this an unusual model which Warrington are developing?

A. There is a National call for a different way of working; with the Prime Minister's Challenge Fund it has allowed Warrington to develop cluster work and move this forward quicker than other areas.

Q. Is there any evidence available to show that the Cluster Model works? Is this a solid change or an academic trial?

A. Different models can look good on paper and in theory should be successful, but in practice can be the opposite. There has been some National research into areas which have adopted a model similar to this and with that softer intelligence along with the King's Fund, we are able to develop a model locally which should make for a strong and successful model.

Q. There is nothing highlighted on the Cluster Map about the Burtonwood area – what are the plans for these areas?

A. Warrington doesn't receive funding for the Burtonwood area in terms of primary care– this funding goes to St Helen's; this makes the strategy trickier and this is yet to be fully worked through. There has been previous engagement with Burtonwood in regards to how they receive their primary care services and feedback has shown that they are, as a whole, currently happy with how it is delivered.

Q. Will there be a Transgender specialist in each Cluster?

A. The necessity for a Transgender specialist in each cluster may not be appropriate, however going forward it could be looked into to have "hyper-clustering" where less in demand specialists can cover more than one Cluster.

Q. Will there be any consideration for home visits from specialist within Clusters?

A. This is yet to be fully worked through, but will be considered going forward with developments.

Q. There are a lot of vacancies within primary care as well as other specialist areas – why can't Warrington attract Specialists to work in our Area?

A. WCCG have this recorded on their Risk Register with Dawn Chalmers, Deputy Chief Nurse, looking at the Workforce in Warrington. There are innovative packages being considered and developed including being in a good position between Universities in Manchester and Liverpool and considering working together across areas.

Q. Other local hospitals have had fairly recent refurbishments, why hasn't Warrington Hospital?

A. It is not felt to be needed at Warrington Hospital, and without an un-needed refurbishment, Warrington Hospital aren't facing any loans which need repaying.

Q. If computer systems throughout GP Practices, the hospital, CCG, etc. don't connect, how will everyone link together?

A. We understand that if there is a lack of communication, then there will be a breakdown in the system, but we intend to hold multiagency meetings before discharging any patient.

Q. There are a lot of children in services that are out of area, for example Alder Hey Hospital; how will this be factored in to the plans?

A. As this is a very specialised service, it will likely to be focused on in Phase 2 or Phase 3 of the transition, but please be assured that we will not be deconstructing things that already work, for example, referring to CDC.

Q. There needs to be strong and brave leadership to take this forward; tweaking the edges won't work.

A. It has been recognised that there are hard decisions to be made and as a CCG we are happy to implement the change but in order to drive this forward, strong leadership needs the support of the public, this was seen during our Medicines Management Consultation earlier in the year where the process was explained to the public and the majority of those consulted with agreed with the CCG's decision.

Q. How will the clusters work in terms of money?

A. Every cluster will be different in terms of needs, therefore we need to look at the right costs for the right people. All practices have signed up to the LES (Local Enhanced Service or Warrington Brand) this is to ensure that appropriate services are wrapped around patients in regards to their own personal needs. This will require using funding differently and we welcome ideas and suggestions from the public on how they would like to see this happen going forward.

Q. As Chair of the CCG, what is your commitment and what are you going to do?

A. This is such a big change that we need to go forward as a team in regards to our partnership work. Collaborative Care Programme Board and engagement will be discussed.

Q. Will we receive feedback?

A. Yes. This is an on-going process and we endeavour to feedback to the public and partners at each stage. We would like to continue with the enthusiasm that has been displayed today.

Q. How can we use movement and physical activity to reduce pressures on the NHS?

A. There is a lot of potential to use movement in order to reduce pressure on the NHS; something we as a town are already focusing on, for example, our Active Warrington Event, Warrington Wolves Fit to Tackle programme, etc. We acknowledge that fitness and movement is a critical part of getting and staying healthy and this will be something we see the benefits from in the next 5 – 10 years. Pledge to be #PartOfTheMovement – there is a desire for change across health in Warrington.

Q. What plans are currently in place to engage with local people?

A. We have lots of groups which involve engagement with the public; mainly the Engagement and Communications Team holding a monthly Health Forum meeting which is open for third sector and members of the public to attend to offer their personal experiences, opinions and suggestions. We acknowledge that this touches less than 5% of Warrington people and we are hoping to expand this. Ongoing engagement takes place with the public, at different meetings, events, through Third Sector organisations and Healthwatch Warrington. Furthermore, the Local Authority and providers have their own routes of engagement, so we now need to look at ways of bringing this together; once this is done, we need to look at who we are missing and come up with ways to engage with them.

