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My Care, My Way

Older People's Forum

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The Service

- Service designed by patients, GPs, third sector and key stakeholders.
- Patient at the centre of care
- More time; more support; more help and more choice support on all aspects of health and well being

"Patients are actively involved and encouraged to participate and thinking about planning their care."
Dr Richard Hooker, GP and clinical lead

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Principles and values for MCMW teams

The principles and values below were developed by the My Care My Way team:

Patient focused and holistic

We attend to patients' physical, emotional and social needs, at home, in the community and through their later life journeys, in ways that work for them.

We are a team

We reinforce team working, collaborative decision-making and great communication.

Prioritising risk

We focus on identifying patients at risk and act in a timely manner to reduce inappropriate admissions and clinical interventions.

Empowering and enabling

We build patients', carers' and families' awareness, skills and motivation so that they can help care for themselves.

Proactive care

We proactively support patients to better manage their health and care before they reach a crisis.

"Yes we can", minimise referrals

We value and nurture our professional skills so that we can provide patients with one-stop solutions whenever possible.

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Roles

My Care My Way depends on each and every one of the team working together with commitment and passion.

This core My Care My team is made up of five main roles below, who draw on a wider network of expertise which could include mental health nurses, social workers, geriatricians, carers amongst others. This core team bring a wide set of clinical skills alongside motivational interviewing, coaching, communication and listening skills.

Patients

Health and Social Care Assistants

Case managers

Senior case managers

GPs

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STAFFING

- Two integrated care centres – St Charles and Violet Melchett
- Each practice is allocated a case manager and a Health and Social Care Assistant
- Staff are assigned a case load and the patient has a named individual
- Staff recruited from a variety of backgrounds to enable a rich team experience
- All staff undertake a 2 week induction programme:
  - Self care, Patient Activation Measures, setting goals and motivational interviewing
  - Third sector referrals and social prescribing

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Patient Story

See here the video Benefits for Patients
http://mycaremyway.co.uk/benefits/

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Social Prescribing

- Kensington and Chelsea Social Council (KCSC) is operating a social prescribing model, known as Self-Care, on behalf of West London Clinical Commissioning Group (WLCCG). The Self-Care model links patients in primary care with sources of health and wellbeing support in the community. The Self-Care programme is targeted at patients aged 65+ with long-term conditions. It provides GP practices in Kensington and Chelsea and the Queens Park and Paddington areas of Westminster with a non-medical referral option.
- The aim of the Self-Care approach - as part of the 'Whole-Systems' initiative and larger integrated 'My Care, My Way' (MCMW) programme - is to increase patient confidence in making informed decisions about their health. Simple lifestyle changes and new healthy habits and goals are encouraged. As a consequence, Self-Care is expected to positively contribute to patients' confidence and motivation, which in turn is expected to contribute towards a long-term reduction in use of primary, secondary, and some tertiary care services.

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SOCIAL PRESCRIBING PATHWAY

Voluntary and community sector providers

KCSC

MCMW
CM's & HSCA's

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01 Awareness

MCMW

Primary care staff are aware of social prescribing and know how to signpost patients through the directory or People First website

KCSC

Ensure that there is up to date information about the services on offer

02 Assessment & Care planning

MCMW

Complete care plan

Use PAM to understand patient's current level of engagement

Use the directory or People First website to identify suitable activities and support

03 Referral

MCMW

Check referral criteria and ensure the referral includes information on any additional support needed and patient's goals

Send referral form in S1 to selfcare nhs email address (tiers 2 & 3) or contact services directly (tiers 0 & 1)

PROVIDER

Contact patient for assessment

Email CM/HSCA if they can't engage the patient

KCSC

Add accepted referrals to charity log

Keep referral criteria updated

04 Activities & Support

MCMW

Check charity log to get progress updates

Respond to any issues raised by provider

PROVIDER

Keep charity log up to date

Email CM/HSCA with any concerns

KCSC

Collate patient's feedback from across the different services

6 sessions

05 Follow up & Sustaining Change

MCMW

Check with the provider if there is no feedback two weeks after the final session

Follow up with patient - and develop a plan to help them sustain change

PROVIDER

Review PAM two weeks after the last session and feedback to MCMW

Gather patient feedback

If needed contact HSCA/CM by e-mail or by phone, to discuss next steps

WHAT IS SOCIAL PRESCRIBING?

Evaluation

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- A new **Social Return on Investment** (SROI) report has been produced by **Envoy Partnership** who were commissioned to conduct research to evaluate the impact of the model and analyse the Self-Care social prescribing model. The report demonstrates that the model has led to reduced avoidable need for hospitalisations, reduced need for GP practice hours, and reduced levels of physical pain and depression for patients.

- This Self-Care social prescribing model and directory of services is managed by **Kensington and Chelsea Social Council** (KCSC) on behalf of **West London Clinical Commissioning Group** (WLCCG).

- Patients are provided with a personal consultation with a Case Manager or Heath and Social Care Assistant at their GP practice, to identify their needs, interests, and goals. One option available is for the patient to be prescribed a service on the Self-Care directory. Patients are contacted by the service provider within a week to arrange their sessions and work on their progression.