Q. Does the public, be formally or informally, have a proper say in any decision making?

A. WCCG's Health Forum are used as our sounding board and any plans are run by delegates; any suggestions or opinions are always fed into any process. Claire Haslam expanded on this by stating that WCCG are good at listening to patient representatives and do use their opinions and views, however, this can be sporadic, which needs to be worked on.

Q. Is there any work going on in regards to preventative stages for diabetes e.g. education?

A. Dr Quincy Chucka is the Clinical Lead on this area of work, and there is a meeting held every month in order to discuss plans going forward. A PPG representative is involved in this and feeds back to the Health Forum.

Q. Muslims children can't take the flu spray vaccines that are currently provided in school; is this being looked into?

A. This has already been passed onto NHS England and we are currently waiting for a response. The CCG will feedback to Warrington Ethnic Communities Association.



## Appendix 3

### Care Co-ordination Case Studies and Feedback

#### Paul

'Paul is 45 years old. He lives across town from his parents. Paul lives alone, smokes 15 cigarettes a day, drinks between 30-35 units of alcohol per week, eats lots of fast food and additionally has suffered from depression following his divorce.

Paul was invited to the surgery following a recent short stay in hospital with a suspected heart attack.

The hospital stay together with his lifestyle triggered a primary care appointment for a care co-ordinated assessment.'

#### Discussion and feedback

- GP input – doing the signposting to faster engagement
- Smoking cessation advice
- Referral to alcohol support services
- Low level CBT goal-setting
- Counselling support for depression
- Isolation
- Diet
- Alcohol consumption
- Advice and Guidance – Health and wellbeing support/mentor
- Directory of services for signposting (for use of public and professionals)
- Cardiac Rehab – preventing heart attack in future.
- Peer support within services to reduce isolation and increase effectiveness of interventions
- Paul possibility works – Service provision the working arrangements maintain employability
- Health and wellbeing mentor to coordinate the care for Paul. Enable trust/friendship to develop
- Steps to “perfect” service delivery
- Collaborative working between services (all types) facilitating sharing “best practice” and good news
- Risk Stratification – Paul: intervene now to minimise deteriorating health.
- IT systems – don't talk to each other – BIG CHALLENGE! Innovative ways of working around barrier.
- Partnership working – Communication is key in success.
- Coproduced services - Experience of service users/patients and carers.
- Knowledge of systems and process of organisations.
- Timescales and duration of input for Paul? - Care coordination
- Personal to the needs of patient
- Systematically review needs and level of input as may change.
- Key points.
- Communication
- Central key worker

- Money
- At which point does the money become a joint pot - e.g. case by case once a person's need is identified.
- Pros and cons of joining pots of money like example of PFI builds.

### **Anne**

'Anne is 78 year old lady with osteoarthritis, hypertension and mild congestive heart failure. Anne has had 2 hip replacements and can only walk short distances. Unofficially cares for her husband, 82 year old Derek who has dementia.

Recently Anne's congestive heart failure deteriorated, her GP arranged for Anne to be seen in the acute medical unit, where she received care and was discharged home within 12 hours.

After this recent hospital visit it was identified she and Derek would benefit from Care Co-ordination'

### **Discussion and feedback**

#### Barriers

- Lack of funding
- Inflexibility
- Lack of willingness
- Too many (poor) buildings
- IT systems rubbish and don't talk to each other
- Communication
- A desire to talk to each other requires investment in culture change
- Accountability
- Recognise egos
- Change of attitude
- One care organisation with the person at it's heart.
- We want our local leaders to take this seriously and show us that they are! Number 1 priority.

#### We have at the moment

- GPs
- SS: District nurses
- Physio
- Third Sector
- Private

#### What we need to put in place to get there... who/where...

- Good, reliable available transport.
- Central team that everyone owns.
- Automatic carers assessment.
- Bank of flexible and well trained "gap fillers" (Q.A and safety assured).
- Proactive outreach is the norm not office based.

- Technology enables remote/virtual meetings/consultation.
- Asset based community work - co-delivered not done to! (Recognise and build on what we have.)

Good looks like...

- Outreach Services in their home
- An appropriate person (or if social services needed) role/coordinating the pathway (primary person)
- One coordinator for both D&A
- Easily contacted and responsive - immediate access to other professionals
- One care organisation not health and social care with one locus of leadership - not medical model
- Only clinical if necessary
- Within 24 hours - 1<sup>st</sup> contact vital with a “make it happen” attitude
- 10 days max for assessment/intense input
- Reviewed regularly with flexibility assured

### **Derek**

‘Derek is an 82 year old man with COPD and heart failure. He has rheumatoid arthritis and dementia and is unable to perform personal care tasks. Derek often wanders out of the house, leaves the gas on unlit and cannot be left alone.

Dereks wife Anne is his unofficial carer. Anne is 78 with osteoarthritis, hypertension and mild congestive heart failure.’

### **Discussion and Feedback**

What can care coordination offer patients?

- O.T assessment – adaptations.
- Social work assessment
- Carers assessment - WIRED
- Alzheimer’s Society
- One person who is the contact for all services needed.
- Protocols
- Processes
- Standards
- Understanding of whole system
- Communications

Who is best to be care coordinator?

- Social worker
  - District nurse
  - Community matron
  - move from transactional to longer term and holistic.
  - Link worker
  - The best person who has most to do with the patient.
- Move away from transactional interactions to a more collaborative approach.

- Care managers – social workers

What needs to take place to make sure good happens?

- Needs to be coordinated
- Quick allocation of the coordinator
- Clear definitions
- Model – What is in and out of scope?
- Health
- Social Care
- Community
- Standards – all coordinators have access to the same information.
- Protocols – Joint funding for care - transformation
- learn from development in Manchester
- People can have complex health needs but living in a supportive family but still need someone to coordinate to get best out of what is on offer.
- Seniors mental health patients with acute physical health issues

### **Rose**

'Rose aged 82 lives alone in an ex council property, she has a supportive family but all who work full time and do not live close.

Rose has had a transient ischaemic attack (TIA). Rose takes a lot of medication and can sometimes get confused when taking them.

During discussions with the GP they learned that Rose's house had no central heating and the gas fire was broken. Rose was also experiencing difficulties when using the shower.

Rose's mobility is deteriorating which is impacted on her ability to care for herself.'

### **Discussion and Feedback**

What would good look like for Rose?

- Key worker – GP link worker – social worker/district nurse.
- Involve 3<sup>rd</sup> sector – Archive Cheshire.
- Case conference – coordinating, liaising on the patients' behalf.
- Case conference should involve all sectors.
- Commissioned – joint – shared
- Assign community staff – aligned to clusters.
- Are all GPs signed up? Do all practices have a link worker?
- Multi-disciplinary teams as per acute in Primary Care
- Somewhere to meet??
- Data sharing – Issue – This needs to be sorted for the model to work.
- Resources
- Regular meetings between all agencies involved in Rose's care – progress, updates.
- Need consistency to work together.

- Use of technology – skype.
- Getting the biggest bang for the collective buck.
- Prevention – Need to get on the front foot

## **Brian**

'Brian is 76 years old and lives alone in a bungalow, he has a carer who visits each morning. Brian recently lost his wife of 50 years. Brian has Parkinson's disease and is registered as partially sighted since a Cerebrovascular accident (CVA) in 2015.

Brian has a severe hand tremor, which has stopped him enjoying his passion of reading due to his tremor and sight problems. Brian is lonely and often visits his GPs, at his last appointment he indicated that his balance was poor and he had been falling over. He had been referred to the Falls Team but had heard nothing.

Brian had previously been referred to the continence team, but the continence service had stopped delivering pads and Brian started buying them himself as he was unaware that he had to contact the service every 3 months to request delivery.'

## Discussion and Feedback

- CCG to set boundaries and give clusters flexibility to tailor care coordination in their area.
- CCG set outcomes for care coordination ability to flex.
- Person at centre - no use changing systems
  - communities/health services
  - without taking the person on out journey
- Start from asking patient to lead
- What is it like living as you
  - Rich narrative
  - Pulling patient stories/themes trends.
- IT systems to support delivery.
- New navigators/coordinators to own care plan and organise coordination's and system.
- Community navigation map.
- Care coordinator – holistic assess (overall needs are)
- Something in place ensure funding stays and service continues.
- Assessment/chat starting with person and building services on to this.
  - going forward with our old habits will not change anything.
  - assuming things wrongly.
- Development of care plan – may not need medicalising plan – comms with other agency.
- Coordinator needs to be aware of services out there to be able to develop plan and support patients.
- Holistic care plan that includes emotional support/social care/health.
- How do we have those conversations/get rid of clinical language/training people to have person centred conversations.
- Would this be care navigators – new or not.