- Key results of the **SROI report** include:
- **£2.80 of social value created per £1 invested**
- **Circa 11.5% reduced hospital admissions**
- **1300 patients were reached in 2017**

1300 patients
reached in 2018

c.11.5%
reduced
hospitalisations

£2.80 of social value created per **£1** invested

% of Patients responding	Before	After	Change
Little or No pain	15%	39%	+24%
No feelings of being depressed	30%	47%	+17%
No feelings of anxiety	29%	43%	+14%

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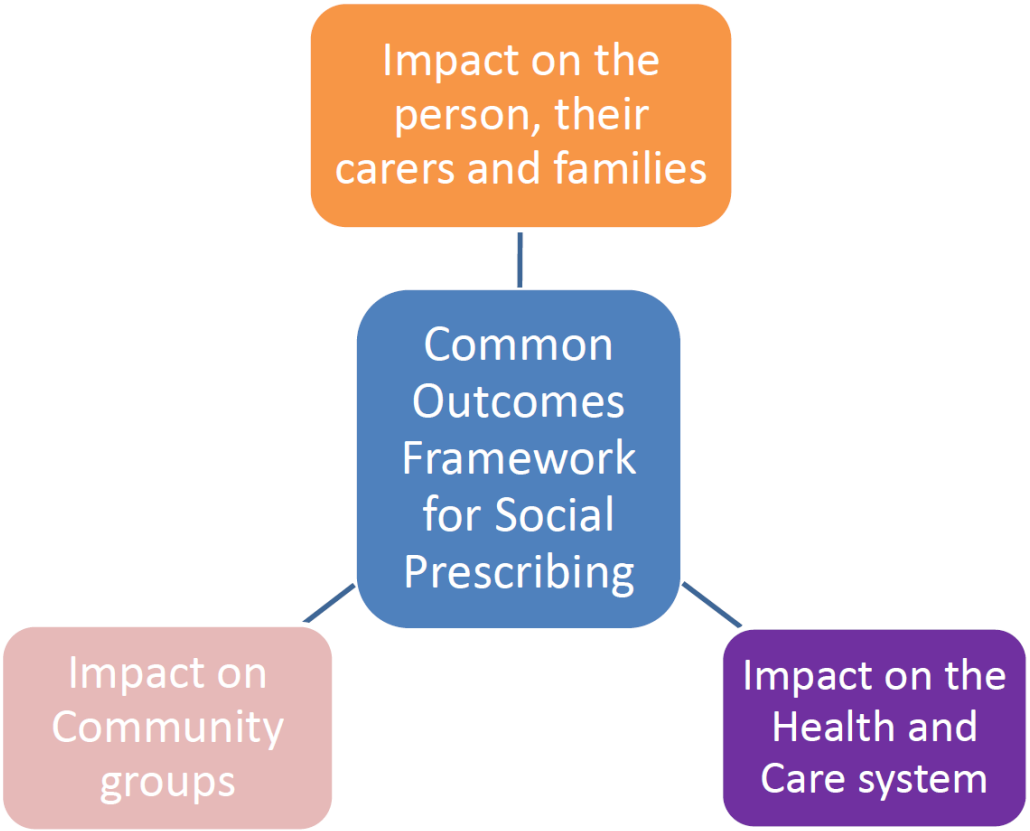
Outcomes



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Case Study

Barbara's case study

Barbara previously had cancer twice and had recently suffered a broken hip due to brittle bones (partly due to intensive radiotherapy treatment). She also suffers from cellulitis, resulting in one leg being almost twice the size of the other. This is extremely painful, heavy-feeling, and impedes her walking. Barbara currently can't get dressed by herself and has carers who come to help with her personal care.

As part of WLCCG's My Care My Way programme, Barbara's GP – with whom she has a very good relationship – initially called to ask if she wanted to be part of the Self-Care project. She was provided with a consultation with her Case Manager. They discussed various options to help with her rehabilitation and get out and about in the community to build her confidence. She recorded a PAM score with her Case Manager of 55.7 and was referred to the walking support service.

The walking support provider got in touch to arrange her weekly sessions, and also to check if she had any additional mental wellbeing needs. For the first session, they went to the end of the road and back – *'not very far'*. She had to rest at the end. For the second session, Barbara needed some shopping, so they walked a little further to the supermarket. During later sessions she was able to walk to the park and was getting further with each session. Barbara felt the service was flexible, and that her walking support worker was very nice and kind.

'I hadn't realised how difficult I would find holding on to a stick and checking both ways for traffic. I wouldn't have been confident going out alone. The worker is very patient when I need to stop and rest. I was worried she would be marching me up and down the road, but in fact she is very kind, and not over-protective.

I just want to say how nice everyone is. Not patronising at all. I'm very impressed, the attitude of all staff – they want to help so much. Everyone who I have dealt with in this service and in the special unit at St Charles has been so good' (a local integrated care hub).

Barbara's motivation and confidence for her own Self-Care improved significantly; her follow-up PAM score improved to 67.8, an increase of 12 points. She feels there is less risk of her falling and of being isolated at home. Barbara is keen to continue getting out and about, and is looking into walking to French language classes near her home.

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Benefits of Integrated Care

- Enriched **personalised** health and social care for our older residents enabling them to live independently for as long as possible.
- Strengthened services at GP practice from **additional** services in a convenient location and improved continuity of care.
- **More time** to discuss a person's (and their carer's) needs.
- Patients will be **centre** of the development of their own care plans to support their health and wellbeing.
- Break down organisational barriers as services are **coordinated** by a range of partners so their physical, environmental and mental needs are actively monitored.
- Working closing with the **third sector** to offer solutions.
- Care is safe, effective, well led and a **good experience** for patients.

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From My Care My Way to Integrated Community Team

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So far, as part of Phase 1, we have focussed on **improving integration for older adults** (65+) and has successfully developed **closer working** between:

My Care My Way + **Other Planned Care support for Older Adults** + **Urgent response for Older Adults**

- 'My Care My Way' – Case Management

- District Nursing
- Memory Assessment Service (MAS)
- Falls Service

- Community Independence Service (CIS)

Adult Social Care | Third Sector | Acute / Hospitals

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For more information

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