- Softer intelligence people who don't access services.
- Need something bespoke to each cluster ability to flex and CCG enable principles to be same.

## **Carol**

'Carol is 60 years old. She lives in a semi-detached house and is now cared for mainly by her 80 year old mother. Carols older brother who cared for her and her mum died three years ago.

Carol has a learning disability and has been diagnosed with COPD. Carol has also got history of cancer in her immediate family.

Carol is registered at her GPs has having a learning disability but has not had her flu jab or Annual Health Check since her brother died. Carol has missed her most recent breast screening appointments.

Carol is overweight, relies on her mum for most things and neither of them have many other social interactions.

Carol was recently hospitalised for severe breathlessness as a result of her COPD.'

## **Discussion and Feedback**

Coordinator Specialist LD Nurse.

- GP is key for health check - COPD review
- Weight issue
- Carer support
- How would it work
- Duty social worker involved
- Offer health file
- Referrals to other services
- Getting Carol an advocate
- GPs to review LD register and call in patients for health checks
- LD nurse to work with GPs to invite them in and how to manage consent/capacity issues.
- Other community services need to be aware of the coordinator (LD nursing team)
- IT Systems
- LD team would need access to hospital, 5BP and GP systems. Gives coordinator ability/permission to call/contact the patient if not responding.
- Putting Carol at the centre – thinking about the individual.
- Whole person
- Start with physical health needs
- Both need support (Carol and mum, but needs overlap)
- Issues
- Health check – GP - needs to assess capacity
- COPD – GP
- Should have a named coordinator (LD register)

- Weight issue – Livewire, Age UK
- Carer – Accessing social care team – Befrienders/support and benefits.
- Cancer history – Screening – GP
- Flue jab – GP – Pharmacy
- Hospital – Need to link with LD team
- Need to consider transport to access services.
- Annual Health Check – Important to identify the issues and coordinate care.
- Needs to understand treatment (LD Team)
- Info needs to be accessible to patient so they can easily understand.

### **Fiona**

'Fiona is 43 years old and lives at home with her husband and young family (twins aged 3 years old). The family dynamics are a little strained and Fiona requires a lot of emotional support from those in her network.

Fiona manages a number of health conditions daily. She has Type 2 Diabetes, IBS, fibromyalgia and a history of has depression.

Recently Fiona has been attending A&E with symptoms relating to alcohol consumption'

### **Discussion and Feedback**

- Community MH 5BP services
- Friends/family connection
- Alcohol Services – Hospital liaison team refers at A&E
- Diabetes support (GP/peer support)
- Possibly link to other MH services
- Physical Health and Medical Health are interlinked (with Emotional Health)
- Needs to be a holistic view of both patients and family.
- Needs for SG assurances, vulnerability, offer of family support.
- The need not to assume; more questions and conversation (MDT MEETINGS)
- Assessments and Intervention are key.
- Care Co-ordination can offer potential to share info, link services and act as lead.
- The need to work together for the benefit of family, services and patients.
- Dietician referrals – GP and Practice Nurses
- Carer support
- What needs to happen to make it Excellence for Warrington ?
- Resources and training
- MDT
- Social care
- IT systems that work together
- Shared funding/budgets
- Professionals who are prepared to talk to each other
- Other health professionals

- Potential to learn from other countries and shared system
- Patient involvement to keep in centre of care
- Family and carers involvement
- Nothing about me without me. #together

#### Training

- Barriers
- funding availability
- Capacity and staff
- The need for a care plan to fit everyone

#### Who could be the care co-ordinator?

- Responsibility needs to be shared with the patient to take ownership of their own care.
- Whoever is best placed to impact (should lead) and who is acceptable to the patient (trust).
- Involvement of the patient to choose and be involved.
- What is the procedure? Where does the lead need to be?
- Social care link
- MH link
- Health professional
- Family support
- Health visitor
- Some seniors could pass responsibility/share responsibility but “pass care”.
- Formalise understanding.

Potential for simple solutions – Shared IT is an ideal but could be difficult and costly to reconfigure. Is there potential for health and social care passports?